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

September 2, 2026

[redacted], PARTNER
CYPRESS COMMUNITIES LLC
[redacted]

RE: CYPRESS COMMUNITIES LLC
32 S. TURBOT AVENUE
MILTON, PA, 17847
LICENSE/COC#: 23280

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *CYPRESS COMMUNITIES LLC* **License #**: *23280* **License Expiration**: *05/05/2027*

Address: *32 S. TURBOT AVENUE, MILTON, PA 17847*

County: *NORTHUMBERLAND* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CYPRESS COMMUNITIES LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/02/1996* **Issued By**: *DLI*

Type: *I-1* **Date**: *11/09/2011* **Issued By**: *Borough of Milton*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *26* **Are 60 Years of Age or Older**: *20*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability**: *6*

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

Inspections / Reviews

06/24/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/26/2026*

08/06/2026 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/13/2026*

Inspections / Reviews *(continued)*

08/28/2026 POC Submission

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

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

09/02/2026 Document Submission

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

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

3c - Post Current License

1. Requirements

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

Description of Violation

At 9:05 a.m. the license inspection summary dated 4/10/25 was posted in a locked glass cabinet and not accessible to all residents and visitors of the home.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

On June 24, 2026, the Administrator immediately posted the Licensing documents and the most recent Licensing Inspection Summary in the facility's public lobby/main entrance area. The postings were placed in a conspicuous, unobstructed, and publicly accessible area visible to residents, families, visitors, and staff upon entering the home. The home reviewed and updated its Administrative Posting and Compliance Policy to ensure that whenever a new license or Licensing Inspection Summary is received from the Department, it is immediately posted in the public area, replacing the old version. The Administrator has been assigned sole responsibility for printing and posting regulatory updates, licenses, and inspection summaries within 24 hours of receipt. On June 24, 2026, the administrative staff were inserviced regarding the requirements of 2600.3(c) and instructed not to remove, cover, or obstruct required public postings. The Administrator will conduct weekly audits starting June 24, 2026, for 4 consecutive weeks, followed by monthly audits thereafter. Compliance with 2600.3(c) has been added to the home's monthly Quality Assurance/Environmental Compliance Checklist. Audit logs documenting the presence and visibility of the current license, latest LIS, and Chapter 2600 regulations will be maintained in the administrative records and made available to DHS licensing inspectors upon request. The Administrator is responsible for implementation. The completion date is 8/10/2026.
Attachment A; Photo of LIS in public location
Attachment B: Education on Regulation 2600.3(c)
Attachment C: Weekly Audits x4

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

Implemented ([redacted] - 09/02/2026)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: Upon Notification of the violation on June 24, 2026, staff member A was immediately removed from direct care duties. Resolution: High school diploma/GED/ High School Transcripts were requested and obtained on June 26, 2026 (Attachment A)
Audit of all staff files performed: 100% audit of all current direct care staff personnel files on June 24, 2026 by the Administrator and Director of Operations to verify that every employee file was compliant with Regulation 2600.54(A) (Attachment B). All other personnel files were found to be compliant with Regulation 2600.54(A) on

54a Direct Care Staff (continued)

June 26, 2026. Preventative measures put in place, effective June 25, 2026: Pre Employment checklist, standardized to ensure compliance, has been implemented. (Attachment C.) The Administrator/Director of Operations must sign off on this checklist before adding any employee to the master work schedule. Monitoring and Quality Assurance will be performed by the Administrator/Director of Operations with a 100% audit of new direct care staff files monthly for the next 6 months and quarterly thereafter as part of the facility's Quality Management Plan. First Monthly audit of staff files performed on July 25, 2026, and all complied with regulation 2600.54(A) (Attachment D)

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

Implemented ([redacted] - 09/02/2026)

65a - FS Orientation 1st Day

3. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.

Description of Violation

Staff person B, whose first day of work was [redacted] did not receive an orientation in general fire safety and emergency preparedness on or before their 1st day of work.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: Immediate corrective action: Staff member B, who lacked the required orientation before or during their first workday, was immediately, on June 25, 2026 (Attachment A), pulled from the schedule and provided with the full general fire safety and emergency preparedness orientation. Signed and dated documentation of this completed orientation including fire evacuation procedures, staff duties during fire drill/emergencies, and designated meeting places was placed directly into the staff member's personnel record on June 26, 2026. The Administrator/Director of Operations conducted a 100% direct care staff file audit on June 24, 2026 (Attachment B). Systemic Correction: Pre hire checklist with orientation to mandate that fire safety and emergency preparedness orientation is completed and signed off on before or on day 1 before providing direct resident care (Attachment C). The Administrator/Director of Operations will conduct a 100% audit of all new hire personnel records before the end of their first week of employment for the next 30 days. Following the initial audit period, compliance with regulation 2600.65(A) will be integrated into the quarterly Quality Management Plan review to ensure continued compliance.

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

Implemented ([redacted] - 09/02/2026)

65b - Rights/Abuse 40 Hours

4. 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.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B did not complete training in the required training within their first 40 scheduled hours worked.

Plan of Correction ***Accept (- 08/28/2026)***

Plan of Correction: Immediate action taken: Staff member B identified in the citation was pulled from the schedule/shift and received the completed orientation on all missing required topics under regulation 2600.65(B) on June 25, 2026. Documentation of this completed training (Attachment A) has been verified and filed in the employee's personnel record in accordance with 2600.65(j). The Administrator/Director of Operations conducted a 100% audit on June 24, 2026 (Attachment B) of all current direct care staff and ancillary staff to verify compliance. The onboarding process was updated to require that 2600.65(b) training topics be scheduled and completed within the first week (before reaching 40 hours) using a standardized new hire checklist (Attachment C). The Administrator/Director of Operations will audit 100% of all new hire personnel files weekly for 4 weeks and then monthly thereafter to ensure compliance with regulation 2600.65(B). (Attachment D). Audit findings will be reviewed during monthly Quality Management meetings.

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

Implemented (- 09/02/2026)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:28 a.m. there was a full, uncovered, unattended trash can in the activity room's shared bathroom.

Plan of Correction ***Accept (- 08/28/2026)***

Plan of Correction: On June 24, 2026 identified uncovered trash can was replaced with a trash can that had a tight-fitting lid. (Attachment A) Administrator and Director of Operations conducted a facility-wide audit of all communal bathrooms, resident rooms, and common areas to identify any regulatory deficiencies. Any deficiencies found were immediately addressed, and this first audit was done on June 24, 2026. Director of Operations and direct care staff performed weekly audits beginning June 26, 2026, for 4 weeks to ensure compliance with 2600.85(D). The final weekly audit was completed on 7-17-2026 (Attachment B). Director of Operations will be responsible for ongoing monitoring of compliance. Staff education was performed with all staff on July 6, 2026, to ensure assistance with the regulation (Attachment C). Ongoing monitoring by housekeeping and direct care staff will check all communal

85d - Trash Receptacles (continued)

bathrooms, resident rooms, and kitchens on every shift to ensure lids are closed and intact. The Director of Operations will conduct 100% monthly audits beginning in August to ensure compliance with regulation 2600.85(d) . Audit findings will be documented and added to the Quality Assurance Meetings.

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

Implemented ([redacted] - 09/02/2026)

87 - Lighting

6. Requirements

2600.
87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

At 9:25 a.m. there was no operable lighting in the stairwell leading to the basement activity room.

At 1:40 p.m. the emergency light installed above the activity area was not functioning.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: Immediate Corrective Action taken: The Administrator placed a work order on June 25, 2026, for the emergency lighting in the old pool area that was found to not be working and needed to be repaired. (Attachment A) Lighting in the stairwell was also identified as not operational on June 24, 2026. Lighting was operational on June 26, 2026, as indicated by (Attachment B and C). The Maintenance Coordinator and Administrator performed a 100% audit of all interior rooms, hallways, stairwells, ramps, evacuation routes, outside walkways, and fire escapes to ensure all fixtures were operational, adequate, and properly marked on June 26, 2026. Remediation: Any additional non-functioning bulbs, faulty fixtures, or inadequately lit exit pathways identified during the audit were repaired or replaced immediately. Mandatory staff education was performed on July 6, 2026, on reporting burnt-out bulbs or lighting outages immediately to the Director of Operations/ Maintenance supervisor or Administrator. (Attachment D) The maintenance director will conduct weekly lighting audits across all interior and exterior pathways for 4 weeks, then monthly to ensure compliance with regulation 2600.87. Results of the monthly lighting audits will be reviewed monthly during the QA committee meetings for at least 3 months to ensure continued compliance. If non-compliance is noted, immediate re-education or repair will occur, and audit frequencies will be maintained by the Maintenance Supervisor

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

Implemented ([redacted] - 09/02/2026)

88a - Surfaces

7. 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 1:30 p.m. there was a large circular piece of tile missing from the floor near the fire exit door by room 27 that

88a - Surfaces (continued)

posed a potential tripping hazard.

At 1:45 p.m. the wood landing for the exit door located in the left side sunroom was unstable, unsteady, and not securely attached to the ground.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Immediate action taken: The Administrator placed a work order on June 25, 2026(Attachment A) for the uneven surface located on the ground floor by the fire doors and the wooden landing outside of the main dining room exit to the exterior of the building. The Maintenance Director immediately repaired the wooden landing on June 25, 2026. (Attachment B). The uneven surface was repaired on June 29, 2026 (Attachment C). A full physical site walkthrough of all resident rooms, common areas, hallways, and functional spaces was conducted on June 25, 2026, by the Maintenance Supervisor and the Administrator to identify any other surfaces requiring repair, cleaning, or hazard mitigation. On July 6, 2026, all direct care staff, housekeeping, and maintenance personnel were retrained on 2600.88(a) requirements. (Attachment D) Staff were instructed on the mandatory reporting process for reporting any surface damage, cleanliness issues, or structural hazards to the Director of Operations and/or the Administrator so a maintenance request via the maintenance ticketing system can be placed within 24 hours of discovery.
The Maintenance Supervisor will conduct weekly environmental rounds for 6 weeks (Attachment E), transitioning to monthly physical plant audits. Audit results, repair logs, and completed maintenance tickets will be maintained in the facility Maintenance Operation Binder. Inspection findings will be reviewed at the facility's Quarterly Assurance Meeting

Licensee's Proposed Overall Completion Date: *08/12/2026*

Implemented ([redacted] - 09/02/2026)

91 - Telephone Numbers

8. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone installed in the common area TV room or by the telephone installed in the 2nd floor library.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of correction: On June 24, 2026, the phone in the common sitting room for the residents was found to lack the required emergency phone numbers. The phone that was noted on inspection in the library was removed from that location on June 24, 2026, as it is not an operational landline. On June 24, 2026, the Director of Operations immediately placed the phone numbers for the nearest hospital, police department, fire department, ambulance, poison control center, local emergency management, and the DHS Personal Care Home Complaint Hotline (1-877-401-8835) were printed and posted directly on or beside all designated landline phones with an outside line.

91 - Telephone Numbers (continued)

(Attachment A) The Administrator verified on June 25, 2026, that all physical extensions and telephones in staff offices. common areas, and resident areas requiring the posting are fully compliant. An audit of all telephones with outside line access throughout the facility was completed on June 25, 2026, by the Administrator to ensure that no other telephone was missing the required emergency contacts, and that any missing, damaged, or outdated postings were immediately replaced. A line item check was added for posted emergency numbers under 2600.91 to the monthly facility safety and environmental inspection checklist (Attachment B). The Administrator or Director of Operations will conduct monthly visual audits of all landline phones across the home to verify that emergency call contact sheets remain intact, legible, and accurate.

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented ([redacted] - 09/02/2026)

101j7 - Lighting/Operable Lamp

9. 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 2:00 p.m. Resident #1 did not have access to a source of light that could be turned on/off at bedside. The lamp to the left of the bed was unplugged and the nearest outlet was too far away to plug the lamp in.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of correction: Immediate action was taken on June 24, 2026. The affected bedroom listed for Resident #1 was inspected immediately, and the lamp was found to be on the left of the resident's bed, unplugged. On June 24, 2026, the Director of Operations placed the lamp on Resident #1's dresser and plugged it in to ensure it was operational. Director of Operations on June 24, 2026 verified that Resident #1 could comfortably and safely reach and operate the light from the bed. A full physical site audit was conducted of all resident rooms on 6/29/2026 to inspect all bedside lighting, outlets, switches, and bulbs by the Director of Operations and the Administrator. Any rooms that were found missing an accessible, working bedside lamp or light source were outfitted immediately on June 25, 2026 (Attachment A). Direct care staff were instructed to inspect bedside lamps during daily bed making, shift change, and report any non-functioning, missing light sources immediately to the Administrator or Director of Operations to be replaced. The Administrator initiated weekly room audits beginning July 6, 2026, for 4 weeks to ensure compliance with 2600.101 j7 and address any deficiencies. The Administrator will perform monthly random audits of at least 20% of resident bedrooms to ensure bedside lamps remain present and fully operational. First Monthly audit for compliance performed August 10, 2026 (Attachment C)

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented ([redacted] - 09/02/2026)

101r - Bedroom - shades/drapes/window covering

10. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

101r Bedroom shades/drapes/window covering *(continued)*

Description of Violation

The curtains on the window in Resident #2's room were sheer and not made of material that provided privacy to the resident.

Plan of Correction ***Accept (- 08/28/2026)***

Plan of Correction: The identified bedroom covering in Resident #2's room was immediately hung on June 25, 2026, as evidenced by (Attachment A) work order placed by the Administrator and (Attachment B) photo of appropriate curtain placed by maintenance with non sheer, privacy window covering that fully covers the entire window area when closed. On June 26, 2026, the Administrator and Facility Maintenance Director conducted a 100% facility wide audit of all resident bedroom windows to inspect window coverings for cleanliness, structural integrity, proper fit, and opacity/privacy. Any defective, torn, soiled, non private window coverings identified during the audit were replaced or repaired immediately. (Attachment C) On June 26, 2026, verbal education was provided to direct care staff regarding checking window coverings during daily routine room checks and scheduled room cleanings and reporting any findings to the Administrator or Director of Operations. The Administrator will perform weekly room audits beginning on July 3, 2026, for 4 weeks, then monthly thereafter to ensure compliance. Audit results and corrective actions will be reviewed during monthly facility Quality Assurance meetings to prevent further occurrences. The Administrator will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented (- 09/02/2026)

102k - No Common Towel

11. Requirements

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

Description of Violation

There was a used towel hanging on the shower rod in the shared bathroom of resident room #123. Three residents occupy resident room 123; towels and washcloths hanging on two separate towel bars were not labeled to indicate to whom the towels and washcloths belonged.

Plan of Correction ***Accept (- 08/28/2026)***

Plan of Correction: Immediate Corrective Action taken on June 24, 2026. The common towel identified during the inspection was immediately removed from the specified bathroom by the Director of Operations. Individual name tags were placed on the wall above the towel rods (Attachment A). Residents were educated on placing their personal towels on the towel rods with their names. The Administrator and Director of Operations, on June 25, 2026, conducted an immediate 100% audit of all resident, communal, and visitor bathrooms throughout the facility to ensure that no other common towels were in use. All towel rods in resident rooms were labeled with individual names, and all common bathrooms had single use paper towels available. Mandatory staff re education on July 6, 2026, by the Director of Operations was conducted in accordance with regulation 2600.102(k) (Attachment C). Training covered the strict prohibition of common towels, proper placement and stocking of towels in bathrooms, and infection control protocols regarding shared linens. The Director of Operations will conduct 4 weekly audits starting July 6, 2026(Attachment B), then monthly to ensure continued compliance. Audit results will be reviewed by the Administrator, who will address any corrective actions that need to be implemented for compliance.

Licensee's Proposed Overall Completion Date: *08/12/2026*

Implemented (- 09/02/2026)

103e - Left Overs

12. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 1:00 p.m. there was an unlabeled, undated slice of apple pie and an unlabeled, undated plastic container of salad dressing in the home's refrigerator.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of correction: Director of Operations on June 24, 2026, immediately discarded the identified unlabeled and undated items found during inspection and audited the storage, refrigerators, and freezers for any further identifiable issues. A comprehensive audit of all dietary storage areas (refrigerators, walk-in coolers, freezers, and dry storage was conducted by the Director of Operations and Administrator to ensure all stored food items were properly packaged, labeled with the item name and date prepared/date opened, and use by date on June 25, 2026. The Director of Operations conducted a daily audit for 7 days to ensure compliance with regulation 2600.103 e (attachment A) Director of Operations performed weekly audits starting on July 7, 2026, for 4 weeks (attachment B), completed on July 28, 2026. Director of Operations also conducted staff education on regulations 2600.103(e) and 103(g) on July 6, 2026 (attachment C). The Director of Operations will conduct unannounced audits of food storage areas for a period of 3 months, transitioning to monthly audits thereafter. Audit findings will be reviewed during monthly Quality assurance meetings to ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented ([redacted] - 09/02/2026)

103g - Storing Food

13. Requirements

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

Description of Violation

At 1:05 p.m. a bag of frozen breadsticks was opened and unsealed in freezer #1 located in the main kitchen.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: Immediately upon discovery, all unsealed or open food items identified during the inspection were either properly transferred into airtight food-grade sealed containers or discarded if contamination was suspected on June 24, 2026. Director of Operations conducted a mandatory training session for all kitchen, dietary, and direct care staff who assist with meals or food handling on proper storage procedures, emphasizing 2600.103 (g). Training focused on ensuring all food items in dry storage, refrigerators, and freezers are stored in closed or sealed containers at all times. (Attachment C) Completed on July 6, 2026. Director of Operations conducted a 7-day daily audit of the kitchen for compliance (Attachment A) completed on July 5, 2026. Director of Operations conducted a weekly audit beginning July 7, 2026, and it was completed July 28, 2026 (Attachment B). The Administrator will conduct weekly unscheduled audits of food storage facilities for 30 days, then transition to monthly routine audits thereafter to ensure ongoing compliance. Any instances of unsealed food discovered during internal checks will result in immediate re-sealing/disposal and one-on-one retraining of responsible staff by the Director of Operations.

Licensee's Proposed Overall Completion Date: *08/11/2026*

103g Storing Food *(continued)*

Implemented ([redacted] - 09/02/2026)

107c Food/Water 3 Day Supply

14. Requirements

2600.
107.c. The home shall maintain at least a 3 day supply of nonperishable food and drinking water for residents.

Description of Violation

On 6/24/26, the home served 28 residents, requiring 84 gallons of emergency drinking water. However, the home had only 30 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of correction: On June 24, 2026, the Administrator obtained an adequate supply of water to hydrate 26 residents for a minimum of 3 days (calculating at least 1 gallon of water per person per day for 3 days). On June 25, 2026, the Administrator physically audited, verified, and documented the amount of water in the Emergency Food and Water Inventory Log. Photo of water supply (Attachment A)
A comprehensive audit of all emergency response supplies and storage areas was conducted on June 25, 2026, by the Administrator to ensure no other supply deficits exist. The home updated its baseline calculation standard for emergency water reserves based on current licensed capacity and total resident census. On this date of August 11, 2026, the facility has a total of 96 gallons of water in the emergency water supply location. A par level and expiration tracking log has been put in place in the designated emergency supply storage that will be audited by the Director of Operations bi-weekly (Attachment B) Dietary Manager will be responsible for ongoing compliance and monitoring and reporting any variences/deficiencies to the Administrator.

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented ([redacted] - 09/02/2026)

130f Testing Smoke Detectors

15. Requirements

2600.
130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

Description of Violation

The home's smoke detectors and fire alarms were not tested during the month May 2026.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: Action taken on June 30, 2026: The Administrator conducted a fire drill, and the Maintenance Supervisor tested all smoke detectors throughout the facility to ensure full operability (Attachment A: Compliance Attestation)

The results of the drill were recorded on the designated Monthly Fire Safety and Smoke Detector Log. The Administrator conducted another fire drill on July 24, 2026. The Maintenance Director tested all smoke detectors throughout the facility for full operability. The Maintenance Director has been assigned primary responsibility for conducting and documenting tests on all smoke detectors during the monthly fire drills. Monthly Smoke Detector Testing Logs will be kept with the Fire Alarm Testing Log, which will include the date and time of testing, operability status (pass/fail), action taken if repairs or battery replacements are needed, a tape with the replacement date will

130f Testing Smoke Detectors (continued)

be applied to the smoke detector, and signature. The administrator will conduct a monthly audit of the Smoke Detector Log by the end of every month to verify that testing was completed and documented. Completed logs will be maintained in the facility's Fire Safety Binder for a minimum of 3 years and will be readily available for review during state licensing inspections. If a smoke detector is found to be inoperable during testing, immediate repair/replacement will occur within 48 hours in accordance with 2600.130(g), and interim safety measures will be implemented per facility emergency procedures.

Licensee's Proposed Overall Completion Date: *08/13/2026*

Implemented ([redacted] - 09/02/2026)

132a - Monthly Fire Drill

16. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of May 2026.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of correction: An unannounced fire drill was held on June 30, 2026, following the discovery of the missing monthly drill. Another unannounced fire drill was held on July 24, 2026, to ensure compliance with regulation 2600.132 (c) (Attachment A). The fire drill record was completed in full compliance, including date, time, evacuation, duration, exit route, number of residents/staff, problems encountered, and alarm activation, and was placed in the facility's fire safety logbook. The administrator established a recurring monthly fire drill schedule to ensure an unannounced drill is planned and executed for every calendar month. To maintain compliance with overall fire safety rules, the schedule accounts for rotating days of the week, times of day, sleeping hours (once every 6 months), and alternate exit routes. (Attachment B). The Administrator will conduct a monthly audit of the fire safety log on the last calendar day of each month to verify that an unannounced fire drill was held and properly logged for the month. Fire drill compliance logs will be submitted to the Quality Assurance Committee by the Administrator for review for a minimum of 6 months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented ([redacted] - 09/02/2026)

141a - Medical Evaluation

17. 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 #1 was admitted to the home on [redacted] The home did not obtain an initial medical evaluation for Resident #1.

Resident #2 was admitted to the home on [redacted] The home did not obtain an initial medical evaluation for

141a - Medical Evaluation (continued)

Resident #2.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: The Administrator immediately contacted Resident #1 and Resident #2's Primary Care Provider for citation 2600.141a. On June 24, 2026, an updated, fully completed, signed, and dated Medical Evaluation form was obtained for Resident #1 and Resident #2 on June 26, 2026 (Attachment A) and placed in the active resident record. A 100% audit of all current resident files was conducted by The administrator and Director of Operations on June 26, 2026, to ensure all active residents have a compliant, fully completed medical evaluation on file. Any incomplete forms were flagged for immediate physician completion. The admission intake protocols were reviewed and updated to include a new resident move-in checklist (Attachment B) that will be completed by the Director of Operations within 72 hours of an admission to ensure compliance. The Administrator will conduct a monthly audit on 100% of new admissions records for 6 months and quarterly thereafter to verify complete and timely medical evaluations. Audit findings will be reviewed during the Monthly Quality Assurance committee meetings to maintain sustained compliance.

Licensee's Proposed Overall Completion Date: *08/11/2026*

Implemented ([redacted] - 09/02/2026)

187b - Date/Time of Medication Admin.

18. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #3 is prescribed Acetaminophen 325 mg tablet. Resident #3's medication administration record does not include the initials of the staff person who administered the Acetaminophen 325 mg tablet on 6/14/26 at 12:00 a.m.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: On June 24, 2026, when the surveyor found a deficiency for Resident #3, the Administrator contacted the med tech who worked the shift regarding missing documentation and verified that the medication was administered and the med tech did not document the administration. On June 24, 2026, medication administration was documented for the medication and verified by the Administrator. An immediate systemic audit of 100% of current MARS was conducted on June 25, 2026, by the Administrator and Director of Operations to ensure all required fields under 2600.187 were completed and verified for accuracy(Attachment A). On June 26, 2026, all med pass-trained staff and supervisory personnel completed mandatory re-education on 2600.187(b) MAR documentation protocols (Attachment B) and the 10 Rights of Medication Administration. (Attachment C) The Director of Operations will perform a monthly audit of all resident MARS for 3 months to maintain ongoing compliance. (Attachment D) Omissions or discrepancies will be corrected immediately and reviewed during internal quality assurance meetings.

Licensee's Proposed Overall Completion Date: *08/13/2026*

Implemented ([redacted] - 09/02/2026)

227g -Support Plan Signatures

20. Requirements

2600.

227g -Support Plan Signatures *(continued)*

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

Description of Violation

The assessment dated [redacted] for Resident #1 was not signed by the assessor.

Plan of Correction ***Accept ([redacted] - 08/28/2026)***

Plan of Correction: Resident #1's care plan was identified during inspection as not being signed by the Administrator. Immediately on June 24, 2026, the Administrator signed Resident #1's support plan. On June 25, 2026, the Administrator and Director of Operations conducted a 100% audit of all current resident Assessment and Support Plans to ensure that all support plans contain valid, dated signatures from both staff and resident. The Administrator and Director of Operations were re-educated on regulation 2600.227(g) on June 26, 2026, to ensure compliance. (Attachment A). The Administrator established a procedure to ensure future support plans are fully signed before placing them in resident charts on June 26, 2026 (Attachment B). Implementation of the following: Support plans will not be considered finalized or filed until all required signatures)staff, resident, and/or legal representative) are present. If a resident or representative is unable or refuses to sign, staff will document the refusal or reason for the missing signature directly on the support plan in accordance with 2600.227(b) Director of Operations will audit 100% of all newly completed or annually revised support plans before filing for the next 90 days. Quarterly random audits of 20% of resident charts will be conducted to ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *08/12/2026*

Implemented ([redacted] - 09/02/2026)