



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MORAVIAN MANORS INC**

LEGAL ENTITY

To operate **MORAVIAN MANOR**

NAME OF FACILITY OR AGENCY

Located at **300 WEST LEMON STREET, LITITZ, PA 17543**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **40**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 21, 2026** until **February 21, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333091**

[Signature]
ISSUING OFFICER

[Signature]
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628P – 04/23



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 9, 2026

Moravian Manors, Inc.
[REDACTED]

RE: Moravian Manor
License/COC #: 333091

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on April 2, 2026, April 3, 2026 and June 25, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2800 (relating to Assisted Living Residences), the Department hereby REVOKES your certificate of compliance License #33309 dated January 1, 2026 until January 1, 2027 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from AUGUST 21, 2026 to FEBRUARY 21, 2027.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2800 (relating to Assisted Living Residences) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 30 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

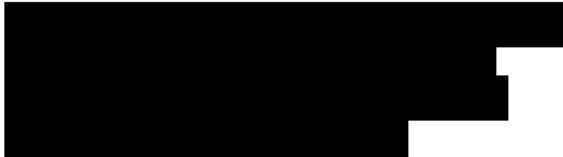
Sincerely,

A handwritten signature in cursive script that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: MORAVIAN MANOR **License #:** 33309 **License Expiration:** 01/01/2027
Address: 300 WEST LEMON STREET, LITITZ, PA 17543
County: LANCASTER **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MORAVIAN MANORS INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: R 4 **Date:** 09/13/2017 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 29 **Waking Staff:** 22

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 04/03/2026

Inspection Dates and Department Representative

04/02/2026 On Site: [REDACTED]
04/03/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 40 **Residents Served:** 28

Special Care Unit

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

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 28
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 1 **Have Physical Disability:** 0

Inspections / Reviews

04/02/2026 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 05/09/2026

05/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/17/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 05/21/2026

05/22/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/17/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 06/16/2026

07/17/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/17/2026

Reviewer: [REDACTED]

Follow Up Type: Enforcement

25a Resident - residence contract

1. Requirements

2800.

25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident [REDACTED] was admitted on [REDACTED]. However, the contract was not signed by the resident until [REDACTED].

Resident [REDACTED] was admitted on [REDACTED]. However, the contract was not signed by the resident until [REDACTED].

Plan of Correction

Accepted [REDACTED] - 05/14/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/clinical coordinator/Admission Director to update the admission checklist so it states contract must be signed within 24 hours of admission.

To enhance the currently compliant operations, on 05/11/2026 the Admission Director will make sure all contracts are signed within 24 hours of admission and mark off on the checklist that it is completed, with a completion date of when contract was signed.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform daily audits on the day after the admission to make sure contract complete, through 12/28/2026 to maintain ongoing compliance with putting in place a written resident-residence contract between the resident and the residence, prior to admission, or within 24 hours after admission, and completing the contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 05/14/2026

Implemented [REDACTED] 07/17/2026)

26b Quality management plan content

2. Requirements

2800.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management reviews dated completed [REDACTED] through [REDACTED] and [REDACTED] through [REDACTED] did not address reportable incident and condition reporting procedures, complaint procedures, staff person training and resident or family councils.

Plan of Correction

Accepted [REDACTED] - 05/22/2026)

26b Quality management plan content (continued)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/13/2026 by the Administrator to update the QAPI report to include reportable incident and condition reporting procedures, complaint procedures, staff person training and resident or family councils.

To enhance the currently compliant operations, on 04/13/2026 the Administrator will make sure that the QAPI report stay current and includes all required information, with a completion date of 05/25/2026.

Effective 05/11/2026 the Administrator will perform monthly audits of on going monthly to make sure it is current and up to date before monthly meeting, through 06/29/2026 to maintain ongoing compliance with ensuring the quality management plan addresses the periodic review and evaluation of all required information to be reported on. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Clinical Coordinator was educated on 4/30/2026, given copy of Regulation(Pink Book) and attended QAPI meeting. QAPI report was updated 4/30/2026 review was completed and any data missing from Jan/Feb/March and April were updated.

Licensee's Proposed Overall Completion Date: 05/25/2026

Not Implemented [REDACTED] 07/17/2026)

51 Criminal background checks

3. Requirements

2800.

51.a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51.b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Staff Member's A's date of hire was [REDACTED]. However, a criminal record check was not completed.

Plan of Correction

Directed [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Director of Human Resources/Compliance Officer , verifying that Policy was updated 2025.

To enhance the currently compliant operations, on 05/11/2026 the Director of HR/Compliance Officer will monitor for compliance on the Criminal Background checks and that they are completed in the appropriate time frame, with a completion date of 06/29/2026.

51 Criminal background checks (continued)

Effective 05/11/2026 the Director of HR/Compliance Officer will perform monthly Audits of on going process, through 06/29/2026 to maintain ongoing compliance with ensuring criminal history checks and hiring policies are in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults), and ensuring the hiring policies are in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Will be completed on 5/22/26 by [REDACTED] -HR

Audit to be completed by 6/5/26, by HR

Monthly audits of new hires to make sure criminal backgrounds were completed.

(Directed)

In addition to the above plan of correction:

- A background check will be completed for Staff Member A by 6/5/26.
- An initial audit will be completed on all current staff records to ensure each staff member has the appropriate background check(s) completed by 6/5/26.
Beginning 6/1/26, monthly audits of all new hires will be completed to ensure background checks have been completed and filed in the staff member's record.
- Documentation of completed audits and background checks will be kept by the home and available for review by the Department.

Directed Completion Date: 06/05/2026

Implemented [REDACTED] - 07/17/2026)

65h 16 hrs annual training

4. Requirements

2800.

65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Staff Member B received zero hours of annual training relating to [REDACTED] job duties during the 2025 training year.

Plan of Correction

Directed [REDACTED] - 05/22/2026)

See attached. In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Designee to create a quick reference for all required training and associated documents. Staff Member B is Agency CNA and will receive the training on the attached form.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform monthly audits, as this will be an going process with new hires monthly, through 12/28/2026 to maintain ongoing compliance with ensuring direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers are trained annually in, including fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, or videos prepared by a fire safety expert and accompanied by an onsite staff person trained by a fire safety expert, and

65h 16 hrs annual training (continued)

emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), and falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable. They will then complete the online training. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Confirming with staff member B's agency for total hours of training and once confirmed will provide the training required by 6/12/26. Audit of all staff trainings will be completed by 6/12/25 and any additional training hours will be completed by 6/26/26

(Directed)

In addition to the above plan of corrections:

- An audit of all other staff training records will be completed to ensure each staff, as applicable, received annual training in accordance with 2800.65(h). All missed hours will be completed no later than 6/12/26 for training year 2025.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 06/12/2026

Not Implemented - 07/17/2026)

65i Training topics**5. Requirements**

2800.

65.i. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia, cognitive and neurological impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Assisted living service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

Description of Violation

Staff Member B did not receive training on the following topics during the 2025 training year:

1. Medication self administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia, cognitive and neurological impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Assisted living service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

65i Training topics (continued)

Plan of Correction

Directed [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Designee to create a quick reference for all required training and associated documents.

To enhance the currently compliant operations, on 05/11/2026 the Designee will orient staff with checklist and initial with them that all areas have been reviewed on their first shift, with a completion date of 12/28/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform monthly audits, as this will be an ongoing process with new hires monthly, through 12/28/2026 to maintain ongoing compliance with ensuring direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers are trained annually in, including fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, or videos prepared by a fire safety expert and accompanied by an onsite staff person trained by a fire safety expert, and emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable. They will then complete the online training. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Staff Member B is an agency CNA, not Moravian staff, and will receive the training that agency staff receive.

Confirming with staff member B's agency for total hours of training and once confirmed will provide the training required by 6/12/26. Audit of all staff trainings will be completed by 6/12/25 and any additional training hours will be completed by 6/26/26

(Directed)

In addition to the above plan of correction:

- Staff Member B will receive education in the topics identified in the violation by 6/12/26.
- An audit of all other staff training records will be completed to ensure each staff, as applicable, received annual training in accordance with 2800.65(i) by 6/5/26. Any staff found to have not received education in the required topics will receive education in the topic by 6/12/26.
- Documentation of staff education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 06/12/2026

Not Implemented [REDACTED] 07/17/2026)

65j Annual training content

6. Requirements

2800.

65.j. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.

65j Annual training content (*continued*)

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff members A, C, and D did not receive training in fire safety during the 2025 training year.

Staff Member B did not receive training on the following topics during the 2025 training year:

- 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.*
- 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- 3. Resident rights.*
- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).*
- 5. Falls and accident prevention.*
- 6. New population groups that are being served at the home that were not previously served, if applicable.*

Plan of Correction

Directed [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/18/2026 by the Administrator/Clinical Coordinator to monitor to make sure that all staff complete their mandatory training in 2026.

To enhance the currently compliant operations, on 05/25/2026 the Administrator/clinical coordinator will monitor for completion of mandatory training and give reminders for completion, with a completion date of 12/31/2026.

Effective June 1, 2026 the Administrator/Clinical Coordinator will perform monthly audits of on going process, through 12/31/2026 to maintain ongoing compliance with ensure direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers are trained annually in , including 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, and emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights, and The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708), and falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Fire Safety training will be provided to Staff members A, B, C, D by 6/12/26, and an audit of trainings will be completed by 6/5/26 and any deficiencies will be brought into compliance by 6/12/26.

(Directed)

In addition to the above plan of correction:

- Staff Member B will receive education in Emergency preparedness procedures and recognition and response to crises and emergency situations, Resident rights, The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708), Falls and accident prevention, and New population groups that are being served at the home that were not previously served, if applicable. Education to be completed by 6/12/26.*

65j Annual training content (continued)

- An audit of all other staff member training records will be completed to ensure all other staff received education in accordance with 2800.65(j). Any training areas identified to be missing for additional staff members will be completed by 6/12/26.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 06/12/2026

Not Implemented [REDACTED] - 07/17/2026)

69 Dementia training**7. Requirements**

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff Member A, date of hire [REDACTED], received only 1.5 hours of dementia specific training during the 2025 training year.

Staff Member B, date of hire [REDACTED], received zero hours of dementia specific training during the 2025 training year.

Staff member D, date of hire [REDACTED] received only 1.5 hours of dementia specific training during the 2025 training year.

Staff Member E, date of hire [REDACTED], received only 1.25 hours of dementia specific training within 30 days of hire.

Plan of Correction

Directed [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/18/2026 by the Administrator/Clinical Educator had meet Clinical Educator in March 2026 to review trainings an added some trainings that had been removed from some staff. Will be meeting with Clinical Educator to make sure changes were made for current training year.

To enhance the currently compliant operations, on 05/18/2026 the Administrator/Clinical Educator will meet to verify current trainings are in compliance. They will meet again beginning of December of current year to make sure all training hours meet compliance for the next training year. Will also confirm that current years training are within compliance, with a completion date of 05/25/2026.

Effective 05/18/2026 the Administrator/Clinical Educator will perform annual reviews of review trainings annually, through 12/14/2026 to maintain ongoing compliance with ensuring administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 4 hours of dementia specific training within 30 days of hire and at least 2 hours of dementia specific training annually thereafter in addition to the training requirements of this chapter. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

69 Dementia training (continued)

Audit to be completed by 6/5/26 and any deficiencies found will be corrected by 6/12/26.

New hire audits to be completed within 2 days of orientation to firm that 4 hour Dementia training was completed.

(Directed)

In addition to the above plan of correction:

- Staff Members A, B, D and E will receive missing hours of education completed by 6/12/26 for training year 2025. These training hours will be completed in addition to the required 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually for training year 2026.*
- Beginning no later than 6/1/26, new hire audits will be completed within 2 days of orientation to ensure at least 4 hours of dementia-specific training is completed within 30 days of hire.*
- Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: 06/12/2026

Not Implemented - 07/17/2026)

81b Resident equip – good repair**8. Requirements**

2800.

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

An uncovered enabler bar is affixed to Resident's bed. The opening of this device measures 16 inches by 13 inches and shifts laterally 6 inches when pressure is applied, posing a potential safety hazard.

The toilet grab bars in Resident's bathroom are not secure. When pressure is applied the left handle shifts laterally 3 inches, the right handle shifts laterally 4 inches, and the device tilts backwards 5 inches lifting from the floor posing a safety hazard.

Plan of Correction

Accept - 05/22/2026)

In response to the violation on by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 06/01/2026 by the Administrator/Clinical Coordinator to first Monday of every month inspections will be done of any toilet grab bars and bed enablers to ensure they are secure and are properly covered.

To enhance the currently compliant operations, on 06/01/2026 the Administrator/Clinical Coordinator will will preform monthly inspections of medical equipment such as enablers and toilet grab bars to make sure they are properly attached, covered and not in need of repair, with a completion date of 01/04/2027.

Effective 06/01/2026 the Administrator/Clinical coordinator will perform monthly inspections of ongoing process, through 01/04/2027 to maintain ongoing compliance with ensuring wheelchairs, walkers, prosthetic devices and other apparatus used by residents are clean, in good repair and free of hazards. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Initial audit was completed on 5/18/26 by clinical coordinator. On 4/3/26 bed enabler covers were ordered and placed on 4/7/26 and Maintenance also tightened grab bars in Resident#4 bathroom on 4/7/26.

81b Resident equip – good repair (continued)

Audits will be monthly on all bed enablers to make sure they are secure, safe, good condition and have a cover on them for injury prevention.

Education provided to staff on 5/8/26 on bed enablers and the need for the covers and to report any unsafe conditions, such as sharp edges, not covered, loose enabler or unfastened enabler. Toilet grab bars and reporting loose/wobbly bars, that lift off the floor, sharp edges, broken arm rests or skis/foot rests.

Licensee's Proposed Overall Completion Date: 06/01/2026

Not Implemented [REDACTED] 07/17/2026)

101h Door lock**9. Requirements**

2800.

101.h. Each living unit must have a door with a lock, except where a lock in a unit under a special care designation would pose a risk or be unsafe. The administrator shall maintain a master key that can open all locks in the event of an emergency.

Description of Violation

Resident [REDACTED]'s bedroom door is unable to be unlocked with the key provided to the resident. The home does not have a master key that can open Resident [REDACTED] door in the event of an emergency as the key copy maintained by the home does not unlock Resident [REDACTED]'s door.

Plan of Correction

Accept [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/03/2026 by the Administrator/Maintenance to to replace the door knob to the residents room.

To enhance the currently compliant operations, on 04/03/2026 the Maintenance will removed the door knob and replaced with a new one, with a completion date of 04/03/2026.

Effective 04/03/2026 the Administrator will perform monthly checks of will follow up on concerns/issues and have Maintenance checking right away, through 12/31/2026 to maintain ongoing compliance with ensuring each living unit has a door with a lock, except where a lock in a unit under a special care designation would pose a risk or be unsafe, and the administrator maintains a master key that can open all locks in the event of an emergency. All staff/agency on shift and administrator have a master key to get into resident rooms. This is our common practice and has been. We will continue to follow up on door issues and make sure their key works properly. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

New door knob does in fact lock and resident was provided with key on 4/3/26 when door knob was replaced. Staff made sure master key worked in new door knob as well and it did.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [REDACTED] 07/17/2026)

103e Leftovers

10. Requirements

2800.

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

On [REDACTED] at 11:42 AM, a clear plastic container of leftover chili was unlabeled and undated in the refrigerator located in the first-floor kitchenette.

The following leftover items were observed on [REDACTED] at 11:49 AM, unlabeled and undated in the refrigerator/freezer of the second-floor kitchenette:

- a plastic container containing a brownie
- a plastic container of spaghetti

Plan of Correction

Accept [REDACTED] 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/10/2026 by the Night shift to have night shift dispose of anything in the refrigerator/freezers that is not labeled with name and date.

To enhance the currently compliant operations, on 05/11/2026 the Night Shift Staff will will dispose of any food that is not labeled or dated, when they are doing the refrigerator/freezer temp checks at night, with a completion date of 05/12/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform weekly audits of on going process, through [] to maintain ongoing compliance with ensuring food served and returned from an individual's plate is not be served again or used in the preparation of other dishes, and leftover food is labeled and dated. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Staff were educated on labeling any food in the refrigerator with name and date and anything not labeled will be discarded on 11-7 shift nightly. Residents will be educated on 5/28/26 at resident council meeting, that anything they put in the common area refrigerator need to be labeled with date and name and if it is not it will be discarded. Weekly audits is checking the refrigerators once a week on different shifts for compliance.

Licensee's Proposed Overall Completion Date: 05/21/2026

Not Implemented ([REDACTED] - 07/17/2026)

107d Procedure EMA submission

11. Requirements

107d Procedure EMA submission (*continued*)

2800.

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

Description of Violation

The residence's written emergency procedures were not sent to the local emergency management agency in 2025.

Plan of Correction**Accept (CR - 05/22/2026)**

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

on 05/01/2026 by the Administrator to on 5/1/2026 administrator added a recurring calendar appointment to to calendars of the Administrator, Director of Health and Wellness, for January 1st every year going forward, to remind them to send the Emergency Procedures binder to the EMA.

on 05/01/2026 by the Administrator to Recurring reminder on calendar of Administrator, Maintenance Director and Director of Health and Wellness for January 1st every year starting January1, 2027. This is in place to remind them to send the Emergency Procedures to the Emergency Management Agency for approval.

To enhance the currently compliant operations, on 01/01/2027 the Designated staff will The designated staff member will sign off on the log when they sent it to EMA and when it was returned from EMA. They will initial and date each time, with a completion date of 01/08/2027.

Effective 01/01/2027 the Administrator, Director of Health and Wellness, Maintenance Director will perform annual audits of to be done the first of every year and is ongoing., through 01/31/2027 to maintain ongoing compliance with reviewing, updating and submitting annually, to the local emergency management agency, written emergency procedures. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

5/1/26 Administrator educated Director of Health and Wellness and Director of Maintenance of Procedure to review Emergency Plans in November and once review is completed, by January 1st, the EMA will be contacted to review the Emergency Plan. This log for review will be kept in the front of the Emergency plan so it can be initialed and dated when complete.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented ([REDACTED] 07/17/2026)

123b Emerg. procedures posted

12. Requirements

2800.

123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

On [REDACTED] and [REDACTED], the residence's emergency procedures were not posted in a conspicuous and public place in the residence.

Plan of Correction**Accept [REDACTED] - 05/22/2026)**

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/03/2026 by the Administrator to posted the Emergency Procedure Binder in the common room by the sign out book.

123b Emerg. procedures posted (continued)

To enhance the currently compliant operations, on 04/10/2026 the Adminsitrator will will check weekly for the placement of the Emergency Procedure Binder, with a completion date of 04/10/2026.

Effective 05/08/2026 the Administrator will perform weekly audits of ongoing process of weekly checks, through [] to maintain ongoing compliance with copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) being posted in a conspicuous and public place in the residence and a copy must be kept. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Staff were updated on the regulation binder location and the need for the common area, on 4/7/26. Administrator is doing weekly checks to make sure the binder is still in the common area, by sign out/in book. This is the ongoing process, to make sure the binder remains there.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented () - 07/17/2026)

132e Fire drill - sleeping hours**14. Requirements**

2800.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

A fire drill was conducted during sleeping hours on [] The next fire drill conducted during sleeping hours was not completed until []

Plan of Correction

Accept () - 05/22/2026)

In response to the violation on [] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

on 05/05/2026 by the Administrator to In response to the violation on [] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 5/5/2026 by the Administrator to to educate the Director of Facility Operations on the regulation of sleeping hour drills, and that sleeping drills must be schedule every 6 moths.

Director of Facility Operations schedules the fire drill, they and the Maintenance Director and Administrator will schedule drills together to make sure dates are in compliance of regulations, with a completion date of 11/30/2026. Effective 05/05/2026 the Administrator will perform annual reviews of reviewed annually and as needed to make sure compliance is met, through 09/30/2026 to maintain ongoing compliance with Holding a fire drill during sleeping hours once every 6 months will be reviewed annually and as needed to make sure drills are completed every 6 months. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Next sleeping fire drill is scheduled for 9/24/26

Licensee's Proposed Overall Completion Date: 05/22/2026

Implemented () - 07/17/2026)

132e Fire drill - sleeping hours (*continued*)

141a Medical evaluation

15. Requirements

2800.

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. The evaluation must include the following:

2. Medical diagnosis including physical or mental disabilities of the resident, if any.

Description of Violation

Resident [REDACTED]'s medical evaluation, dated [REDACTED] does not indicate if the information on the form was generated based on the physician's evaluation, if the resident requires assistance or supervision with ADLs/IADLs, or if the resident's needs can be met safely at the Assisted Living Residence.

Plan of Correction**Directed [REDACTED] - 05/22/2026)**

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Administrator/Clinical Coordinator to Created an Admission checklist for the admission process from beginning to end. Listing the ADME as the first item on list.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will ensure that all documents are collected before the admission can be completed. Goal is to have the ADME completed no more than 30 days before admission, with a completion date of 05/18/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform weekly audits of on going weekly audit to make sure we are in compliance, through 12/28/2026 to maintain ongoing compliance with ensuring each resident has 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. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Medical evaluations are currently being audited and will be completed by 6/12/26 by Clinical Coordinator and RN. Any non compliant evaluations will be completed by 6/12/26 and Clinical Coordinator and RN were educated 5/8/26. Before medical evaluation is filed in chart it will be checked by Clinical Coordinator/Administrator for completion of all information.

(Directed)

In addition to the above plan of correction:

- Resident [REDACTED] medical evaluation will be updated by 6/12/26 to ensure the form was generated based on the physician's evaluation, if the resident requires assistance or supervision with ADLs/IADLs, or if the resident's needs can be met safely at the Assisted Living Residence.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 06/12/2026**Implemented [REDACTED] - 07/17/2026)**

141b1 Annual medical evaluation

16. Requirements

2800.

141.b. A resident shall have a medical evaluation:

1. At least annually.

Description of Violation

Resident [REDACTED] medical evaluation, dated [REDACTED] does not indicate that a tuberculin skin test has been administered with negative results within 2 years as this area was left blank. Resident [REDACTED]'s tuberculin test was last administered on [REDACTED] and the results of this test remain pending.

Resident [REDACTED] medical evaluation, completed [REDACTED] does not indicate the resident's ability to self-administer medications or the resident's cognitive functioning needs, as these areas are blank. Additionally, the document does not indicate if the form was signed by a physician, physician assistant, or certified registered nurse practitioner whose license is in good standing, if the information on the form was generated based on the physician's evaluation, if the resident requires assistance or supervision with ADLs/IADLs, or if the resident's needs can be met safely at the Assisted Living Residence.

Plan of Correction

Accept [REDACTED] - 05/14/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Administrator/Clinical Coordinator to ensure that all ADME's have complete information are to be reviewed by the Administrator or Clinical Coordinator.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will review the ADME to make sure all information is included and there are no incomplete areas, with a completion date of 08/31/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform monthly audits of on going process, through 12/29/2026 to maintain ongoing compliance with ensuring each resident has a medical evaluation at least annually and all documents will be reviewed every 11 months instead of annually so designated staff can make sure all information is captured for the yearly medical exam and no information is missing. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 12/28/2026

Not Implemented [REDACTED] - 07/17/2026)

181c Self-Administer Assessment

17. Requirements

2800.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

181c Self Administer Assessment (continued)

Description of Violation

Resident [REDACTED] self administers medications to include [REDACTED] and [REDACTED]. However, Resident [REDACTED] has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self administer medications.

Resident [REDACTED] self administers [REDACTED]. However, Resident [REDACTED] has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self administer medications.

Plan of Correction

Accept [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Clinical Coordinator/Disignee to remove any medications from resident rooms, that are not approved for self administration.

To enhance the currently compliant operations, starting on 05/11/2026 the Clinical Coordinator/Designee will monitor any residents that are not approved for self administration of medications/treatments. Will also update families that their loved one is not approved to self administer and to refrain from bringing in medications/treatments that they are not approved to have or administer and to make sure AME's include whether they can or cannot self administer, with a completion date of 05 18/2026.

Effective 05/18/2026 the Clinical Coordinator/Designee will perform monthly inspections of on going process no end date, through [] to maintain ongoing compliance with the resident's assessment identifying if the resident is able to self administer medications as specified in § 2800.227(e) (relating to development of the support plan), and a resident who desires to self administer medications being assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self administer and the need for medication reminders. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Families were notified 4/2/26 via phone call to POA.

Staff education was done 5/8/26 on self administration by residents and that they need a physician eval to do so and if they see medications in a resident room to notify Nurse so they can see if they have an order to self administer the medication/treatment and if not notify the PCP for an order to self administer or order for Nursing to administer, if they feel it is warranted.

Licensee's Proposed Overall Completion Date: 05/21/2026

Not Implemented [REDACTED] - 07/17/2026)

183d Current medications

18. Requirements

2800.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

183d Current medications (continued)

Description of Violation

On [REDACTED] at 10:39 AM, [REDACTED] prescribed for Resident [REDACTED] was in the residence's medication cart; however, the medication was discontinued on [REDACTED]

Plan of Correction

Accept [REDACTED] 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Med Tech's /Nursing to Create a guideline for staff to follow when doing cart audits for expired or near expiration.

To enhance the currently compliant operations, on 05/11/2026 the Med Tech's/Nursing will monitor the med cart monthly for expired or near expired medications and follow guidelines on attached form, so there is no gap from when meds expire to delivery from Pharmacy, with a completion date of 05/11/2026.

Effective 06/01/2026 the Administrator/Clinical Coordinator will perform monthly audits of on going process to ensure compliance, to maintain compliance with the residence developing and implementing procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. No end date, ongoing process.

Medication was disposed of on 4/2/26 by LPN. The medication was not reordered because it had been discontinued 12/2025.

Monthly med cart audits will start 5/11/26 and do not have an end date as they are on going and will be completed by LPN/Med Tech. They will be double checking for any discontinued/expired medications/treatments.

Administrator/Clinical Coordinator will follow up on audits to make sure they are being completed monthly.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [REDACTED] 07/17/2026)

184a Resident meds labeled

19. Requirements

2800.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for Resident [REDACTED], does not include the special instruction to hold the medication if the resident's systolic blood pressure is under [REDACTED]

The pharmacy label for Resident [REDACTED], does not include the special instruction to hold the medication if the resident's systolic blood pressure is under [REDACTED].

Repeated Violation - [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 05/22/2026)

184a Resident meds labeled (continued)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Clinical Coordinator/Designee to educate staff regarding the packaging for medication and treatments and the importance of the original packaging staying in the original packaging.

To enhance the currently compliant operations, on 05/11/2026 the Clinical Coordinator/Designee will will monitor during med cart audits to make sure medications and treatments are in their original packing, with a completion date of 05/18/2026.

Effective 05/11/2026 the Clinical Coordinator/Designee will perform weekly checks of on going process, no end date, through ongoing to maintain ongoing compliance with the original container for prescription medications being labeled with a pharmacy label that includes , including the prescribed dosage and instructions for administration. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Med carts audits are done monthly and Clinical Coordinator/Administrator will verify checks are being completed when assigned. This is an ongoing process to be able to make sure medication have original labels on them, open/expiration dates. Staff were educated on the importance of the medication being kept in the original package on 5/8/26.

Licensee's Proposed Overall Completion Date: 05/21/2026

Not Implemented [REDACTED] - 07/17/2026)

185a Storage procedures**20. Requirements**

2800.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] as needed. On [REDACTED] this medication was not available in the residence.

Resident [REDACTED] is prescribed [REDACTED] as needed. On [REDACTED] this medication was not available in the residence.

Resident [REDACTED] is prescribed [REDACTED], and [REDACTED] as needed. On [REDACTED] these medications were not available in the residence.

Plan of Correction

Directed [REDACTED] - 05/22/2026)

185a Storage procedures (continued)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Med Tech's /Nursing to Create a guideline for staff to follow when doing cart audits for expired or near expiration. A spreadsheet was create by the clinical coordinator that all PRN medications were added to 5/8/26, that include their expiration dates. Staff were educated on the form 5/8/26. Form will be kept in the Narcotic book with the medication cart and will be updated every Friday for any new medications to be added or to reorder any medications that will expire with in the next 30 days. This will provide enough time to receive medication before the one in the cart expires. Clinical Coordinator to follow up on Mondays to make sure audit was completed by staff of PRN's.

To enhance the currently compliant operations, on 05/11/2026 the Med Tech's/Nursing will monitor the med cart monthly for expired or near expired medications and follow guidelines on attached form, so there is no gap from when meds expire to delivery from Pharmacy, with a completion date of 05/11/2026.

Effective 06/01/2026 the Administrator/Clinical Cordnator will perform monthly audits of on going process to ensure compliance, to maintain compliance with the residence developing and implementing procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. No end date, ongoing process

(Directed)

In addition to the above plan of correction:

- The identified medications prescribed for Residents [REDACTED] and [REDACTED] will be available for administration by 6/1/26.
- Documentation of completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 05/21/2026

Not Implemented ([REDACTED] - 07/17/2026)

187b Date/time of med admin

21. Requirements

2800.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED], give 1 capsule by mouth three times a day. The resident's October 2025 and January 2026 Medication Administration Records (MAR) indicated the medication was administered by Staff Member F on [REDACTED] at 8:00 PM and [REDACTED] at 8:00 PM; however, these doses were not administered to the resident.

Resident [REDACTED] is prescribed [REDACTED], give .5 tablet by mouth at bedtime. The resident's October 2025 MAR indicated that this medication was administered by Staff Member F on [REDACTED] at 8:00 PM; however, this dose was not administered to the resident.

Plan of Correction

Accept [REDACTED] - 05/22/2026)

10/3/25 spoke with nurse that had medication error and reviewed the 5 right of medication administration and did

187b Date/time of med admin (continued)

the same on 1/4/26. Reportables were done for both incidents and faxed to DHS.

This an on going process of review with the nursing staff and med tech's. All staff administer medications are to keep their medication packets and for each resident they administer medications to. They will match the MAR medication to the packets to make sure they are matching doses and medication. They are to check off on the packet and then the MAR. Once done count the # of pills on the MAR and the # of pills in the cup to administer. Write the date and their initials on the packet. Once their shift is over they will clip all of the packets together for Clinical Coordinator of Administrator to review. This was started 5/8/26 when staff were educated.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [REDACTED] - 07/17/2026)

187d Follow prescriber's orders**22. Requirements**

2800.

187.d. The residence shall follow the directions of the prescriber.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED], give 1 capsule by mouth three times a day. This medication was not administered to the resident as prescribed on [REDACTED] and [REDACTED] at 8:00 PM.

Resident [REDACTED] is prescribed [REDACTED], give .5 tablet by mouth at bedtime. This medication was not administered to the resident as prescribed on [REDACTED] at 8:00 PM.

Plan of Correction

Accept [REDACTED] - 05/22/2026)

10/3/25 spoke with nurse that had medication error and reviewed the 5 right of medication administration and did the same on 1/4/26. Reportables were done for both incidents and faxed to DHS.

This an on going process of review with the nursing staff and med tech's.

All staff administer medications are to keep their medication packets and for each resident they administer medications to. They will match the MAR medication to the packets to make sure they are matching doses and medication. They are to check off on the packet and then the MAR. Once done count the # of pills on the MAR and the # of pills in the cup to administer. Write the date and their initials on the packet. Once their shift is over they will clip all of the packets together for Clinical Coordinator of Administrator to review. This was started 5/8/26 when staff were educated.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [REDACTED] 07/17/2026)

190a Completion of course—meds**23. Requirements**

2800.

190a Completion of course—meds (*continued*)

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

██████████ was administered to Resident ██████████ on ██████████ at 1:31 PM.
 ██████████ was administered to Resident ██████████ on ██████████, and ██████████ at 8:00 AM.
 ██████████ was administered to Resident ██████████ on ██████████, and ██████████ at 8:00 AM.

Plan of Correction

Directed ██████████ - 05/22/2026)

Staff person C completed course on 7/17/24 with ██████████ medication Observations and Attestation. Medication observations have been completed on Staff person every 6 months, handwashing/gloving and chart reviews

(Directed)

- Staff Member C will be removed from medication administration duties until the Department-approved medication administration course has successfully been completed in its entirety. The home will file Staff Member C's medication administration training documentation to include the full initial user report in Staff Member C's training record.
- Education will be provided to all staff responsible for monitoring and obtaining staff medication administration training records by 6/12/26.
- An initial audit of all staff member medication administration training records will be completed by the administrator or designee by 6/12/26 to ensure staff have completed the medication administration course in its entirety and proper documentation is filed in the staff member's record.
- Beginning 6/1/26, the administrator or designee will audit all newly training staff training records within 2 days of medication administration training completion to ensure the entire course has been completed properly and initial user reports are properly filed in the staff member's record.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 06/12/2026

Implemented ██████████ 07/17/2026)

225a2 Assessment – significant change

24. Requirements

2800.

225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident ██████████ most recent assessment, dated ██████████ indicates the resident ambulates independently, however the resident utilizes a walker to assist with ambulation. Resident ██████████ most recent medical evaluation, completed ██████████ indicates a dietary need of no added sodium. However, the assessment states the resident has no dietary needs. This assessment has not been updated to reflect the resident's current needs related to ambulation and diet.

225a2 Assessment – significant change (continued)

Resident [REDACTED]'s assessment, dated [REDACTED], indicates the resident ambulates independently. However, Resident [REDACTED] utilizes a walker and motorized scooter to assist with ambulation. The resident's assessment has not been updated to reflect the resident's ambulation needs.

Resident [REDACTED] assessment, dated [REDACTED], indicates the resident ambulates independently. However, Resident [REDACTED] utilizes a walker and wheelchair to assist with ambulation. The resident's assessment has not been updated to reflect the resident's ambulation needs.

Resident [REDACTED] assessment, dated [REDACTED] indicates the resident ambulates, transfers, and turns/positions independently and has no mobility needs. However, Resident [REDACTED] utilizes a rollator, cane, and bed enabler. The assessment does not indicate a need for these assistive devices. Resident [REDACTED]'s assessment also indicates Resident [REDACTED] cannot self-administer medications. However, the resident has been approved by a physician to self-administer several medications unsupervised. This assessment was not updated to reflect the resident's current assisted living care needs.

Plan of Correction**Accept [REDACTED] - 05/22/2026)**

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/08/2026 by the RN/Designated Staff to RN on 4/8/26 updated care plans to include assistive devices.

To enhance the currently compliant operations, on 06/01/2026 the Clinical Coordinator/Administrator/other dept will meet monthly to complete ASP that are due the next month and update any ASP for residents that have had significant changes, with a completion date of 01/04/2027.

Effective 04/08/2026 the RN,/Clinical Coordinator/Administer will perform monthly reviews of on going process no end date, through [] to maintain ongoing compliance with the administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN completing additional written assessments for each resident, and a residence using its own assessment form if it includes the same information as the Department's assessment form, and additional written assessments being completed if the condition of the resident significantly changes prior to the annual assessment. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Resident 1 was completed 4/17/26, residents [REDACTED] and [REDACTED] will be changed 5/22/26. Auditing is currently being done and will be completed by 6/5/26. Education to staff will be provided 5/22/26 on identifying residents needs, changes and importance of reporting it to designated staff to ensure changes are made to assessment within the 5 days. Training provided by Clinical Coordinator and Administrator.

Licensee's Proposed Overall Completion Date: 06/05/2026

Not Implemented [REDACTED] 07/17/2026)

225b Assessment content

25. Requirements

225b Assessment content (*continued*)

2800.

225.b. The assessment must, at a minimum include the following:

2. The mobility needs of the resident.
3. The ability of the resident to self administer medication.

Description of Violation

Resident [REDACTED] assessment, dated [REDACTED] indicates the resident's mobility is "moderate"; however, the description of mobility needs only states "mobility" and does not provide a description of the resident's ability.

Resident [REDACTED] assessment, dated [REDACTED] does not include the ability of the resident to self-administer medication as this area is left blank.

Plan of Correction**Accept** [REDACTED] - 05/22/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 06/01/2026 by the Administrator/Clinical Coordinator/other Departments to to coordinate departments involved in the care plans to meet monthly to make sure all areas are updated to the residents current needs.

To enhance the currently compliant operations, on 06/01/2026 the Administrator/Clinical Coordinator/other departments will meet monthly to update any care plans that are do and to update any new needs that need to be addressed, with a completion date of 06/29/2026.

Effective 06/01/2026 the Administrator/Clinical Coordinator/other departments will perform monthly reviews of on going process each month, through 01/04/2027 to maintain ongoing compliance with the assessment, at a minimum including, including the mobility needs of the resident, and the ability of the resident to self-administer medication. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Resident 1assessment updated 4/17/26.

Auditing is currently be done by Clinical Coordinator and RN and a finish date of 6/5/26.

Process will be to have monthly meetings with Clinical staff, Therapy Services and Activities to discuss any resident due for assessment and any resident changes/needs that will then be shared with provider and then added to assessment.

Licensee's Proposed Overall Completion Date: 06/05/2026

Not Implemented [REDACTED] - 07/17/2026)

227d Support plan – med/dental

26. Requirements

2800.

227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

227d Support plan – med/dental (continued)**Description of Violation**

Resident [REDACTED]'s most recent assessment, dated [REDACTED], includes an addendum indicating the resident has a bed enabler to assist with transferring independently. However, the support plan, dated [REDACTED], does not include the specific need for the device, any risks associated with the use of the device, the resident's ability to use the device safely, or identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident [REDACTED] utilizes a bed enabler. However, the resident's support plan, dated [REDACTED] does not include the specific need for the device, the intended use and any risks associated with the use of the device, the resident's ability to use the device safely for the purpose intended, or identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction**Accepted [REDACTED] 05/22/2026)**

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Clinical Coordinator to make a list of all residents that bed enablers and toilet grab bars.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will check list complied to the ASP and update as needed, with a completion date of 05/18/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform monthly audits of on going process, since residents needs changes, through 01/04/2027 to maintain ongoing compliance with each residence documenting in the resident's final support plan the dietary, 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, and this requirement does not require a residence to pay for the cost of these medical and behavioral care services, and the final support plan documenting the assisted living services and supplemental health care services, if applicable, that will be provided to the resident. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

5/18/26 the support plans for Resident [REDACTED] and [REDACTED] were updated regarding the bed enablers and covers were placed on them as well, to prevent injury.

Clinical Coordinator will inspect enablers monthly to make sure they are in compliance, good condition and covers are in place.

Licensee's Proposed Overall Completion Date: 05/22/2026**Not Implemented ([REDACTED] - 07/17/2026)**

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

Facility Information

Name: MORAVIAN MANOR **License #:** 33309 **License Expiration:** 01/01/2027
Address: 300 WEST LEMON STREET, LITITZ, PA 17543
County: LANCASTER **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MORAVIAN MANORS INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: R 4 **Date:** 09/13/2017 **Issued By:** L&I

Staffing Hours

Resident Support Staff: **Total Daily Staff:** 42 **Waking Staff:** 32

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Interim **Exit Conference Date:** 06/29/2026

Inspection Dates and Department Representative

06/25/2026 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 40 **Residents Served:** 28

Special Care Unit

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

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 28
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 14 **Have Physical Disability:** 2

Inspections / Reviews

06/25/2026 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 07/27/2026

Inspections / Reviews (*continued*)

08/10/2026 POC Submission

Submitted By: [REDACTED] Date Submitted: 08/10/2026
Reviewer: [REDACTED] Follow Up Type: *Bypass Document Submission*

08/10/2026 Bypass Document Submission

Submitted By: [REDACTED] Date Submitted: 08/10/2026
Reviewer: [REDACTED] Follow Up Type: *Enforcement*

5a1 DHS access

1. Requirements

2800.

5.a. The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:

1. Agents of the Department.

Description of Violation

An agent of the Department requested access to a staff list for direct care, ancillary, agency, and volunteer staff. A complete staff list with names, dates of hire, titles, and contact information was not received.

Plan of Correction

Directed [REDACTED] - 08/10/2026)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 07/21/2026 by the Administrator to Attached list was created to help us track information requested and be able to provide it in a timely manner, especially when requesting information from other Departments.

To enhance the currently compliant operations, on 07/21/2026 the Administrator will DHS survey form is in the front of Inspection Binder for each license. When DHS arrives, the form will be utilized to track requested information and provide a better way to make sure all requested information was delivered, with a completion date of 07/22/2026. Effective 07/21/2026 the Administrator will perform quarterly checks to make sure forms are still in place and update if needed through 07/31/2027 to maintain ongoing compliance with Administrator or Clinical Coordinator will utilize form that is in the inspection binder, to provide requested information/documents in a timely manner and to alleviate missing any requested information. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

(Directed)

In addition to the above plan of correction:

- *The administrator or designee will develop a staff list of all staff members including substitute staff and volunteers identifying each staff member's name, job title, date of hire and contact information by 9/4/26.*
- *The administrator or designee will audit this list monthly starting 9/4/26 for a minimum of 6 months to ensure the list will be readily available to the Department upon request.*

Directed Completion Date: 09/04/2026

26b Quality management plan content

2. Requirements

2800.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The residence's quality management review completed in May 2026 for the months of April and May 2026 did not include licensing violations and plans of correction, a review of reportable incidents or staff person training.

Plan of Correction

Directed [REDACTED] - 07/28/2026)

The quality management plan will be updated to ensure each periodic quality management review includes, at

26b Quality management plan content (continued)

minimum, a documented review and evaluation of reportable incidents and conditions, complaint procedures, staff person training, licensing violations, and plans of correction, as applicable. The review will also identify any areas needing improvement and document the measures implemented to address those areas.

The quality management review completed in May 2026 for March, April, and May 2026 will be amended to include a review of licensing violations and plans of correction, reportable incidents, and staff person training records for the reviewed period. Any findings or trends identified during the amended review will be documented, and corrective measures will be implemented as needed.

Steps to Prevent Recurrence

1. The Administrator or designee will revise the quality management review checklist to include required review areas: reportable incidents and conditions, complaint procedures, staff person training, licensing violations, plans of correction, and resident or family councils, if applicable.
2. The Administrator or designee will review the revised checklist with designated staff responsible for quality management documentation.
3. Each periodic quality management review will be completed using the revised checklist and will include supporting documentation for each required area reviewed.
4. Identified areas needing improvement will include a written action step, responsible person, target completion date, and follow-up outcome.

Responsible Person: AL Administrator or Designee

(Directed)

In addition to the above plan of correction:

- Education will be provided to all staff responsible for completing the quality management review on regulation 2800.26(b) by 9/4/26.

A quality management plan will be held by 9/4/26 and will include a review of all areas in accordance with regulation 2800.26(b).

Directed Completion Date: 09/04/2026

65I Record of training

3. Requirements

2800.

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

Description of Violation

The residence's record of direct care staff training for Staff members A and B did not include the length of each training session.

Plan of Correction

Directed () - 07/28/2026)

Corrective Action: The training records for Staff members A and B were reviewed and updated to include the length of each training session. Any missing supporting documentation, including certificates when applicable, was added to the employee training records, which was 16 minutes.

Preventive Measures: The training record process will be updated to require documentation of course length before a training record is considered complete. Staff responsible for maintaining training files will be re-educated on required documentation elements and will use a standardized training record checklist or form for all direct care staff trainings.

Monitoring: The Administrator or designee will audit direct care staff training records weekly for four weeks, then

65l Record of training (continued)

monthly for three months, to ensure all required elements are present. Audit findings will be documented, and any deficiencies will be corrected immediately.

Responsible Party: Administrator or designee.

(Directed)

In addition to the above plan of correction:

- All staff training records completed in June 2026 and July 2026 be audited by the administrator or designee by 9/4/26 to ensure each training includes all required information in accordance with 2800.65(l).*
- Ongoing audits will begin no later than 9/4/26.*
- Education to be provided to applicable staff members by 9/4/26.*

Directed Completion Date: 09/04/2026

81b Resident equip – good repair**4. Requirements**

2800.

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 [REDACTED] at 10:39 AM, the bedside enabler of Resident [REDACTED] was wrapped in gauze being used as an enabler cover. The opening of Resident [REDACTED] bedside enabler measured 10"x12" below the gauze creating a potential entrapment hazard.

On [REDACTED] at 10:19 AM, the bedside enabler of Resident [REDACTED] was attached to a wooden board strapped to the bed frame. However, the bar shifted approximately 2" away from the bed when pressure was applied creating a potential safety hazard.

On [REDACTED] at 10:13 AM, the cover of Resident [REDACTED]'s enabler was not secured to the device. The resident reported "I slip a little bit" when grabbing the bar, requiring the resident to grab the bar with two hands to prevent the cover from sliding. The stretchy material of the cover's fabric causes the resident's hand to easily slide down when grabbing the bar.

Plan of Correction

Directed [REDACTED] - 07/28/2026)

Resident [REDACTED] enabler replaced 7/27/26

Resident [REDACTED] waiting on new enabler to be ordered by family.

Resident [REDACTED] enabler was replaced 6/30/26

We have established 1 enabler that meets all criteria and will be using it going forward as of 6/25/26.

We continue with monthly checks to make sure enablers and toilet grab bars are in good working condition.

(Directed)

In addition to the above plan of correction:

- Immediately Resident [REDACTED] bedside enabler device will be properly secured to the bed until a new device is received.*
- An initial audit of all other bedside enabler devices in the home will be completed by 9/4/26 to ensure*

openings are properly covered and devices are safely secured to the bedframes.

- Education will be provided to all staff on proper procedures regarding resident bedside enabler devices to include required coverings and proper securement to resident bedframes by 9/4/26.

Directed Completion Date: 09/04/2026

103e Leftovers

5. Requirements

2800.

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

On [REDACTED] at 10:09 AM, a previously opened and partially consumed bottle of Brisk raspberry teas was not labeled or dated and being stored the refrigerator of the first-floor kitchenette.

On [REDACTED] at 10:36 AM, a takeout container containing food was not labeled and stored in the refrigerator of the second-floor kitchenette.

Plan of Correction

Directed [REDACTED] - 07/28/2026)

We are continuing weekly audits of both refrigerators, one on first floor and one on second floor. Stickers and pens have been added to make it easier for staff/residents to label food as well as hung reminders on the refrigerators. When food is found unlabeled it is discarded in the trash.

(Directed)

In addition to the above plan of correction:

- Education will be provided to all staff and residents on regulation 2800.103(e) by 9/4/26.

Directed Completion Date: 09/04/2026

181c Self-Administer Assessment

7. Requirements

2800.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident [REDACTED] has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer these medications. However, Resident [REDACTED] self-administers medications to include:

[REDACTED]

181c Self Administer Assessment (continued)

Plan of Correction

Directed [REDACTED] 07/28/2026)

Resident [REDACTED]'s medications and self administration status will be reviewed immediately. The resident will be assessed by a physician, physician assistant, or certified registered nurse practitioner to determine the resident's ability to safely self administer medications and whether medication reminders are needed. The assessment outcome will be documented and incorporated into the resident's support plan as required.

The Administrator/designee will review current residents who self administer prescription or over the counter medications to verify that each resident has the required assessment completed by an approved medical provider and that the support plan accurately reflects the resident's medication self administration status and need for reminders.

Monitoring and Quality Assurance: The Administrator/designee will complete audits of residents who self administer medications to ensure the required assessment is present and the support plan is accurate. Audits will be completed weekly for four weeks and then monthly for three months. Any identified concerns will be corrected promptly and reviewed through the community's quality assurance process.

(Directed)

In addition to the above plan of correction:

- The administrator or designee will remove all medications from Resident [REDACTED]'s room and provide education to Resident [REDACTED] on [REDACTED] need for an assessment to determine if Resident [REDACTED] can self administer medications by 9/4/26.
- Education will be provided to all staff and residents on regulation 2800.181(c) by 9/4/26.
- The initial audit will be completed no later than 9/4/26.
- The home's ongoing monitoring will begin no later than 9/4/26.

Directed Completion Date: 09/04/2026

184a Resident meds labeled

8. Requirements

2800.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for Resident [REDACTED] s [REDACTED], and [REDACTED], do not include the instructions for administration.

The pharmacy label for Resident [REDACTED] s [REDACTED] and [REDACTED], do not include the instructions for administration.

Repeated Violation [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 08/10/2026)

Systemic Changes/Prevention: Nursing and medication administration staff will be re educated on the requirement that the original container for each prescription medication must include a pharmacy label with the prescribed dosage and instructions for administration. Staff will be instructed to verify medication labels during medication cart checks, when medications are received from the pharmacy, and when any medication order or dosage changes occur. The medication cart audit process will include verification that pharmacy labels are complete and that any

184a Resident meds labeled (continued)

missing or unclear administration instructions are reported and corrected immediately.

Monitoring: The Administrator or designee will audit medication carts weekly for four weeks, then monthly for three months, to verify that prescription medication containers have pharmacy labels that include the prescribed dosage and instructions for administration. Any deficient label will be corrected immediately by contacting the pharmacy and documenting the corrective action taken. Audit findings will be reviewed with appropriate staff and maintained for regulatory review.

Responsible Person: Personal Care/Assisted Living Administrator or designee.

Pharmacy was contacted and added administration instructions to the med packets week of 7/20/26

Licensee's Proposed Overall Completion Date: 07/27/2026

Not Implemented - 08/10/2026)

185a Storage procedures**9. Requirements**

2800.

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

Description of Violation

On [REDACTED] at 1:23 PM, Resident [REDACTED]'s glucometer was not calibrated to the correct date. On [REDACTED], the resident's glucometer indicated the date was [REDACTED]

Plan of Correction

Accept - 08/10/2026)

The glucometer for Resident [REDACTED] was immediately reviewed and corrected to reflect the accurate date. Staff were reminded that glucometers and other medical equipment must be checked for accurate date, time, function, and readiness prior to use to ensure safe medication and treatment practices.

To prevent recurrence, all medication technicians and appropriate direct care staff will receive re-education regarding the proper storage, access, security, distribution, use, and routine verification of medication-related equipment, including glucometers. Education will include confirming that glucometers are set to the correct date and time before resident use and reporting any equipment concern immediately to the nurse or supervisor.

The Administrator/designee will conduct random weekly audits of glucometers and other medication-related equipment for four weeks to verify correct date, time, storage, and availability for safe use. If compliance is maintained, audits will continue monthly for three months. Any identified concerns will be corrected immediately, documented, and reviewed with the responsible staff member.

Licensee's Proposed Overall Completion Date: 07/28/2026

Not Implemented - 08/10/2026)

187a Medication record

10. Requirements

2800.

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

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [REDACTED] is prescribed [REDACTED]. However, the medication administration record does not indicate the diagnosis or purpose for these medications.

Resident [REDACTED] is prescribed [REDACTED]
[REDACTED] and [REDACTED]. However, the medication administration record does not indicate the diagnosis or purpose for these medications.

Resident [REDACTED] is prescribed [REDACTED], and [REDACTED]. However, the medication administration record does not indicate the diagnosis or purpose for these medications.

Plan of Correction

Accept [REDACTED] - 08/10/2026)

Corrective Action: The medication administration records for Resident [REDACTED], Resident [REDACTED], and Resident [REDACTED] were reviewed and updated to include the diagnosis or purpose for each prescribed medication identified in the violation. The updated information was verified against the current physician orders, medication profiles, and resident records to ensure accuracy.

Action to Protect Other Residents: A review of all current resident medication administration records will be completed to confirm that each medication has a documented diagnosis or purpose. Any missing information will be obtained from the physician order, pharmacy profile, or prescriber and added to the medication record promptly.

Staff Education: Medication administration staff and designated supervisory staff will be re-educated on the requirement that every medication record must include the diagnosis or purpose for each medication, including PRN medications. Staff will also be instructed to review new medication orders and monthly medication record updates for completeness before use. We realized this is a Point Click Care issue and staff are being educated on the 2 areas where the diagnosis codes need to be placed for it to show on the MAR.

Ongoing Monitoring: The Administrator or designee will audit medication administration records weekly for four weeks and monthly for three months thereafter to ensure each medication includes a diagnosis or purpose. Audit findings will be documented, and any identified concerns will be corrected immediately. Continued noncompliance will result in additional staff education and follow-up review.

Licensee's Proposed Overall Completion Date: 07/28/2026

Not Implemented [REDACTED] - 08/10/2026)

225a2 Assessment – significant change

11. Requirements

2800.

225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [REDACTED] assessment, dated [REDACTED], indicated no sensory needs related to vision. However, Resident [REDACTED] is diagnosed with [REDACTED], and on [REDACTED] Resident [REDACTED] was also diagnosed with age related [REDACTED]. However, an additional written assessment was not completed for Resident [REDACTED]

Resident [REDACTED]'s assessment, dated [REDACTED], indicated the resident has no needs related to toileting or bladder. However, the resident is prescribed [REDACTED] for urinary incontinence. The assessment also indicated Resident [REDACTED] has no sensory needs related to vision. However, the resident is diagnosed with [REDACTED] and underwent eye surgery on both eyes. An additional written assessment was not completed for Resident [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/10/2026)

Corrective Action for Residents Identified

The Administrator or designee will review the assessments for Resident [REDACTED] Resident [REDACTED] Resident [REDACTED] and Resident [REDACTED] and complete additional written assessments to reflect each resident's current condition, diagnoses, needs, medication self-administration status, and services required. Updated assessments will be reviewed with appropriate staff to ensure the residents' current needs are understood and addressed.

Systemic Review and Prevention

The Administrator or designee will review current resident records to identify residents with recent changes in condition, new diagnoses, changes in medication self-administration, or changes in care needs to determine whether an additional written assessment is required. Any assessment found to be incomplete or inconsistent with the resident's current needs will be updated promptly.

Nursing and applicable direct care staff will be re-educated on the requirement to notify the Administrator or designee of any significant change in condition, new diagnosis, or change in resident needs so that an additional written assessment can be completed when required.

Monitoring and Ongoing Compliance

The Administrator or designee will audit resident records weekly for four weeks, then monthly for three months, to verify that assessments are updated when significant changes occur and that documented needs match current diagnoses, medications, and services. Audit findings will be reviewed and any identified concerns will be corrected promptly.

225a2 Assessment – significant change (continued)

Licensee's Proposed Overall Completion Date: 08/07/2026

Not Implemented () - 08/10/2026)

225b Assessment content**12. Requirements**

2800.

225.b. The assessment must, at a minimum include the following:

2. The mobility needs of the resident.
3. The ability of the resident to self-administer medication.

Description of Violation

Resident [REDACTED]'s assessment, dated [REDACTED], indicated the resident ambulates, transfers, and repositions independently. However, Resident [REDACTED] utilizes a walker for ambulation and a bedside mobility device. An additional written assessment was not completed for Resident [REDACTED].

Resident [REDACTED]'s assessment, dated [REDACTED] indicated the resident cannot self-administer medication. However, Resident [REDACTED] self-administers the following medications: [REDACTED] and [REDACTED].

Resident [REDACTED]'s assessment, dated [REDACTED], indicated the resident cannot self-administer medication. However, Resident [REDACTED] self-administers the following medications: [REDACTED], and [REDACTED].

Plan of Correction

Directed () - 08/10/2026)

Corrective Action for Residents Identified

The Administrator or designee will review the assessments for Resident [REDACTED] Resident [REDACTED] Resident [REDACTED] and Resident [REDACTED] and complete additional written assessments to reflect each resident's current condition, diagnoses, needs, medication self-administration status, and services required. Updated assessments will be reviewed with appropriate staff to ensure the residents' current needs are understood and addressed.

Systemic Review and Prevention

The Administrator or designee will review current resident records to identify residents with recent changes in condition, new diagnoses, changes in medication self-administration, or changes in care needs to determine whether an additional written assessment is required. Any assessment found to be incomplete or inconsistent with the resident's current needs will be updated promptly.

Nursing and applicable direct care staff will be re-educated on the requirement to notify the Administrator or designee of any significant change in condition, new diagnosis, or change in resident needs so that an additional written assessment can be completed when required.

Monitoring and Ongoing Compliance

225b Assessment content (continued)

The Administrator or designee will audit resident records weekly for four weeks, then monthly for six months, to verify that assessments are updated when significant changes occur and that documented needs match current diagnoses, medications, and services. Audit findings will be reviewed and any identified concerns will be corrected promptly.

(Directed)

In addition to the above plan of correction:

- The administrator or designee will update Resident [REDACTED] assessment by 9/4/26.*
- Education will be provided to all staff responsible for completing resident assessments on the requirement for each resident to be assessed on the mobility needs of the resident and the ability of the resident to self-administer medication. Education to be provided by 9/4/26.*

Directed Completion Date: 09/04/2026

227d Support plan – med/dental**13. Requirements**

2800.

227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident [REDACTED] utilizes a bedside mobility device. However, the resident's support plan, dated [REDACTED], did not include the specific need for the device, any risks associated with the use of the device, the resident's ability to use the device safely, or identification of the specific device used and whether a cover is required to meet FDA guidelines.

Resident [REDACTED] utilizes an assistive bed mobility device. However, Resident [REDACTED]'s support plan did not include the specific need for the device, any risks associated with the use of the device, the resident's ability to use the device safely, or identification of the specific device used and whether a cover is required to meet FDA guidelines.

Plan of Correction

Accept [REDACTED] - 08/10/2026)

Corrective Action: The support plans for Resident [REDACTED] and Resident [REDACTED] will be reviewed and updated to include the specific need for the bedside or assistive bed mobility device, risks associated with use of the device, the resident's ability to safely use the device, identification of the specific device being used, and whether a cover is required to meet FDA guidelines. Updates will be completed by the Administrator or designee in collaboration with nursing and care staff.

Protection of Residents: Residents currently using bedside or assistive bed mobility devices will be assessed to ensure the device remains appropriate, safe, and clearly documented in the resident's support plan. Staff will be informed of any updated care instructions to ensure consistent implementation and resident safety.

Systemic Changes: The support plan review process will be revised to include specific documentation requirements for all bedside and assistive bed mobility devices. This will include the reason for use, identified risks, resident safety ability, device description, and whether a cover is required. Staff responsible for completing or reviewing support plans will receive education on these documentation expectations.

227d Support plan – med/dental (continued)

Monitoring: The Administrator or designee will audit support plans for residents using bedside or assistive bed mobility devices weekly for four weeks and monthly for three months to verify that all required information is documented. Any identified concerns will be corrected promptly and reviewed with appropriate staff.

Licensee's Proposed Overall Completion Date: 08/07/2026

Not Implemented [REDACTED] - 08/10/2026)