

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

September 9, 2026

[REDACTED], CEO
ODD FELLOWS HOME OF PENNSYLVANIA INC
999 WEST HARRISBURG PIKE
MIDDLETOWN, PA, 17057

RE: CRESCENT VIEW ASSISTED LIVING
999 WEST HARRISBURG PIKE
MIDDLETOWN, PA, 17057
LICENSE/COC#: 33892

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/07/2026, 07/15/2026 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: CRESCENT VIEW ASSISTED LIVING

License #: 33892

License Expiration: 10/01/2026

Address: 999 WEST HARRISBURG PIKE, MIDDLETOWN, PA 17057

County: DAUPHIN

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: ODD FELLOWS HOME OF PENNSYLVANIA INC

Address: 999 WEST HARRISBURG PIKE, MIDDLETOWN, PA, 17057

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 01/25/1999

Issued By: Department of Labor & Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 66

Waking Staff: 50

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Complaint, Incident

Exit Conference Date: 07/15/2026

Inspection Dates and Department Representative

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

07/15/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 98

Residents Served: 49

Special Care Unit

In Residence: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 1

Are 60 Years of Age or Older: 49

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 3

Have Mobility Need: 17

Have Physical Disability: 1

Inspections / Reviews

07/07/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/20/2026

Inspections / Reviews (*continued*)

08/24/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 08/31/2026

08/28/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/09/2026

09/09/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

42b Abuse/Neglect

1. Requirements

2800.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #6 is provided with moderate supervision from staff which includes some supervision in the home and needs attendance when outside the home, and/or tends to wander, as per [REDACTED] most recent assessment and support plan dated [REDACTED]. Per staff interviews and safety check documentation, the resident required 2-hour safety checks. On [REDACTED] safety checks were documented at [REDACTED] by Staff Member A and [REDACTED] by agency staff. On [REDACTED] Staff Member B documented a Health Status Note that at about [REDACTED] that morning, while staff was passing the [REDACTED] meds, [REDACTED] peeped into the room and Resident #6 was still sitting in [REDACTED] recliner with eyes closed. Staff left to continue med pass. However, the Resident #6 was seen on camera footage leaving the home unsupervised at [REDACTED]. The resident was found at [REDACTED] outside on the ground in the West View Terrace Entrance parking lot by Staff Member A. The resident was soaking wet, wearing pajama pants and a T-shirt, with [REDACTED] eyes rolling back in [REDACTED] head and moaning with abrasions and bruising on [REDACTED] legs. EMS transported the resident to [REDACTED] Hospital where [REDACTED] was diagnosed with [REDACTED].

Plan of Correction

Accept ([REDACTED] - 08/24/2026)

C. Resident R6 on [REDACTED] eloped and was found on the ground by West View Terrence Entrance. R6 was sent to the ER for evaluation and treatment. Upon return [REDACTED] was placed in the health center, and wander guard is in place. [REDACTED] was not identified as an elopement risk prior to this incident

L. 8/17/2026, the DON or Designee shall review AL residents for elopement risks. Documentation of this audit shall be kept.

E. By 8/30/2026, All Direct Care Staff shall receive education on the following: safety checks and timely and accurate documentation. Documentation shall be kept

A. Beginning 8/17/2026, The DON/Designee will review 24-hour report, safety checks by PCAs and nursing documentation for timely and accurate information daily, for 30 days.

R. To ensure consistent adherence to Regulation 2800.42b, compliance review will be conducted during the monthly Quality Management meeting. This review shall take place at the next QM meeting in September 2026, documentation shall be kept.

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

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

54a Direct care staff quals

3. Requirements

2800.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff Member C did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a Direct care staff quals (continued)

Staff Member D did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Staff Member E did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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

C. Staff C, D, and E did not have proof of diploma or GED on file.

L. By 8/18/2026, The HR Department or Designee shall complete a review of current staff for GED or high school diploma. Documentation of this audit shall be kept.

E. By 8/20/2026, The Administrator or designee shall provide education to HR staff regarding this regulation and the requirement for a GED or high school diploma prior to hiring direct care staff.

A. Beginning 8/18/2026, The HR Rep or Designee will complete weekly audits for 4 weeks to confirm staff have GED or high school diploma.

R. To ensure consistent adherence to Regulation 2800.54a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting in September 2026, documentation shall be kept.

(Directed)

In addition to the above plan of correction, staff members whose records did not include a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry will be removed from direct care duties until a diploma, GED, or active registry status is received by the employee or a waiver is approved by the Department.

Directed Completion Date: 09/09/2026

Implemented () - 09/09/2026)**65a Fire Safety-1st day****4. Requirements**

2800.

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

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

Description of Violation

Staff Member C, whose first day of work was (), did not receive orientation on the following topics:

(1) Evacuation procedures.

(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

65a Fire Safety 1st day (continued)

- (3) The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

Staff Member D, whose first day of work was [REDACTED], did not receive orientation on the following topics:

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

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

C. Staff member C and D did not have fire safety training on day one. Staff will review and educate them on fire safety on their first day. Fire safety training updated 8/19/2026. Staff D completed updated fire safety. Staff D no longer works here.

L. By 8/19/2026, DON/designee will review our staff and agency regarding fire safety training and if needed they will be updated.

E. By 8/30/2026, DON/designee will Education provided to staff regarding day 1 fire safety education for all staff.

A. Weekly audits for 4 weeks by DON/designee to review education is completed. Documentation shall be kept

R. Review To ensure consistent adherence to Regulation 2800.65.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting in September 2026, documentation shall be kept.

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

Implemented ([REDACTED] - 09/09/2026)**65e Rights/Abuse 40 Hours****5. Requirements**

2800.

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

- 1. Resident rights.
- 2. Emergency medical plan.
- 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 4. Reporting of reportable incidents and conditions.
- 5. Safe management techniques.
- 6. Core competency training that includes the following:
 - i. Person-centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

65e Rights/Abuse 40 Hours (continued)

Description of Violation

Staff Member B completed [REDACTED] 40th scheduled work hour by [REDACTED]. However, this staff member did not complete training in the following topics:

- (2) Emergency medical plan.
- (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101 10225.5102).
- (4) Reporting of reportable incidents and conditions.
- (5) Safe management techniques.
- (6) Core competency training that includes the following:
 - i. Person centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Agency Staff Member C completed [REDACTED] 40th scheduled work hour by [REDACTED]. However, this staff member did not complete training in the following topics:

- (1) Resident rights.
- (2) Emergency medical plan.
- (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101 10225.5102).
- (4) Reporting of reportable incidents and conditions.
- (5) Safe management techniques.
- (6) Core competency training that includes the following:
 - i. Person centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Agency Staff Member D completed [REDACTED] 40th scheduled work hour by [REDACTED]. However, this staff member did not complete training in the following topics:

- (1) Resident rights.
- (2) Emergency medical plan.
- (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101 10225.5102).
- (4) Reporting of reportable incidents and conditions.
- (5) Safe management techniques.
- (6) Core competency training that includes the following:
 - i. Person centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Staff Member E completed [REDACTED] 40th scheduled work hour by [REDACTED]. However, this staff member did not complete training in the following topics:

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

65e Rights/Abuse 40 Hours (continued)

- (5) Safe management techniques.
- (6) Core competency training that includes the following:
 - i. Person-centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Plan of Correction

Accept () - 08/28/2026)

C. Staff member C, D, E. will be provided with the above education. Staff B and C no longer employed. D and E received education 8/26/2026

L. By 8/30/2026 DON/designee Review of current staff for compliance and corrective actions as needed.

E. DON/designee. Education provided to staff regarding the rights/abuse 40-hour mandatory education requirements by 8/30/2026.

A. DON/designee will complete Weekly audits for 4 weeks of current and new staff to ensure 40-hour mandatory education has been completed timely.

R. Review To ensure consistent adherence to Regulation 2800.65.e, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting September 2026; documentation shall be kept.

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

Implemented () - 09/09/2026)

65h 16 hrs annual training**6. 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 A received 0 hours of annual training relating to () job duties during training year 2025.

Plan of Correction

Accept () - 08/24/2026)

C. Staff member A will complete 16-hour annual training prior to next shift.

L. Review of all staff to ensure 16-hour annual training is completed by DON/designee for by 8/21/2026.

E. DON/designee provided our staff education by 8/30/2026 regarding the mandatory 16- hour annual training requirement.

A. DON/designee to complete Weekly audits for 4 weeks of current and new staff to ensure 16-hour annual training courses have been completed timely.

R. Review To ensure consistent adherence to Regulation 2800.65.h, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting in September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

65i Training topics

7. 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 A did not receive training in the following topics during the training year 2025:

(1) Medication self-administration training.

(2) Instruction on meeting the needs of the residents as described in the assessment tool, medical evaluation and support plan.

(3) Care for residents with dementia and 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 mental retardation, or both, if the population is served in the residence.

Plan of Correction

Accept () - 08/24/2026

Please review attached

C. Staff member A will be provided with the above annual education before next scheduled shift.

L. Review of staff will be completed by DON/designee to ensure they have the training and if not, they will be trained before next scheduled shift.

E. Staff education will be provided by DON/designee by 8/30/2026 with the annual educational requirements.

A. Weekly audits x 4 weeks by DON/designee to confirm annual education is being completed timely and accurately.

R. Review. Review To ensure consistent adherence to Regulation 2800.65.i, compliance review will be conducted during the monthly Quality Management meeting. This review

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

Implemented () - 09/09/2026

65j Annual training content

8. 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.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.708).
5. Falls and accident prevention.

65j Annual training content (continued)

Description of Violation

Staff Member A did not receive training in the following topics during the training year 2025:

- (1) Fire safety completed by a fire safety expert or by a 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 - 10225.5102).
- (5) Falls and accident prevention.

Plan of Correction

Accept () - 08/24/2026

C. Staff member A did not receive training in the above areas during 2025. Staff A will complete the training prior to next scheduled shift.

L. Review to be completed by DON/designee of all current staff for compliance. If out of compliance the staff members will complete the training before next scheduled shift.

E. Education provided to staff by DON/designee to be completed by 8/30/2026 regarding the annual education requirements.

A. weekly Audits x 4 weeks completed by DON/designee

R. Review. Review To ensure consistent adherence to Regulation 2800.65.j, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting in September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026

69 Dementia training

9. 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 B, date of hire () received only 2 hours of dementia specific training within 30 days of hire.

Staff Member C, date of hire () received 0 hours of dementia specific training within 30 days of hire.

Staff Member D, date of hire () received 0 hours of dementia specific training within 30 days of hire.

Plan of Correction

Accept () - 08/24/2026

C. Staff member B, C, and D will complete the above training requirements. Staff member B is no longer employed.

L. Review of AL staff to ensure all have met the requirements to be completed by DON/designee by 8/21/2026.

E. DON/designee to provide Education to staff on the mandatory 4 hour dementia training within 30 days as well as the annual 2 hour training. To be completed by 8/30/2026

A. DON/designee to complete Audits weekly x 4 weeks regarding completion of the 4 hour training and annual

69 Dementia training (continued)

2-hour dementia training.

R. Review. Review To ensure consistent adherence to Regulation 2800.69, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting in September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

85a Sanitary conditions**10. Requirements**

2800.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/15/2026 at 11:38 PM, a handheld () with dark green/black spots of mold within the container was present on the edge of Resident #7's bathtub.

Plan of Correction

Accept () - 08/24/2026)

C. Resident 7's dirty () was discarded and replaced Immediately at time of survey.

L. Environmental rounds to be completed by DON/designee to ensure no other residents have this same concern by 8/18/2026

E. Education provided to staff provided by DON/designee regarding sanitary conditions are maintained to be completed by 8/30/2026.

A. Weekly audits x 4 weeks of resident rooms and conditions to be completed by DON/Designee.

R. Reviews. Review To ensure consistent adherence to Regulation 2800.85.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

132h Designated meeting place**11. Requirements**

2800.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 1/26/2026 at 11:38PM, 5 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction

Accept () - 08/24/2026)

C. On 1/26/2026 5 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. We cannot correct this fire drill.

L. DON/designee to review last 12 months of fire drills for compliance. Completed 8/19/2026

E. Education provided to staff by DON/designee regarding the monthly fire drill requirements for AL to be

132h Designated meeting place (continued)

completed by 8/30/2026.

A. Monthly audits of AL fire drills to confirm compliance for 3 months to be completed by DON/designee.

R. Review. Review To ensure consistent adherence to Regulation 2800.132.h, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

141b1 Annual medical evaluation**12. Requirements**

2800.

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

1. At least annually.

Description of Violation

Resident #8's medical evaluation was completed on [REDACTED] The resident's previous medical evaluation was completed on [REDACTED]

Plan of Correction

Accept () - 08/24/2026)

C. Resident 8's annual medical evaluation was completed [REDACTED] Previous medical evaluation was [REDACTED]
Evaluation completed by staff at time of survey.

L. Review of annual evaluations for all AL residents by DON/designee completed on 8/18/2026

E. Education provided to staff by DON/designee regarding the requirement of annual medical evaluation to be completed by 8/30/2026.

A. Weekly audits x 4 weeks by DON/designee of residents who are due for evaluations that week and for completion.

R. Review. Review To ensure consistent adherence to Regulation 2800.141.b, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

183b Medications and syringes locked**13. Requirements**

2800.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On 7/15/2026 at 11:32 AM, a bottle of Ammonium Lactate with a pharmacy label was unlocked, unattended, and accessible in Resident #7's bedroom.

On 7/15/2026, at 11:46 AM, a bottle of Lidocaine pain relief cream was unlocked, unattended, and accessible in resident room #232.

183b Medications and syringes locked (continued)*Repeated Violation – 1/22/2025, et al***Plan of Correction****Accept () - 08/24/2026)***C. Open medication found in resident 7's room. Medication removed and locked up.**L. DON/Designee to complete Review of residents who self-administer to ensure they could lock the medications up when out of the room or not in use 8/19/2026.**E. Education provided by DON/Designee on making sure medications are locked up when not in use to be completed by 8/30/2026**A. DON/designee to complete Weekly audits x 4 weeks of residents who self-administer medications to ensure they are locked up in their rooms.**R. Review Review To ensure consistent adherence to Regulation 2800.183.b, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.***Licensee's Proposed Overall Completion Date: 09/09/2026****Implemented () - 09/09/2026)****183e Storing Medications****14. Requirements**

2800.

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

Description of Violation*On 7/15/2026 at 2:30 PM, Resident #9's medication sachet had been open at the top, allowing contaminants to enter the pouch.**On 7/15/2026 at 2:37 PM, blister #18 on a blister pack containing a Benzonatate 200MG capsule for Resident #9 was previously punctured and the capsule was placed back into the blister and a sticker placed over the blister.**Repeated Violation – 1/22/2025, et al***Plan of Correction****Accept () - 08/24/2026)***2800.183.e- Prescription medications, OTC medications and CAM shall be stored in an original manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.**C. Resident 9 had medications that were not in original containers. Either taped up in blister pack or sachet opened before use. They were removed at time of survey.**L. DON/designee will inspect all medication carts for proper storage of medications by 8/19/2026.**E. DON/designee will educate staff on what to do if blister pack opens or med sachet becomes open prior to use by 8/30/2026.**A. Weekly audits x 4 weeks of medication carts for proper medication storage.**R. Review. Review To ensure consistent adherence to Regulation 2800.183.e, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept*

183e Storing Medications (*continued*)

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

Implemented () - 09/09/2026)

184a Resident meds labeled

15. 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

Resident #7 had physician's orders for Novolog Flexpen 100U/ML, inject 20 units subcutaneously daily before breakfast, hold if BG ≤ 80 ; give half dose if >80 to <95 . Novolog Flexpen 100U/ML, inject 36 units sub-q once daily before lunch, hold if BG ≤ 80 ; give half dose if >80 to <95 . Novolog Flexpen 100U/ML, inject 54 units sub-q with supper. Hold if BG ≤ 80 ; give half dose if >80 to <95 . Novolog Flexpen 100U/ML, inject sub-q per ss before meals if BG 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; $>350=10U$. However, the pharmacy label for Novolog Flexpen only indicated inject 54 units sub-q with supper. Hold if BG ≤ 80 ; give half dose if >80 to <95 .

Plan of Correction

Accept () - 08/24/2026)

C. Resident 7's Novolog did not have the correct dose label from the pharmacy. Pharmacy was immediately made aware at time of survey.

L. DON/designee to check and correct all insulin used in AL by 8/19/2026.

E. Education provided to staff by DON/designee and pharmacy regarding proper labeling of insulin. To be completed by 8/30/2026

A. DON/Designee to complete Weekly audits x 4 weeks of insulin for proper labeling.

R. review. Review To ensure consistent adherence to Regulation 2800.184.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026g, documentation shall be kept.

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

Implemented () - 09/09/2026)

185a Storage procedures

16. 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 #7 was prescribed Novolog inject sub-q per SS before meals if BG 150-200 = 2U; 201-250 = 4U; 251-300 = 6U; 301-350 = 8U; $>350 = 10U$.

- On 7/3/2026 at 16:00, a blood sugar reading of 202 was documented on the resident's July 2026 Medication Administration Record. On 7/3/2026 at 4:06 PM, a blood sugar reading of 209 was logged in the resident's glucometer.

185a Storage procedures (continued)

- On 7/5/2026 at 6:00 AM, a blood sugar reading of 254 was documented on the resident's July 2026 Medication Administration Record. There was no blood sugar reading logged in the resident's glucometer around this timeframe.
- On 7/5/2026 at 16:00, a blood sugar reading of 350 was documented on the resident's July 2026 Medication Administration Record. On 7/5/2026 at 4:14 PM, a blood sugar reading of 368 was logged in the resident's glucometer.
- On 7/7/2026 at 11:00 AM, a blood sugar reading of 250 was documented on the resident's July 2026 Medication Administration Record. On 7/7/2026 at 11:05 AM, a blood sugar reading of 205 was logged in the resident's glucometer.

Resident #7 was prescribed Novolog inject 36 units sub-q once daily before lunch *hold if BG < or = 80; give half dose if >80 to <95. On 7/7/2026 at 11:30 AM, a blood sugar reading of 36 was documented on the resident's July 2026 Medication Administration Record. On 7/7/2026 at 11:05AM blood sugar reading of 205 was logged in the resident's glucometer.

Plan of Correction

Accept () - 08/24/2026)

C. Resident 7 takes routine NovoLog with parameters. Blood sugars in the MAR did not match the Blood sugars on the glucometer for multiple different dates. Other dates labeled no insulin available.

L. DON/designee to review all residents in AL who take insulin for accurate accuchecks and following physician orders by 8/19/2026.

E. Education will be provided to staff by DON/designee regarding E box use for insulin as well as accurate transcription of blood sugar from glucometer to MAR to be completed by 8/30/2026.

A. DON/designee to complete Weekly audits x 4 weeks of residents on insulin for proper transcription of blood sugars and use of Emergency box.

R. Review To ensure consistent adherence to Regulation 2800185.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

187d Follow prescriber's orders**17. Requirements**

2800.

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

Description of Violation

Resident #7 was prescribed Novolog inject sub q per SS before meals if BG 150 200 2U; 201 250 4U; 251 300 6U; 301 350 8U; >350 10U.

- On 7/1/2026, Resident #7 was not administered the SS Novolog medication as there was no insulin available in the home.
- On 7/5/2026 at 4:14 PM, a blood sugar reading of 368 was logged in the resident's glucometer for which the resident should have received 10U. On 7/5/2026 at 16:00, the resident was administered 8U.

Resident #7 was prescribed Novolog inject 54 units sub q with supper *hold if BG < or 80; give half dose if >80 to <95. On 7/1/2026 at 17:00, Resident #7 was not administered this Novolog medication as there was no insulin available in the home.

187d Follow prescriber's orders (continued)

Plan of Correction

Accept () - 08/24/2026)

C. Resident 7 was prescribed Novolog before meals. It was not administered following physician orders.

L. DON/Designee to complete Review of AL residents on insulin for following physician orders by 8/19/2026.

E. Education provided by DON/designee to staff regarding following insulin orders to be completed by 8/30/2026.

A. DON/Designee to complete Weekly audits x 4 weeks of residents on following physician orders.

R. Review To ensure consistent adherence to Regulation 2800.187.d, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

190a Completion of course—meds

18. Requirements

2800.

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 Member H, who has not successfully completed the Department approved medications administration course, as evidenced by a lack of an initial student med admin training user report, administered medications to the following residents:

Resident #6 Latanoprost 0.005% eye drops 5/21/2026, 5/28/2026, 5/29/2026 20:00

Resident #7 Dapagliflozin 10MG 7/1/2026 7/3/2026, 7/7/2026 7/15/2026 6:00

Plan of Correction

Accept () - 08/28/2026)

C. Staff member H did not have performance based testing within the past 2 years gave resident R 6 and R 7 medications. Staff member H completed annual training 8/26/26.

L. DON/designee to complete Review of staff regarding successful completion of Dept approved Medication administration and performance based competency test within the past 2 years and completion of the initial online user report by 8/20/2026.

E. Education regarding requirements of staff to successfully complete Dept approved Medication administration and performance based competency within 2 years to be given by DON/designee and completed by 8/30/2026.

A. DON/Designee to complete weekly audits for 4 weeks.

R. Review To ensure consistent adherence to Regulation 2800.190.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

190b Insulin injections

19. Requirements

190b Insulin injections (*continued*)

2800.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Resident #7 had prescribers orders for Mounjaro and was administered this medication by Staff Member F on 6/3/2026, 6/10/2026, 6/17/2026, 6/24/2026, and 7/8/2026 at 8:00AM. The home did not have a waiver for the administration of GLP-1 agonist medications and Staff Member F was not licensed.

Plan of Correction

Accept () - 08/24/2026)

C. Resident 7 had orders for Mounjaro. Staff member F (med tech) administered medication without waive in place for GLP-1 administration.

L. DON/Designee to complete review Any resident on a GLP-1 by 8/18/2026.

E. DON/designee to complete education that Until waiver has been completed and approved LPN/RN must administer a GLP-1 by 8/30/2026.

A. Review of GLP-1 MAR weekly x 4 weeks by DON/designee for proper staff administering medication.

R. Review To ensure consistent adherence to Regulation 2800.190.b, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026 documentation shall be kept.

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

Implemented () - 09/09/2026)

224a2 30 days prior to admission

20. Requirements

2800.

224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #10 was admitted on [REDACTED] The resident's initial assessment was not completed until [REDACTED]

Plan of Correction

Accept () - 08/24/2026)

C. Resident 10 was admitted, and the initial assessment was completed after admission and did not meet conditions in paragraph 3.

L. DON/designee to review admissions over previous 30 days from 7/19/2026-8/19/2026.

E. Education provided to staff by DON/designee regarding the requirement to be assessed within 30 days prior to admission to be completed by 8/30/2026.

A. DON/designee to complete Weekly audits x 4 weeks of potential admissions for Initial assessment completion within 30 days of admission.

R. Review To ensure consistent adherence to Regulation 2800.224.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

224a2 30 days prior to admission (*continued*)

Implemented () - 09/09/2026)

224c1 Initial SP 30 days prior/adm

21. Requirements

2800.

224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #10 was admitted on (); however, the resident's written preliminary support plan was not completed until ()

Plan of Correction

Accept () - 08/24/2026)

C. Resident 10 was admitted, and the support plan was not completed until after admission. They did not meet the conditions in paragraph 2.

L. DON/designee to review admissions over previous 30 days from 7/19/2026-8/19/2026.

E. DON/designee to Provide education to AL staff regarding need to have support plan developed within 30 days prior to admission by 8/30/2026.

A. Admissions will be audited weekly x 4 weeks by DON/designee to confirm support plan was developed within 30 days prior to admission.

R. Review To ensure consistent adherence to Regulation 2800.224.c, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026, documentation shall be kept.

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

Implemented () - 09/09/2026)

225a1 Assessment – annually

22. Requirements

2800.

225.a.1. 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: Annually.

Description of Violation

Resident #8's most recent assessment was completed on () The resident's previous assessment was completed on ()

Plan of Correction

Accept () - 08/24/2026)

C. Resident 8 assessments were completed over 1 year apart.

L. DON/designee to review AL residents for assessments being completed at least annually by 8/19/2026

E. Staff education by DON/designee on the requirement to complete the assessment form at least annually to be completed by 8/30/2026.

A. DON/designee to complete Weekly audits x 4 weeks of residents to ensure compliance.

R. Review To ensure consistent adherence to Regulation 2800.225.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting on September 2026,

225a1 Assessment – annually (continued)

documentation shall be kept.

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

Implemented () - 09/09/2026)

225a2 Assessment – significant change**23. 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 #7's assessment, dated () did not include the resident's (). On 7/1/2026, the resident received orders for wound care (). An additional written assessment was not completed.

Resident #8's assessment, dated () included an assessment that the resident is unable to manage finances, is provided with total assistance with managing finances, and that the resident's family is to manage the resident's finances. The home provided financial management supports to the resident through the resident's trust. However, an additional written assessment was not completed with these updates.

Resident #8's assessment, dated () included an assessment that the resident needed safety checks Q2 hours and supervision outside of the home. However, the assessment indicated the resident required minimal supervision which is described as "no supervision in the home or when in familiar surroundings but needs attendance in unfamiliar places" and did not reflect the resident's need for supervision outside the home.

Resident #9's assessment, dated () included an assessment that the resident needed 1x staff to assist in unfamiliar settings and outside of community. However, the assessment indicated the resident required minimal supervision which is described as "no supervision in the home or when in familiar surroundings but needs attendance in unfamiliar places" and did not reflect the resident's need for supervision outside the home.

Plan of Correction

Accept () - 08/28/2026)

C. Resident 7 had a significant change, and the written assessment was not completed. 7 updated 8/11/2026, 8 updated 8/10/2026 and 9 updated 8/10/2026

L. DON/designee to review Any resident with significant changes within 7/19/2026 8/19/2026.

E. Education provided to staff by DON/designee regarding need for a new written assessment if the resident has significant change to be completed by 8/30/2026

A.DON/designee to complete Weekly audits x 4 weeks of residents for significant change and assessment completion.

R. Review To ensure consistent adherence to Regulation 2800.225.a, compliance review will be conducted during the monthly Quality Management meeting. This review shall occur at the next QM meeting in September 2026, documentation shall be kept.

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

225a2 Assessment – significant change (*continued*)

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