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

August 31, 2026

[redacted], ADMINISTRATOR
TITHONUS BEDFORD LP
[redacted]

RE: COLONIAL COURTYARD AT BEDFORD
220 DONAHUE MANOR ROAD
BEDFORD, PA, 15522
LICENSE/COC#: 32948

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/08/2026, 07/09/2026 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: *COLONIAL COURTYARD AT BEDFORD* **License #**: *32948* **License Expiration**: *06/05/2027*

Address: *220 DONAHUE MANOR ROAD, BEDFORD, PA 15522*

County: *BEDFORD* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *TITHONUS BEDFORD LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/12/2000* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *102* **Waking Staff**: *77*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/09/2026*

Inspection Dates and Department Representative

07/08/2026 - On-Site: [redacted]

07/09/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *83* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *19* **Residents Served**: *14*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *0*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *32* **Have Physical Disability**: *1*

Inspections / Reviews

07/08/2026 Full

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

Inspections / Reviews *(continued)*

08/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/20/2026*

08/17/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/30/2026*

08/31/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2026*

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

20b8 - Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home holds funds for Resident #1. Quarterly itemized accounts were not provided to the resident. The only quarterly statements provided to the resident are dated 2/21/25, 1/26/26 and 4/28/26. No quarterly statements were provided for the second, third and fourth quarters of 2025.

The home holds funds for Resident #6. Quarterly itemized accounts were not provided to the resident. The only quarterly statements provided to the resident are dated 2/21/25, 1/26/26 and 4/28/26. No quarterly statements were provided for the second, third and fourth quarters of 2025.

The home holds funds for Resident #7. Quarterly itemized accounts were not provided to the resident. The only quarterly statements provided to the resident are dated 2/21/25, 1/26/26 and 4/28/26. No quarterly statements were provided for the second, third and fourth quarters of 2025.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction – 20.b.8 Quarterly Financial Statements
Immediate Corrective Action:
The Administrative Services Director completed a review of the financial records for Residents #1, #6, and #7 on 7/9/26. The missing quarterly itemized financial statements for the second, third, and fourth quarters of 2025 will be prepared from the residents' financial transaction records and provided to the residents and their designated persons, as applicable. Copies will be maintained in each resident's record. As of 7/9/26
Systemic Corrective Action:
On 7/9/26 and ongoing Administrative Services Director will review the home's financial management procedure to ensure that every resident for whom the home holds funds receives an itemized financial statement on a quarterly basis. As of 1/26/26 quarterly financial statement tracking log is implemented identifying the resident, quarter covered, date statement was prepared, date provided, recipient, and staff initials this was started on 1/26/26 and completed ongoing.
The Administrative Services Director will use a calendar reminder system to ensure quarterly statements are generated and distributed within the required time frame this was sat up as of 7/9/26.
Education was provided to the Administrative Services Director from the Executive Operations Officer on 7/9/26 to provided education and guidance on the correction of the quarterly statements.
Monitoring:
The Administrative Services Director and Executive Operations Officer will audit 100% of resident financial accounts quarterly for three consecutive quarters to verify that required statements were completed, provided to the resident/designated person, and copies maintained in the resident record as of 7/9/26. Any identified discrepancy will be corrected immediately.
Following the initial three-month monitoring period, quarterly financial statement compliance will remain part of the home's ongoing quality assurance review as of 7/9/26.

20b8 Quarterly Account (continued)

Responsible Person: Administrative Services Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/14/2026*

Implemented (- 08/27/2026)

25a - Written Contract and Review

2. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall 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 #2 was admitted to the home on . However, the resident home contract was not reviewed and signed by the resident and the resident's responsible party until .

Plan of Correction ***Accept (- 08/17/2026)***

Plan of Correction 25.a Written Contract and Review
Immediate Corrective Action:
The Community Relations Director on 7/9/26 reviewed Resident #2's resident home contract and confirmed that the contract was completed and signed after the resident's admission. The Executive Operations Director will educate the admission process with the Community Relations Director on 7/10/26 of to reinforce that the resident home contract must be completed, reviewed, and explained prior to admission or within 24 hours after admission.
Systemic Corrective Action:
The admission checklist will be revised by the Community Relations Director as of 8/11/26 to include a specific verification that the resident home contract has been completed, reviewed/explained, and signed within the required timeframe.
The Community Relations Director will be responsible for verifying completion of the contract during the admission process. No admission packet will be considered complete until the contract requirement has been verified and checklist is in Residents business file.
Monitoring:
As 7/10/26 Community Relations Director will audit 100% of new admissions for three months to verify that the resident home contract was completed, reviewed, explained, and signed within the required timeframe. Results will be documented on an admission compliance audit form.
Any deficiency identified during an audit will be corrected immediately and the staff member responsible will receive additional education.
Responsible Person: Community Relations Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/14/2026*

Implemented (- 08/27/2026)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract for Resident #3, dated [redacted] was not signed by the resident.

Repeated Violation - 9/23/25, et al.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction – 25.b Contract Signatures
Immediate Corrective Action:
Resident #3's resident-home contract was reviewed by the Community Relations Director and updated with signatures as of 7/9/26. The Community Relations Director will make every effort to obtain the required resident signature on the existing contract, or, if necessary, execute a corrected/current contract consistent with applicable requirements.
Systemic Corrective Action:
The Community Relations Director will review the resident-home contract requirements who is responsible for admissions and resident records. As of 8/11/26 admission/record-completion checklist created by the Community Relations Director will be implemented requiring verification of signatures by the administrator/designee, resident, payer when applicable, and designated person when applicable and agreed to by the resident.
The Community Relations Director and Executive Operations Officer will verify all required signatures before the admission record is considered complete. Education was provided to the Community Relations Director by the Executive Operations Officer on 7/10/26 to provide training and education for contract completion.
Monitoring:
As of 7/10/26 Community Relations Director will conduct a 100% audit of all current resident-home contracts to verify required signatures are present. Any missing signatures will be addressed immediately. Current resident audits was completed by 8/11/26.
All new resident-home contracts will be audited by the Community Relations Director and Executive Operations Officer from 8/1/26 and ongoing to ensure the signature requirements are consistently met.
Responsible Person: Community Relations Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/14/2026*

Implemented ([redacted] - 08/31/2026)

65a - FS Orientation 1st Day

4. Requirements

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

65a - FS Orientation 1st Day *(continued)*

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

Description of Violation

Staff Member A, hired on [redacted], Staff Member B, hired on [redacted] Staff Member C, hired on [redacted] and Staff Member D, hired on [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.

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.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction – 65.a First-Day Fire Safety Orientation

Immediate Corrective Action:

The Administrative Services Director reviewed the personnel/training records for Staff Members A, B, C, and D. The required general fire safety and emergency preparedness topics will be provided to the affected staff members immediately and documented in their personnel/training records.

Training will include evacuation procedures; staff duties during fire drills and emergencies; designated meeting locations; smoking safety and smoking-area procedures, when applicable; location and use of fire extinguishers; smoke detectors and fire alarms; and telephone use/emergency services notification. Training for these staff member was provided on 7/31/26 and placed in the file.

Systemic Corrective Action:

The home's new-hire orientation checklist will be revised by the Administrative Services Director on 8/1/26 to specifically identify each required fire safety orientation topic. The Administrative Services Director will verify completion of the orientation prior to or during the employee's first work day.

A staff training matrix will be maintained to track orientation completion for all employees, including direct care, ancillary, substitute personnel, and volunteers as applicable. Education was provided to the Administrative Services Director on 7/9/26 by the Executive Operations Officer to provide guidance on the checklist for completion of training hours and in files for New hire orientation.

Monitoring:

Starting 7/9/26 Administrative Services Director audited 100% of personnel files for all current employee to verify required first-day fire safety orientation is documented. This audit was completed on 8/10/26 by the Administrative Services Director. The training matrix will be reviewed monthly starting 8/1/26 and ongoing for three months and thereafter as part of the home's routine compliance monitoring by the Administrative Services Director and Executive Operations Officer.

Responsible Person: Administrative Services Director and Executive Operations Officer

65a - FS Orientation 1st Day (continued)

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/30/2026*

Implemented (- 08/31/2026)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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

Description of Violation

Staff Member A, hired on Staff Member B, hired on Staff Member C, hired on and Staff Member D, hired on did not receive orientation on 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.

Plan of Correction ***Accept (- 08/17/2026)***

Plan of Correction – 65.b Rights/Abuse 40-Hour Orientation
Immediate Corrective Action:
The administrative Services Director reviewed Staff Members A, B, C, and D will receive documented education on r Documentation of completion will be maintained in each affected employee's training record. Training for these staff member was provided on 7/31/26 and placed in the file by the Administrative Services Director.

Systemic Corrective Action:
The employee orientation program and training checklist will be reviewed and revised to clearly identify all required topics that must be completed within the first 40 scheduled working hours.
The Administrative Services Director will maintain a staff training matrix showing each employee's hire date, required training deadline, date completed, and trainer.
The home's new-hire orientation checklist will be revised by the Administrative Services Director on 8/1/26 to specifically identify each required resident rights, the emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions. The Administrative Services Director will verify completion of the orientation prior to or during the employee's first work day.

65b - Rights/Abuse 40 Hours (continued)

A staff training matrix will be maintained to track orientation completion for all employees, including direct care, ancillary, substitute personnel, and volunteers as applicable. Education was provided to the Administrative Services Director on 7/9/26 by the Executive Operations Officer to provide guidance on the checklist for completion of training hours and in files for New hire orientation.

Monitoring:
Starting 7/9/26 Administrative Services Director has audit 100% of personnel files for all staff to verify resident rights, the emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions. This audit was completed on 8/10/26 by the Administrative Services Director. The training matrix will be reviewed monthly starting 8/1/26 and ongoing for three months and thereafter as part of the home's routine compliance monitoring by the Administrative Services Director and Executive Operations Officer.
Responsible Person: Administrative Services Director and Executive Operations Officer

Licensee's Proposed Overall Completion Date: *08/30/2026*

Implemented ([redacted] - 08/31/2026)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.
   xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care Staff Member A hired on [redacted] direct care Staff Member B, hired on [redacted] and direct care Staff Member C, hired on [redacted] have been providing unsupervised ADL services. However, Staff Members A, B and C did not complete training that included a demonstration of job duties, followed by supervised practice.

65d Initial Direct Care Training (continued)

Staff Members A, B and C have also not completed the following initial direct care staff person training:
i. Safe management techniques.
ii. ADLs and IADLs
iii. Personal hygiene.
iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
v. The normal aging cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction 65.d Initial Direct Care Training
Immediate Corrective Action:
Staff Members A, B, and C will not provide unsupervised ADL services until the required training and supervised practice have been completed and documented.
The Administrative Services Director will review each affected employee's training record and arrange completion of all required initial direct care training, including demonstration of job duties followed by supervised practice, the trainings were all completed for Staff ABC on 7/31/26 by the Administrative Services Director
Systemic Corrective Action:
The home's direct care staff training program will be reviewed to ensure all required initial training topics are completed before staff provide unsupervised ADL services.
A competency checklist will be implemented requiring:

1. *Completion of required classroom/instructional training;*
2. *Demonstration of job duties;*
3. *Documented supervised practice;*
4. *Verification of competency by the designated trainer/supervisor; and*
5. *Administrator/designee approval before unsupervised ADL services are permitted.*

As of 79/26 a training matrix completes by Administrative Services Director will track each employee's required training and completion dates. Education was provided to the Administrative Services Director on 7/9/26 by the Executive Operations Officer to provide guidance on the checklist for completion of training hours and in files for New hire orientation.

Monitoring:

65d - Initial Direct Care Training (continued)

Starting 7/9/26 Administrative Services Director has conduct a 100% audit of direct care employee training records to verify required initial training and competency documentation. This audit was completed on 8/10/26 by the Administrative Services Director. The training matrix will be reviewed monthly starting 8/1/26 and ongoing for three months and thereafter as part of the home's routine compliance monitoring by the Administrative Services Director and Executive Operations Officer.

Responsible Person: Administrative Services Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/30/2026*

Implemented ([redacted] - 08/31/2026)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

Residents #8, #9, and #10 wear WanderGuard bracelets that automatically lock the main egress doors when they are in close proximity. This prevents these and other residents from freely exiting the building.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction – 121.a Unobstructed Egress
Immediate Corrective Action:
The Safety Maintenance Director and Executive Operations Officer immediately reviewed the use and programming of the WanderGuard devices worn by Residents #8, #9, and #10.
On 7/8/26 the home immediately removed the wiring from the program device configuration that automatically locks or prevents residents from freely exiting the building. The main egress doors will remain accessible and unobstructed in accordance with applicable fire and life-safety requirements.
Residents' individual safety needs will be reviewed and appropriate, less restrictive measures will be implemented as clinically/individually appropriate.

Systemic Corrective Action:
The Safety Maintenance Director and Executive Operations Officer will review the home's policies concerning egress, resident safety, elopement/wandering risks, and the use of electronic monitoring devices. As of 7/8/26 on ongoing. The home will establish a procedure requiring Administrator approval and review of any electronic monitoring or wandering-management device before implementation. Provided all staff training for proper operation of the door and there nonlocking system with procedures on 7/14/26, training provided by Safety Maintenance Director and Executive Operations Officer.

Monitoring:
The Safety Maintenance Director and Executive Operations Officer will conduct weekly egress checks to verify that all required egress routes and doors remain accessible and unobstructed. As of 7/8/26 and ongoing

121a Unobstructed Egress (continued)

Thereafter, egress will be reviewed weekly and incorporated into the home's routine environmental/safety audit.
Responsible Person: Safety Maintenance Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/14/2026*

Implemented ([redacted] - 08/27/2026)

141b1 - Annual Medical Evaluation

8. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction 141.b.1 Annual Medical Evaluation
Immediate Corrective Action:
The Resident Wellness Director reviewed Resident #3's medical record. The resident's medical evaluation will be obtained and documented immediately.
The resident's record was updated by the Resident Wellness Director and the medical director on 7/8/26.
Systemic Corrective Action:
The Resident Wellness Director will establish a medical evaluation tracking log for Move in and use monthly for all residents as of 8/1/26. The log will identify the date of the most recent medical evaluation and the next annual due date.
The Resident Wellness Director will notify the resident/responsible party and appropriate healthcare provider in advance of the annual due date when necessary. Education was provided to the Resident Wellness Director by the Executive Operations Officer on 7/10 /26 about proper procedures with tracking medial evaluation dates and documentation.
Monitoring:
As of 7/9/26 Resident Wellness Director will review the medical evaluation tracking log monthly for three months and quarterly there after to ensure all residents have a current annual medical evaluation.
Any evaluation approaching its due date will be identified and follow up will be documented.
Responsible Person: Resident Wellness Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented ([redacted] - 08/31/2026)

187b - Date/Time of Medication Admin.

9. Requirements

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

Description of Violation

Resident #4 is prescribed the medication Midodrine 10mg with parameters to hold if systolic blood pressure in over 120. On 7/4/26 and 7/6/26, the resident's systolic blood pressure for the morning administration time was recorded as 126 and 130 on the resident's July 2026 Medication Administration Record (MAR). The medication was not administered. However, the MAR indicates that the Midodrine was administered.

Plan of Correction ***Accept (- 08/17/2026)***

Plan of Correction – 187.b Date/Time of Medication Administration
Immediate Corrective Action:
Resident #4's July 2026 MAR was reviewed by the Resident Wellness Director and corrected on 7/9/26. The medication order and the documented blood pressure parameters will be reviewed with the responsible medication staff.
Staff will be educated that when a medication is held because a prescribed parameter is met, the MAR must accurately reflect that the medication was not administered and must include the required information at the time the medication decision is made.
The affected MAR will be reviewed and corrected in accordance with applicable documentation requirements without altering the original record improperly.
Systemic Corrective Action:
All medication administration staff will receive education on 8/18/26 on accurate, timely MAR documentation, including documentation when medications are held based on physician-prescribed parameters by the Resident Wellness Director.
The medication administration policy will be reviewed with emphasis on recording medication administration information at the time medication is administered or held.
Monitoring:
On 7/9/26 Resident Wellness Director will conduct weekly MAR audits for four weeks, followed by twice-monthly audits for two months, and then monthly audits for three additional months, to be completed by 12/31/26.
Audits will specifically include medications with parameters to hold, refuse, or administer based on vital signs/laboratory values.
Any discrepancy will be addressed immediately with the staff member involved and documented.
Responsible Person: Resident Wellness Director
Proposed Completion Date: 08/20/2026

Licensee's Proposed Overall Completion Date: *08/20/2026*

Implemented (- 08/31/2026)

202 - Prohibitions

10. Requirements

2600.
202. The following procedures are prohibited:
1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).

202 - Prohibitions *(continued)*

Description of Violation

Residents #8, #9, and #10, who do not reside in the Secure Dementia Care Unit (SDCU), wear WanderGuard bracelets. These bracelets activate an audible alarm and lock the main egress doors when the residents are in close proximity to it. The use of this device to control resident movement constitutes a mechanical restraint.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

See attached.
Plan of Correction – 121.a Unobstructed Egress
Immediate Corrective Action:
The Safety Maintenance Director and Executive Operations Officer immediately reviewed the use and programming of the WanderGuard devices worn by Residents #8, #9, and #10.
On 7/8/26 the home immediately removed the wiring from the program device configuration that automatically locks or prevents residents from freely exiting the building. The main egress doors will remain accessible and unobstructed in accordance with applicable fire and life-safety requirements.
Residents' individual safety needs will be reviewed and appropriate, less restrictive measures will be implemented as clinically/individually appropriate.

Systemic Corrective Action:
The Safety Maintenance Director and Executive Operations Officer will review the home's policies concerning egress, resident safety, elopement/wandering risks, and the use of electronic monitoring devices. As of 7/8/26 on ongoing.
The home will establish a procedure requiring Administrator approval and review of any electronic monitoring or wandering-management device before implementation. Provided all staff training for proper operation of the door and there nonlocking system with procedures on 7/14/26, training provided by Safety Maintenance Director and Executive Operations Officer.

Monitoring:
The Safety Maintenance Director and Executive Operations Officer will conduct weekly egress checks to verify that all required egress routes and doors remain accessible and unobstructed. As of 7/8/26 and ongoing
Thereafter, egress will be reviewed weekly and incorporated into the home's routine environmental/safety audit.
Responsible Person: Safety Maintenance Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/14/2026*

Implemented ([redacted] - 08/31/2026)

224a - Preadmission Screen Form

11. 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

The preadmission screening for Resident #2, who was admitted to the home on [redacted] was not dated.

224a Preadmission Screen Form *(continued)*

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

Plan of Correction 224.a Preadmission Screening Form
Immediate Corrective Action:
Resident #2's preadmission screening documentation was reviewed by the Community Relations Director and Executive Operations Officer . The Community Relations Director and Executive Operations Officer will determine whether the missing date can be appropriately documented based upon the available admission records and applicable documentation requirements. Residents #2 was completed by the Community Relations Director and date was placed on the preadmission screening of the correct date of completion[redacted]
Systemic Corrective Action:
The admission process will be revised by the Community Relations Director as of 8/11/26 to include a preadmission screening checklist requiring verification that the screening form is dated and completed within the required timeframe.
The Community Relations Director and Executive Operations Officer will verify completion of the preadmission screening before admission is finalized. Education was provided to the Community Relations Director by the Executive Operations Officer on 7/10/26 to provide training and education for contract completion.
Monitoring:
As of 7/8/26 Community Relations Director and Executive Operations Officer will audit 100% of new admissions for three months to verify that the preadmission screening form is completed, dated, and maintained in the resident's record.
Any discrepancy will be corrected immediately.
Responsible Person: Community Relations Director and Executive Operations Officer
Proposed Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/14/2026*

Implemented ([redacted] - 08/27/2026)

227g -Support Plan Signatures

12. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan, and the assessor did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 08/17/2026)***

2. 227.g Support Plan Signatures
Plan of Correction 227.g Support Plan Signatures
Immediate Corrective Action:
Resident #5's support plan was reviewed by the Resident Wellness Director. The Resident Wellness Director will obtain the required signatures and dates from the resident and assessor, as applicable, and ensure the completed support plan is maintained in the resident's record. The Resident Wellness Director on 7/8/26 updated the Support Plan with proper signatures and placed in the appropriate record for Resident #5.

Systemic Corrective Action:

227g -Support Plan Signatures (continued)

The support plan process will be reviewed with all staff responsible for assessment and support plan development. A support plan completion checklist will be implemented by the Resident Wellness Director on 7/10/26 requiring verification that all individuals who participated in development of the support plan have signed and dated the document.
The Resident Wellness Director will verify completion of signatures before the support plan is considered finalized.
As 7/8/26 the signatures of the require parties was obtained by the Resident Wellness Director and placed in file.
Education was provided to the Resident Wellness Director by the Executive Operations Officer on 7/10/26 about proper procedures with tracking medial evaluation dates and documentation and signatures.

Monitoring:
As of 7/10/26 Resident Wellness Director and Executive Operations Officer will conduct a 100% audit of current resident support plans to verify required signatures and dates are present. The audit was completed as of 7/30/26.
For three months, all newly completed or revised support plans will be reviewed by the Resident Wellness Director and Executive Operations Officer for required signatures and dates.
Any missing signature will be addressed immediately and documented.
Responsible Person: Resident Wellness Director and Executive Operations Officer

Proposed Overall Completion Date: 08/14/2026

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented ([redacted] - 08/31/2026)