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

August 14, 2026

[redacted], ADMINISTRATOR/CO-OWNER
ADVANCED PERSONAL CARE HOME INC
PO BOX 5, 245 CENTER STREET
CLARKSVILLE, PA, 15322

RE: ADVANCED PERSONAL CARE HOME
245 CENTER STREET, PO BOX 5
CLARKSVILLE, PA, 15322
LICENSE/COC#: 44048

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/23/2026 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**: *ADVANCED PERSONAL CARE HOME* **License #**: *44048* **License Expiration**: *12/15/2026*

**Address**: *245 CENTER STREET, PO BOX 5, CLARKSVILLE, PA 15322*

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

## Administrator

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

## Legal Entity

**Name**: *ADVANCED PERSONAL CARE HOME INC*

**Address**: *PO BOX 5, 245 CENTER STREET, CLARKSVILLE, PA, 15322*

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

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *11/16/1992* **Issued By**: *L&I*

**Type**: *C-2 LP* **Date**: *08/10/1989* **Issued By**: *L&I*

## Staffing Hours

**Resident Support Staff**: *3* **Total Daily Staff**: *38* **Waking Staff**: *29*

## Inspection Information

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

**Reason**: *Renewal, Complaint* **Exit Conference Date**: *06/23/2026*

## Inspection Dates and Department Representative

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

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *39* **Residents Served**: *32*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents**: *0*

### Number of Residents Who:

**Receive Supplemental Security Income**: *27* **Are 60 Years of Age or Older**: *20*

**Diagnosed with Mental Illness**: *28* **Diagnosed with Intellectual Disability**: *3*

**Have Mobility Need**: *3* **Have Physical Disability**: *2*

## Inspections / Reviews

### 06/23/2026 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/09/2026*

### 07/13/2026 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *08/07/2026*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/17/2026*

## Inspections / Reviews *(continued)*

**07/20/2026 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *08/07/2026*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/31/2026*

**08/14/2026 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *08/07/2026*

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

## 16c - Written Incident Report

**1. Requirements**

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

**Description of Violation**

*On resident #1's date of death, resident #1 ceased to breathe. However, the resident's death was not reported to the Department's personal care home regional office or the Department's personal care home complaint hotline within 24 hours in a manner designated by the Department and was not reported to the Department until* [redacted]

*On resident #2's date of death, resident #1 ceased to breathe.. However, the resident's death was not reported to the Department's personal care home regional office or the Department's personal care home complaint hotline within 24 hours in a manner designated by the Department and was not reported to the Department until* [redacted]

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

*Both residents were in hospice. We were unaware that hospice resident deaths were required to be reported. Both resident #1 and resident #2 deaths were reported as soon as we became aware that they needed to be reported. Administrator* [redacted] *and administrative assistant* [redacted] *will do a review of all charts and all residents deaths to assure all deaths are reported to all required agencies in a timely manner. The review of all charts will be completed by 7-24-26. Now and in the future all residents deaths will be reported to the department PCH complaints hotline and to the department with in 24 hours. A review of all charts will be done every month by administrator and administrative assistant for 6 months and then every three months moving forward, Documentation of chart reviews will be kept. All staff will be trained on regulation by 7-30-26.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 18 - Compliance With Laws

**2. Requirements**

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

**Description of Violation**

*In accordance with the Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance." However, at approximately 11:18 a.m. there was no carbon monoxide detector located in close proximity of, but not less than 15 feet from the fossil fuel burning natural gas operated stove range top in the home's kitchen area.*

*REPEAT VIOLATION 6/26/25*

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

*A UL listed carbon monoxide detector was installed in close proximity to, but not less than 15 feet from, the natural gas stove in the kitchen on 6/24/26 by administrator. The detector was tested and found to be operational. The*

## *18 - Compliance With Laws (continued)*

*battery installation date was recorded on the battery of the carbon monoxide detector. A check of all carbon monoxide detectors and stand-alone smoke detectors will be done by Administrator and Administrative Assistant to ensure they are all in proper working order and in proper placement. Checks will be started immediately and done twice a week for three months and then once a week moving forward. Documentation will be kept.*
*All staff will be trained by Administrator, on the Care Facility Carbon Monoxide Alarms Standards Act by 7/30/26. Documentation will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ( - 08/14/2026)***

## 60a - Staff/Support Plan

**3. Requirements**

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

**Description of Violation**

*There were no qualified staff trained to pass medications present in the personal care home on numerous dates and times ranging from 5/31/26 through 6/23/26 to include:*

- *6/2/26 from 11:00 p.m. to 11:59 p.m.*
- *6/3/26 from 12:00 a.m. to 6:30 a.m.*
- *6/5/26 from 11:00 p.m. to 11:59 p.m.*
- *6/6/26 from 12:00 a.m. to 6:30 a.m.*
- *6/17/26 from 11:00 p.m. to 11:59 p.m.*
- *6/18/26 from 12:00 a.m. to 6:30 a.m.*
- *6/18/26 from 11:00 p.m. to 11:59 p.m.*
- *6/19/26 from 12:00 a.m. to 6:30 a.m.*
- *6/20/26 from 11:00 p.m. to 11:59 p.m.*
- *6/21/26 from 12:00 a.m. to 6:30 a.m.*
- *6/22/26 from 11:00 p.m. to 11:59 p.m.*
- *6/23/26 from 12:00 a.m. to 6:30 a.m.*

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

*Schedule was immediately modified by administrative assistant to assure there is at least one med tech every shift. Administrator and administrative assistant will review all schedules weekly before posting them to verify there is at least one med tech on every shift, this includes making sure all open staff shifts such as vacations and call offs are covered. Completion date is 6-24-26. A chart of schedules being checked will be kept by Administrator.*
*In the future we will attempt to have all staff med tech certified by 12-31-26.*

*Proposed Overall Completion Date: 12/31/2026*

*DIRECTED*
*Within 10 days of receipt of the plan of correction: The administrator shall ensure all steps in the plan of correction are initiated. 7/20/26*

**Directed Completion Date:** *07/30/2026*

## 60a - Staff/Support Plan *(continued)*

***Implemented ( - 08/14/2026)***

## 65f - Training Topics

**4. Requirements**

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

**Description of Violation**

*Direct care staff person A, hired , did not receive required annual training for the 2025 training year to include:*
*(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*

*Direct care staff person B, hired did not receive required annual training for the 2025 training year to include: (2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*

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

*Direct Care Staff person A and Direct Care Staff person B were trained on 7/6/26 on Instruction of meeting the needs of the residents as described in the pre-admission screening form. assessment tool, med evaluation and support plan. A review of all staff charts will be completed by Administrator and Administrative Assistant by 7/30/26 to assure all staff have all required annual trainings. Documentation of staff review will be kept. Moving forward a review of staff trainings will be completed every 3 months. Documentation of staff chart reviews will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ( - 08/14/2026)***

## 65g - Annual Training Content

**5. 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:
3. Resident rights.

**Description of Violation**

*Direct care staff person A, hired did not receive required annual training for the 2025 training year to include:*
*(3) Resident Rights*

*Direct care staff person B, hired , did not receive required annual training for the 2025 training year to include: (3) Resident Rights*

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

*Direct Care Staff person A and Direct Care Staff person B were trained on 7/6/26 on Resident Rights.*

## 65g - Annual Training Content (continued)

*A review of all staff charts will be completed by Administrator [redacted] and Administrative Assistant [redacted] by 7/30/26 to assure all staff have all required annual trainings. Documentation of staff review will be kept. Moving forward a review of staff trainings will be completed every 3 months. Documentation of staff chart reviews will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 85a - Sanitary Conditions

**6. Requirements**

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

**Description of Violation**

*At approximately 11:38 a.m. there was an unlabeled, used hairbrush that was found in the second drawer of the three-tier Sterlite drawer set in the home's shared full bathroom #2.*

*At approximately 12:08 p.m., there was a pervasive odor of urine in the home's bathroom #3 shower stall.*

*At approximately 12:55 p.m., the bathtub in the second floor bathroom #1 was dirty and had brown splatter stains of unknown origin in addition to bits of dust and other unidentifiable debris scattered across the entire tub basin.*

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

*The hairbrush was immediately removed by administrator from bathroom #2 and disposed of, the drawer was sanitized. A personal Items policy has been implemented which requires all personal items to be labeled and stored in each residents own room. Documentation of audits will be kept starting 6-24-26*
*Bathroom #2 was immediately deep c-leaned, including floors, baseboards, shower and toilets by direct care staff. A three time daily (once per shift) sanitation log and deep-clean schedule for all bathrooms has been implemented: documentation will be kept starting 6-24-26.*
*Bathroom #1 was sanitized and all debris was removed from tub by direct care staff. A bathroom Sanitation log will be added to the deep-clean schedule that will require staff to inspect, clean and sign off on bathroom cleanliness. Administrator will conduct unannounced audits twice weekly starting 6-24-26 for the next 30 days to ensure compliance. Documentation will be kept.*
*All staff will be re-trained on Regulation 85a regarding sanitary conditions by 7/30/26 by Administrator.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 85b - Infestation

**7. Requirements**

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

**Description of Violation**

*At approximately 11:24 a.m. in bathroom #2 off the home's living room area, there were as many as 12 fruit flies observed flying in the bathroom near the toilet and garbage can and there was a fly trap hanging above the toilet*

## 85b - Infestation (continued)

*that had numerous dead and living flies stuck to the trap.*

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

*The fly trap in bathroom #2 was removed immediately by administrative assistant on 6-24-26. A deep cleaning of the bathroom was done by direct care staff, focusing on the area around the toilet, interior of all drains and the base/interior of the garbage can on 6-24-26. A pest and odor check has been included in the daily bathroom sanitation log. Administrator will conduct unannounced twice weekly inspections of all bathrooms starting 6-25-26 to ensure no pest are present and that all waste receptacles are being maintained properly for the next 60 days. Documentation will be kept. All staff will be trained on regulation 2600.85.b by Administrator by 7/30/26. Documentation of training will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ( - 08/14/2026)***

## 88a - Surfaces

**8. Requirements**

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*At approximately 12:00 p.m., the floorboards in the hallway leading into the home's bathroom #3 were cracked and sinking and held together with what appeared to be two different types of black and silver tape. Additionally, the floorboards in front of the shower stall were sinking into the subfloor and dipped approximately one-inch when stepped upon.*

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

*On 6/23/26 the hallway leading to the bathroom number three and the floor area in front of the shower stall were immediately blocked off to resident traffic using highly visible safety cones and barriers to prevent injuries by administrative assistant.*
*A licensed flooring contractor was contacted to repair the damaged floorboards and compromised subfloor so they can be structurally reinforced, projected completion is 8/15/26. New compliant, slip-resistant flooring will be installed flush with the surrounding hallway to eliminate the 1-inch dip., projected completion date is 8/15/26.*
*On July 6th 2026 Administrator and Administrative Assistant conducted a 100% facility-wide sweep of all resident hallways, bathrooms, and shower stalls to check for uneven flooring, soft spots, water damage, or unapproved tape repairs. All staff will be trained on regulation 2600.88.a focusing on identifying early signs of sub-floor compromise, the immediate reporting protocol and the prohibition of makeshift fixes. Documentation of training will be kept. Administrative Assistant and Administrator will conduct physical inspections of all flooring weekly starting 6-25-26 for the first 4 weeks and then monthly for the following 5 months. Results will be documented. The results of these physical audits will be documented and corrected immediately. Documentation of all findings and repairs will be kept.*

*Proposed Overall Completion Date: 08/15/2026*

*DIRECTED*
*Within 10 days of receipt of the plan of correction: The administrator shall ensure all steps in the plan of correction are initiated. 7/20/26*

## 88a - Surfaces *(continued)*

**Directed Completion Date:** *07/30/2026*

***Implemented ( - 08/14/2026)***

## 95 - Furniture and Equipment

**9. Requirements**

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

**Description of Violation**

*At approximately 12:17 p.m., the hand sink drain in bathroom #4 that also served as the laundry room was clogged and water was unable to drain from the sink basin.*

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

*On 6/23/26 the hand sink in bathroom #4 was immediately taken out of service to prevent further overflow. A highly visible "Out of Service" sign was posted, and the sink basin was completely drained and sanitized to eliminate infection control hazards. Direct Care Staff person [redacted] inspected the plumbing line on 6/23/26. The clog was found to be from a resident disposing [redacted] snuff canteen into the sink. The clog was cleared and the drain was tested to ensure rapid, unimpeded water flow. The sink was cleaned and sterilized and then open for use once again.*
*On 6/24/26 Administrative Assistant [redacted] did a 100% facility-wide audit of all resident and common-area hand sinks, utility sinks, and laundry drainage lines to ensure proper water flow and identify any sluggish drains. Any slow-draining sinks found during the audit were immediately snaked and cleared to prevent full clogs from developing. The Preventative Maintenance program was developed and includes a bi-weekly chemical mechanical flushing of drains in high use where debris are more likely to cause blockages. Documentation of all findings and repairs will be kept.*
*All staff will be trained on Regulation 2600.95 focusing on immediate reporting of sluggish or slow-draining basins before a total blockage occurs.*
*The Administrator [redacted] or Administrative assistant [redacted] will physically test the drainage of the sink in bathroom number 4 along with random sampling of all facility sinks for 4 weeks, and monthly thereafter for 5 months. Documentation of all will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ( - 08/14/2026)***

## 100a - Exterior - Free of Hazards

**10. Requirements**

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

**Description of Violation**

*At approximately 9:00 a.m., the three concrete steps leading to the personal care home's front door, as well as the two concrete steps leading to the front door of the administrator's office building had rubber mats that were not secured to the concrete, moved when stepped upon, and created a tripping hazard for the home's residents.*

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

*The rubber mats were immediately removed from the front steps of the home and from the steps of the administrator's office to eliminate the tripping hazard.*
*A new "Grounds Safety Policy" was established. Any exterior mats must be permanently secured to the concrete*

## 100a Exterior Free of Hazards (continued)

*using approved industrial grade anchors. All staff will be re trained on identifying and reporting potential fall hazards by Administrator [redacted] by 7/30/26. Documentation will be kept.*
*A monthly Safety Walkthrough form has been implemented. Administrator [redacted] will inspect all building entryways on the 4th of every month to verify that mats are secure, and surfaces are clear of hazards. Documentation will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 101j7 - Lighting/Operable Lamp

**11. Requirements**

2600.
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 approximately 10:55 a.m. there was no operable source of light at bedside for resident #3 in resident room [redacted]*

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

*An operable lamp was immediately placed by Resident #3's bedside by administrative assistant.*
*A weekly room inspection checklist has been implemented starting 6 24 26 that will include making sure all resident rooms have all required items. Administrator will conduct random audit of these checklists starting 7 1 26 and perform physical spot checks of resident rooms bi weekly to ensure compliance. Documentation of audits will be kept.*
*All staff will be retrained on regulation 101j7 by Administrator by 7/30/26. Documentation of training will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 102k - No Common Towel

**12. Requirements**

2600.
102.k. Use of a common towel is prohibited.

**Description of Violation**

*At approximately 11:24 a.m. there were five sets of used but dry bath towels and wash clothes hanging on the wall directly across from the shower stall in bathroom #2 and none of the towels were labeled with the name of any resident.*

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

*All towels and wash cloths were immediately removed from bathroom #2 by administrative assistant on 6/23/26.*
*The daily bathroom checklist includes linen compliance verification. Administrator will do biweekly random checks starting 6 29 26 of bathrooms to assure all regulations are being followed. Documentation of random check findings will be documented and corrected immediately.*
*All staff will be trained on regulation 102k by administrator by 7/30/26. Documentation of training will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 121a Unobstructed Egress

**13. 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 12:35 p.m., the emergency exit door to the emergency exit decking from the second floor located inside of resident room #1 belonging to residents [redacted] required an excessive amount of force to open and egress was obstructed on the emergency exit pathway.*

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

*All items were cleared immediately from the exit pathway in Room #1 by administrative assistant on 6/23/26.*
*The administrative assistant sprayed the door with WD-40 on 6/23/26 and the door currently opens easily with no force.*
*A room inspection checklist was started on 6-24-26 by administrator and administrative assistant and has been implemented to include checking exit pathways and exit doors. Administrator will do bi-weekly checks for the next 90 days to assure compliance is being maintained. Documentation of findings of checklist will be kept and corrected immediately.*
*All staff will be trained on Regulation 121a by 7/30/26 by administrator. Documentation of training will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 133.3 Exit Signs Letter Size

**15. Requirements**

2600.
133.3. Exit Signs The following requirements apply for a home serving nine or more residents: Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

**Description of Violation**

*On 6/23/26 the home served 32 residents, however, the exit sign posted above the doorframe from the kitchen to the front door had exit sign letters that measured no more than 3 inches in height with principal strokes of letters that were approximately ½ inch wide. Additionally, the same exit signage was posted at the emergency exit door to the side deck and the emergency exit door to the rear deck of the home.*

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

*Non-compliant exit signs were removed immediately by administrator on 6-24-26. Regulatory exit signs were placed above all exits immediately on 6-24-26 by administrative assistant.*
*All staff will be trained on regulation 133.3 by 7/30/26 focusing on reporting anything that is not in compliance or needs repair. Documentation of training will be kept.*
*Administrator and or administrative assistant will do checks twice weekly starting 6-24-26 to assure all exit signs are in proper place and in compliance, that all letters are at least 6 inches in height and letters are at least 3/4 inches wide. Documentation of exit signs checks will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 186a - Authorized Prescriber

**16. Requirements**

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

**Description of Violation**

*Resident #7 is prescribed Novolog Flexpen Syringe, Inject per sliding scale when testing up to four times daily before meals and at bed: blood sugar: Sliding scale: 80-120=2U, 121-199=4U, 200-249=6U, 250-299=8U, 300-349=10U; >350 call MD. However, the home did not have current prescription in writing by an authorized prescriber for resident #7's Novolog Flexpen Syringe.*

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

*The residents medical record was immediately reviewed by medication supervisor on 6-24-26. A current written prescription was obtained from the authorized prescriber and placed in the residents' medical records on 6-24-26 by medication supervisor.*
*The MAR was reviewed by medication supervisor to ensure it accurately reflects the current physician's order on 6-24-26*
*An audit of all residents' mar to previous months mar and med to mar will be completed by medication supervisor and/or administrator and administrative assistant by 7-30-26 to verify each medication has current written prescriptions from an authorized prescriber. Documentation of audit will be kept and any issues will be corrected immediately. Any outdated prescriptions identified during the audit will be obtained and filed in the residents' records. A new prescription will be requested from the prescribing physician by medication supervisor when and as needed. Documentation of all audits will be kept and corrections will be made immediately.*
*The facility medication supervisor will implement a weekly audit of all medication orders, mar to previous months mar and med to mar for 4 weeks starting on 6-25-26 and then monthly to ensure current written prescriptions are maintained for every prescribed medication. A medication order checklist will be used for admission, readmission, follow up hospital returns and whenever any medication orders are received. Documentation of med to mar and mar to mar audits will be kept by medication supervisor and administrator.*
*Administrator and Medication Supervisor will re-train all Med pass certified staff on Regulation 2600.186.a focusing on the requirement of having a current, signed prescribers order prior to medication administration and how to properly audit orders during monthly MAR changes or cycle fills, and the process for securing written confirmation for telephone or verbal orders within the state-mandated timeframe by 7-30-26. Documentation of training will be kept.*

**Licensee's Proposed Overall Completion Date:** *07/30/2026*

***Implemented ([redacted] - 08/14/2026)***

## 252 - Record Content

**17. Requirements**

2600.
252. Content of Resident Records - Each resident's record must include the following information:
23. If the resident dies in the home, a copy of the official death certificate.

**Description of Violation**

*Resident #1 ceased to breath on date-of-death #1, however, there was no copy of the official death certificate in resident #1's resident record.*

## 252 - Record Content (continued)

*Resident #2 ceased to breath on date-of-death #2, however, there was no copy of the official death certificate in resident #2's resident record.*

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

*A copy of Resident #1 and Resident #2's death certificate was requested by administrative staff to their family members on 6/24/26. A follow up call to both resident #1 and Resident#2 family was made by administrator on 7/15/26 to check on status of death certificates. Resident #1 there was no answer and a message was left to please return the call. Administrator spoke with Resident #2's family, and they said they have received the death certificate and will be sending a copy to the personal care home tomorrow. Once death certificates are received, they will be immediately placed into resident charts accordingly by administrator or administrative assistant.*
*Administrator and administrative assistant will do an audit of all closed resident records to ensure they have all required documents. Documentation of all findings will be kept and corrected immediately. This will be completed by 7/31/26.*
*A resident chart checklist will be done on each resident chart by administrator and administrative assistant; this shall be completed by 8/13/26. Documentation of findings will be kept and corrected immediately. The complete audit of resident charts both open and closed will be completed by 8/13/26.*

*Proposed Overall Completion Date: 08/13/2026*

*DIRECTED*
*Within 10 days of receipt of the plan of correction: The administrator shall ensure all steps in the plan of correction are initiated. 7/20/26*

**Directed Completion Date:** *08/13/2026*

***Implemented ( - 08/14/2026)***