

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

September 28, 2026

[REDACTED], VICE PRESIDENT
HAYES MANOR INC
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131

RE: HAYES MANOR
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131
LICENSE/COC#: 14223

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/06/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HAYES MANOR

License #: 14223

License Expiration: 08/22/2026

Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA 19131

County: PHILADELPHIA

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: HAYES MANOR INC

Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA, 19131

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other

Date: 04/12/1985

Issued By: PA L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 36

Waking Staff: 27

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 07/06/2026

Inspection Dates and Department Representative

07/06/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 65

Residents Served: 34

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 5

Are 60 Years of Age or Older: 34

Diagnosed with Mental Illness: 13

Diagnosed with Intellectual Disability: 2

Have Mobility Need: 2

Have Physical Disability: 0

Inspections / Reviews

07/06/2026 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 07/27/2026

07/30/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/24/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/04/2026

Inspections / Reviews (*continued*)

08/07/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/24/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/24/2026

09/28/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/24/2026

Reviewer: [REDACTED]

Follow-Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 7/6/2026 at 10:14 am, the home's current license inspection summary, dated 7/29/2025, was not posted in a conspicuous and public place in the home. The home's license inspection summary from 2/19/25 was displayed instead.

Plan of Correction

Accept () - 07/30/2026)

1. On 7/6/2026 The outdated license inspection summary was removed immediately and replaced with the current Department-issued license inspection summary in a conspicuous public location within the home by the office manager. (Pic enclosed)
2. On 7/17/2026 the admin reviewed the violation with all office staff and managers and verified placement of the last inspection summary.
3. The admin or designee will post the most current license inspection summary immediately upon receipt.
4. On 7/20/2026 a state ready book was established, and a copy of the inspection summary was also placed in it in the front office as a backup should the original require replacement.
5. On 7/21/2026 the admin in-serviced all managers and office staff on the new protocol.
6. The office manager will monitor the presence of the summary monthly as of 7/20/2026.
7. The admin will review documentation quarterly to ensure compliance.

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

Implemented () - 09/28/2026)

5a1 - DHS Access

2. Requirements

2600.

- 5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 7/6/2026, at the time of inspection, an agent of the Department, requested access to the home's policies and procedures related to incident reporting, quality management, emergency management and emergency medial plan, medications and records management, and documentation related to fire drills, inspections and observed drills. Staff person A, the designee could not provide access to these documents as they were locked in an office that only the administrator has access to. The administrator was unavailable at the time of the inspection to grant access.

Plan of Correction

Accept () - 07/30/2026)

1. On 7/17/2026 the admin reviewed the violation with all office personnel and managers.
2. On 7/20/2026 the admin made available access to any outside agency the home's policies and procedures related to incident reporting, quality management, emergency management and medical plan, medication records, documentation inspections and observation related to fire drills.
3. On 7/20/2026 a state ready red binder has been established with all required documentation and placed in the

5a1 - DHS Access (continued)

front office for easy access. (See attached)

4. On 7/20/2026 A copy of all required documents was also placed in the medical office as a backup to grant access when needed.
5. On 7/21/2026 the admin in-serviced all managers and staff on the new protocol regarding the needed corrections to prevent future violations regarding access to needed and or required documentation from DHS and any other outside agencies.
6. On 7/22/2026 the admin verified placement and will conduct quarterly audits for placement of required documents.

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

Implemented () - 09/28/2026)

16b - Incident Policies**3. Requirements**

2600.

- 16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

On 7/6/2026, the home did not provide a written policy on the prevention, reporting, notification, investigation and management of reportable incidents as requested by the Department at the time of inspection.

Plan of Correction

Accept () - 07/30/2026)

1. On 7/17/2026 the admin reviewed the violation with office staff and managers.
2. On 7/20/2026 the admin verified that the home's written policy and procedures regarding prevention, reporting, notification, investigation and management of reportable incidents were readily available in the medical unit. () also checked to make sure they were updated.
3. On 7/20/2026 the admin also placed a copy of the policy and procedures regarding all requirements of reportable incidents in the state ready book located in the front office as well as the medical unit.
4. On 7/21/2026 the admin in-serviced all managers and staff on the new protocol regarding the needed corrections to prevent future violations regarding access to needed and or required documentation from DHS and any other outside agencies.
5. On 7/22/2026 the nurse manager verified placement and will continue to do so monthly.
6. On 7/24/2026 the admin observed for placement of the documents and will monitor for placement quarterly for compliance.

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

Implemented () - 09/28/2026)

26a - Quality Management Plan**4. Requirements**

2600.

- 26.a. The home shall establish and implement a quality management plan.

26a - Quality Management Plan (continued)

Description of Violation

On 7/6/2026, the home did not provide a quality management plan as requested by the Department at the time of inspection.

Plan of Correction

Accept () - 07/30/2026)

1. On 7/17/2026 the admin reviewed the violation with all office personnel and managers.
2. On 7/20/2026 the admin reviewed the quality management policy and checked for updates. A copy is enclosed. The plan includes quality indicators, monitoring activities, corrective action process, performance improvement measures, and annual evaluation procedures.
3. The quality management book is monitored monthly by the nurse manager during the recap process. This has been an ongoing monthly process since 2022 and will continue.
7. The quality management book is kept in the medical office. On 7/22/2026 the nurse manager verified placement and will continue to do so monthly.
4. As of 7/21/2026 a copy is now kept in the state ready book which is in the front office for easy access.
5. On 7/21/2026 the admin in-serviced all managers and staff on the new protocol regarding the needed corrections to prevent future violations regarding access.
6. On 7/23/2026 the admin observed for placement and will monitor for placement quarterly for compliance.

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

Implemented () - 09/28/2026)

64c - Annual Training

5. Requirements

2600.

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

Description of Violation

() the home's administrator, completed only 15 hours of Department-approved training in training year 2025.

Plan of Correction

Accept () - 07/30/2026)

- 1 On 7/17/2026 the admin reviewed the violation with all office personnel and managers.
- 2 On 7/17/2026 the admin had HR verify () annual training for 2025. Attached is a copy of the admin training.
 - Fire safety – 2 hours
 - Resident Rights- 1 hour
 - OAPSA- 1 hour
 - Falls and accident prevention- 1 hour
 - Food Serv Safe Certification- 8 hours
 - PCH related topics- Northampton- 3 hours
 - Best Med Practice- Northampton- 3 hours
 - Prevention abuse & neglect- NH – 3 hours
 - Policy and Procedures PCH- NH- 3 hours

64c - Annual Training (continued)

Total: 25 hours of training received for 2025. Copies of certificates and attached.

3 As of 7/20/2026 a training tracking system utilizing the DHS Staff Record Review has been implemented by HR to monitor continuing education annual requirements and provide advance notification before training deadlines.

Attached is a copy of the tracking system used for the 2025 staff training, this audit was completed by 7/23/2026.

4 Training hours will be monitored monthly by HR as of 7/23/2026.

5 Training records will be reviewed quarterly by the admin to ensure compliance. Admin reviewed HR audit on 7/24/2026.

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

Implemented () - 09/28/2026)

65f - Training Topics**6. Requirements**

2600.

65.f. 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 and cognitive 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. Personal care 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 home.

Description of Violation

Direct care staff persons C and D did not receive training in safe management training during training year 2025.

Plan of Correction

Accept () - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all office personnel and managers.

2 On 7/20/2026 HR verified training needed for direct care staff persons C and D and scheduled training for safe management for 2025.

3 Direct care staff C and D in to complete training on 7/22/2026. This training was provided by the admin. A copy of the training is attached.

4 An audit of all staff training was completed by HR on 7/23/2026 for 2025 and 2026.

5 Training hours will be monitored monthly by HR as of 7/23/2026.

6 Training records will be reviewed quarterly by the admin to ensure compliance. Admin reviewed HR audit on 7/24/2026.

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

Implemented () - 09/28/2026)

85e - Trash Outside Home

8. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/6/2026 at 9:43 am, the outside dumpster was uncovered. The Dumpster has two lids however, one of the lids was flipped back making half of the dumpster uncovered, while plastic spoons and other trash and debris lay on the ground to the right of the dumpster.

Plan of Correction**Accept () - 07/30/2026)**

1 On 7/17/2026 the admin reviewed the violation with all office personnel and managers.

2 On 7/20/2026 the admin and maintenance manager walked outside grounds to observe the dumpster area.

3 On 7/21/2026 area swept and cleaned by housekeeping staff, new signage posted regarding lids and cleanliness. (Pics included)

4 On 7/21/2026 the admin in-serviced all managers and staff on the new protocol regarding the needed corrections to prevent future violations regarding the dumpsters. Staff were instructed that dumpster lids must remain closed except during active disposal of trash. Any debris must be removed immediately.

5 Environmental rounds have been added to the daily maintenance checklist to verify that the dumpster area remains clean and covered.

6 The maintenance manager or designee will monitor compliance daily and the admin will observe during rounds for compliance.

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

Implemented () - 09/28/2026)**91 - Telephone Numbers****9. Requirements**

2600.

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

Description of Violation

On 7/6/2026 at 10:16 am, there were no emergency telephone numbers, including the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline, on or by the telephone in the nursing office.

Plan of Correction**Accept () - 07/30/2026)**

1 On 7/6/2026 an emergency sticker was immediately attached to the phone on the outside line in the nursing office by the nurse manager. This sticker included numbers for the nearest hospital, police, fire, ambulance, poison control, emergency management, and PCH hotline.

2 On 7/17/2026 the admin reviewed the violation with all staff and managers.

3 On 7/20/2026 all outside lines were observed by the front office staff for emergency stickers on or by each outside phone in the building. Replacement stickers were provided if needed.

4 On 7/21/2026 the admin in-serviced all managers and staff on the new protocol of checking for stickers while making daily rounds to prevent future violations.

91 - Telephone Numbers (continued)

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

Implemented () - 09/28/2026)

124 - Notice to Fire Department

10. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home's letter to the Philadelphia Office of Emergency Management, dated 6/15/2026, does not include the location of the bedrooms, or the assistance needed to evacuate in an emergency.

Plan of Correction

Accept () - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all office personnel and managers.

2 On 7/24/2026 the admin and maintenance manager updated the fire evacuation plan to include the location of the resident's room, and level of assistance required by the residents to evacuate during an emergency. The updates were forwarded to the OEM's office via email on 7/27/26. (Pls. see attached)

3 The maintenance manager will monitor the monthly evacuation plan for any updates or changes and notify OEM when and if needed.

4 The admin or designee will monitor quarterly for compliance.

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

Implemented () - 09/28/2026)

130h - Inoperable Smoke Detector

11. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

On 7/6/2026, the home did not have an inoperable smoke detector policy.

Plan of Correction

Accept () - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all office personnel and managers.

2 On 7/21/2026 the admin and maintenance manager reviewed the inoperable smoke detector policy for changes and updates.

3 On 7/21/2026 the admin in-serviced all managers and staff on the inoperable smoke detector policy to prevent future violations.

4 The admin will review the policy quarterly for updates or changes required.

5 A copy of the inoperable smoke detector policy is attached.

130h - Inoperable Smoke Detector (continued)

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

Implemented () - 09/28/2026)

141b1 - Annual Medical Evaluation**15. Requirements**

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on ()

Repeated violation- 7/29/2025

Plan of Correction

Accept () - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all staff and managers.

2 On 7/20/2026 the nurse manager explained that the request for a completed DME from resident's #1 PCP was requested as per previous agreement 60 days prior to it's due date and re-requested 30 days afterwards.

3 On 4/1/26 a copy of the DME for its annual completion was sent to residents 1 PCP. Various calls were made to the PCP on 5/1/26, 5/15/26, and 6/2/26 as a follow-up requesting that the DME be completed and returned ASAP.

4 On 7/11/2026 resident#1 completed DME was finally received from the PCP.

5 The nurse manager completed a full chart audit on 7/21/2026 to identify that all annual DME's were completed within the allotted time frame.

6 A discussion with the resident, PCP, () on 7/21/26 to explain the results of receiving a violation from DHS due to non-compliance. The admin suggested a change in PCP or to allow another medical professional to complete the annual if PCP cannot comply.

7 On 7/21/26 the admin conducted an in-service with all nursing staff and managers regarding the necessary steps to follow in obtaining required documents on time.

8 On 7/22/2026 the nurse manager completed an audit on all resident charts to verify compliance and will continue to do so monthly during the recap process.

9 On 7/24/2026 the admin reviewed resident charts and will continue quarterly for compliance.

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

Implemented () - 09/28/2026)

143a - Emergency Medical Plan**16. Requirements**

2600.

143.a. The home shall have a written emergency medical plan that includes the following:

Description of Violation

On 7/6/2026, the home did not provide a written emergency medical plan as requested by the Department at the time of inspection.

Plan of Correction

Accept () - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all staff and managers.

2 On 7/20/2026 the admin and nurse manager reviewed the emergency medical plan as it was updated in June.

143a - Emergency Medical Plan (continued)

An encrypted copy of a few residents' information is enclosed for review. It includes all required information.

3 An audit was completed on 6/26/26 by the nurse manager during the recap process.

4 On 7/21/26 the nurse manager reviewed each of the resident charts and updated any information needed including current pictures.

5 On 7/21/26 the admin conducted an in-service with all nursing staff and managers regarding the emergency medical plan and updates.

6 On 7/22/26 the admin and nurse manager both have all required emergency information involving all residents on a thumb drive to utilize in case of an emergency if needed.

7 On 7/21/26 the admin conducted an in-service with all nursing staff and managers regarding the medical emergency plan.

8 On 7/22/2026 the nurse manager completed an audit on all resident charts to verify compliance and will continue to do so monthly during the recap process.

9 On 7/24/2026 the admin reviewed resident charts and will continue quarterly for compliance.

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

Implemented (████) - 09/28/2026)

185a - Implement Storage Procedures**17. Requirements**

2600.

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

Description of Violation

On 7/6/2026, the home did not provide a policy on medications as requested by the Department at the time of inspection.

On 7/6/26 At 1:40 pm, resident #1's glucometer was calibrated to 12:40 pm.

Plan of Correction

Accept (████) - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all staff and managers.

2 On 7/6/2026 resident #1 glucometer was calibrated 1 hour behind. The incident occurred during the time-of-day light saving.

3 On 7/6/2026 the glucometer was recalibrated to the correct time.

4 On 7/7/2026 the nurse manager and medtech on duty reviewed all glucometers to ensure that they were calibrated to the correct date and time.

5 On 7/21/26 the admin conducted an education with all nursing staff and managers regarding the pre-screening forms.

6 On 7/23/2026 an audit of all glucometers was completed by the nurse manager to monitor readings, date, and appropriate time of all readings. This process will continue monthly with the medication renewal process.

7 The admin will review the glucometers and information quarterly.

185a - Implement Storage Procedures (continued)

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

Implemented () - 09/28/2026

187a - Medication Record**18. Requirements**

2600.

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

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

Description of Violation

Resident #1 is prescribed one Caltrate tablet by mouth daily. However, resident #1's medication administration record does not list this medication.

Plan of Correction

Accept () - 07/30/2026

1 On 7/17/2026 the admin reviewed the violation with all staff and managers.

2 On 7/6/2026 the MAR was corrected immediately to accurately reflect resident #1 prescribed medication.

3 On 7/7/2026 the med-tech on duty along with the nurse manager completed a review on all resident MARs to ensure that all ordered medication was correct.

4 On 7/21/2026 the nursing staff received an education regarding MAR transcription procedures and a three-step order verification.

A) The 1st accurately read and transcribe medication.

B) The 2nd with the PCP or ordering medical professional.

C) The 3rd with the pharmacy.

5 As of 7/21/2026 the med-tech 7p-7a is now required to do a 24-hour review of all new orders.

6 On 7/23/2026 the nurse manager completed a monthly audit of all resident MARs to verify that physician orders accurately match medication records.

7 On 7/24/2026 the admin reviewed resident charts and will continue quarterly for compliance.

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

Implemented () - 09/28/2026

187d - Follow Prescriber's Orders

19. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed one 400-mg tablet of Magnesium Oxide daily. However, resident #2 was administered one 420-mg tablet daily from 7/1 to 7/6/2026 at 9:00 am.

Plan of Correction

Accept ([REDACTED] - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all staff and managers.

- **This violation was given on a resident who resides in our independent unit. [REDACTED] is not a personal care resident. Please see all supporting documents, including [REDACTED] application, DME from the VA.**

2 On 7/6/2026 the medication order was immediately corrected to ensure the resident receives the physician-prescribed 400 mg dosage. Corrected MAR included.

3 On 7/7/2026 the nurse manager and med-tech on duty reviewed all resident MARs to verify accuracy.

4 On 7/21/2026 the nursing staff was re-educated to verifying all information on physician orders including but not limited to the right resident, right meds, right dosage, right time, right route, any observation of any adverse reaction.

5 As of 7/21/2026 the med-tech 7p-7a is now required to do a 24-hour review of all new orders.

6 On 7/23/2026 the nurse manager completed an audit of all resident physician orders match pharmacy dispensing records and MARs.

7 On 7/24/2026 the admin reviewed resident charts and will continue quarterly for compliance.

I believe we received this violation in error as the resident is an independent resident that does not reside in PCH. I am requesting that this violation be removed. Thank you.

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

Implemented ([REDACTED] - 09/28/2026)

190a - Completion Medication Course

20. Requirements

2600.

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 only completed one practicum observation since their initial certification date of [REDACTED]. The staff person did not complete two additional medication administration observations or a practice activity within 60 days of the practicum due date. Staff person C administered medications to residents, including the following doses to resident #1 on 7/3, 7/4, and 7/5/2026, at 9:00 am: Furosemide 40 mg, Aspirin chewable low dose 81 mg, Ezetimibe 10 mg, Bisoprolol Fumarate 5 mg, and Montelukast 10 mg.

190a - Completion Medication Course (*continued*)

Plan of Correction

Accept () - 08/07/2026)

- 1 On 7/17/2026 the admin reviewed the violation with all staff and managers.
- 2 On 7/7/2026 the nurse manager contacted a certified medication administration trainer to conduct a practicum observation with staff member C.
- 3 On 7/7/2026 the nurse manager and HR reviewed all the med-techs files to ensure that all training and observations were up to date.
- 4 On 7/10/2026 the approval medication administration trainer was in to educate, observe, and monitor during a medication pass with staff member C.
- 5 As of 7/13/2026 the nurse manager and HR will keep track of all required and necessary documentation on all med-techs quarterly to verify compliance.
- 6 On 7/21/26 the admin conducted an education with all nursing staff and managers regarding ongoing compliance with med-tech practicums and observations.
- 7 On 7/24/2026 the admin reviewed the documentation and will continue to observe quarterly.

- 8 On 7/30/26 the administrator reviewed the violation response from DHS for corrections.
- 9 On 7/30/26 Staff person C was removed from distributing medication. () will function as a PCA until certified.
- 10 The medication trainer was in on 8/4/26 to register staff person C for medication training certification. (Pics included)
- 11 On 8/3/26 the admin reviewed the audit completed by HR and the nurse manager. Pls. see attached.
- 12 The admin will forward a copy of staff person C certification when received. () has 15 days to complete.

Licensee's Proposed Overall Completion Date: 08/04/2026

Implemented () - 09/28/2026)

224a - Preadmission Screen Form

21. Requirements

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

Description of Violation

Resident #3's preadmission screening form, dated () does not include a determination that the needs of the resident can be met in the home.

Repeated violation- 7/29/2025

Plan of Correction

Accept () - 07/30/2026)

- 1 On 7/17/2026 the admin reviewed the violation with all staff and managers.
- 2 On 7/7/2026 the nurse manager completed a pre-screening form and placed it in resident " " chart to correct the violation.

224a - Preadmission Screen Form (continued)

3 On 7/20/2026 the admin and nurse manager reviewed the process of properly auditing for deficiencies in documentation.

4 On 7/21/26 the admin conducted an education with all nursing staff and managers regarding the pre-screening forms.

5 On 7/23/2026 the nurse manager completed an audit of all resident charts to verify that pre-admission screens completed and in place.

6 On 7/23/2026 the admin re-assigned the lead medtech the duty to complete a separate monthly audit after the completion of monthly recaps as a second chart review for documentation.

7 As of 7/23/2026 the nurse manager will continue to audit all resident charts during the monthly renewal process for re-ordering medication.

8 The admin will monitor pre-screening forms quarterly.

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

Implemented () - 09/28/2026)

225a - Assessment 15 Days**22. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #3, who was admitted to the home on [REDACTED].

Plan of Correction

Accept () - 07/30/2026)

1 On 7/17/2026 the admin reviewed the violation with all staff and managers.

2 On 7/7/2026 the nurse manager completed an assessment on resident # and placed it in [REDACTED] chart.

3 On 7/20/2026 the admin and nurse manager reviewed the process of properly auditing for deficiencies in documentation.

4 On 7/21/26 the admin conducted an education with all nursing staff and managers regarding the 15-day assessment forms and requirements.

5 On 7/22/2026 the nurse manager completed an audit of all resident charts to verify that 15-day assessments were completed and in resident charts.

6 On 7/23/2026 the admin assigned the lead medtech the duty to complete a separate monthly audit after the completion of monthly recaps as a second chart review for resident required documentation.

7 On 7/23/2026 the nurse manager verified all resident assessments were in place and will be reviewed by the manager monthly.

8 As of 7/24/2026 the admin will review resident charts quarterly.

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

225a - Assessment 15 Days (*continued*)

Implemented ([REDACTED] - 09/28/2026)