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

August 31, 2026

[redacted], PRESIDENT
EC OPCO SC LLC
[redacted]

RE: CELEBRATION VILLA OF NITTANY VALLEY
150 FARMSTEAD LANE
STATE COLLEGE, PA, 16803
LICENSE/COC#: 23374

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *CELEBRATION VILLA OF NITTANY VALLEY* **License #**: *23374* **License Expiration**: *07/03/2027*

Address: *150 FARMSTEAD LANE, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *EC OPCO SC LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/02/2012* **Issued By**: *Centre County*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *50*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *20* **Residents Served**: *16*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *50*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *18*

Have Physical Disability: *0*

Inspections / Reviews

07/09/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2026*

08/07/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/11/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/12/2026*

Inspections / Reviews *(continued)*

08/31/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

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 7/9/26 the home's License Inspection Summary report dated 7/30/25 was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 08/07/2026)***

ACTION: On July 9, 2026, Executive Director printed the 2025 annual inspection and placed it in the binder now labeled "Annual Survey Report" that is located outside of the Executive Director's office and available to the public.

TRAINING: On July 9, 2026 the Executive Director was educated on regulation 2600.3c by the Regional Director of Operations. A record of that training will be kept in accordance with 2600.65i.

ONGOING: Executive Director will conduct a weekly audit of the inspection binder to ensure compliance with 2600.3c for the next 4 weeks. A record of this audit will be kept in the Executive Director's office and a review of the findings will be completed during the August 2026 QA meeting.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/19/25 at approximately 4:00 a.m. the home's fire alarm was activated and fire trucks were dispatched to the home. The home did not report this incident to the department.
Repeated violation 2/25/26.

Plan of Correction ***Accept (- 08/07/2026)***

ACTION: A late report was completed and sent to the department on 7/13/26 by the Director of Nursing.

An Incident Reporting Checklist was implemented to ensure all reportable events are identified promptly, reported within the required timeframe, and documented appropriately. This checklist is a digital file that the Administrator and Director of Nursing can access.

The Executive Director or Director of Nursing will verify that each reportable incident has been submitted within 24 hours and that confirmation of the submission is maintained in the facility's records.

16c - Written Incident Report (continued)

Training: On July 14, 2026 a training was conducted by the Regional Director on regulation 2600.16 with the Executive Director, the Director of Nursing, the Resident Care Coordinator and the Maintenance Director. A record of this training will be kept in accordance with regulation 2600.65i.

ONGOING:

Effective July 31st the Executive Director will conduct a monthly audit of all incident reports for a minimum of three months to verify that all reportable incidents were submitted within the required 24-hour timeframe.

Audit findings will be reviewed the Executive Director at the home's monthly QA meetings starting in August 2026 for the next three month. Any identified concerns will be addressed immediately through retraining and corrective action.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

17 - Record Confidentiality

3. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At approximately 10:02 a.m., the laptop on the medication cart located in the back hall, outside of the dining room, was unlocked, unattended and assessable to resident records.
Repeated violation 7/30/25.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

ACTION:
The resident information was immediately removed from public view at the time of inspection on July 9, 2026. On July 9, 2026, staff assigned to the area were instructed to properly store confidential information by the Director of Nursing.

The medication technician "Staff member C" received counseling and re-education on July 16, 2026 on regulation 2600.17. A record of this counseling is on the employee file.

Training:

All staff with access to resident records received training on regulation 2600.17 by the Director of Nursing on July 15th and 16th, 2026. A record of this training will be kept in accordance with regulation 2600.65i.

17 - Record Confidentiality (continued)

Ongoing:

July 26th 2026, The Administrator, Director of Nursing or Resident Care Coordinator will conduct random weekly observations of medication passes and electronic device use for the next 3 months to ensure compliance with regulation 2600.17.

We review of this audit will be conducted during the home's next QA meeting in August 19,2026 2026 for three months.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

25b - Contract Signatures

4. 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 dated [redacted] for resident #1 was not signed by the resident.
Repeated violation 7/30/25.

Plan of Correction ***Accept (- 08/07/2026)***

Action: The resident's lease was reviewed with the resident on July 13,2026 and missing signatures were obtained at that time by the Executive Director.

An audit of all resident charts will be conducted and completed by August 18, 2026 to ensure all residents contracts have been signed or noted, when appropriate, that resident is unable to sign, by the Executive Director. A record of this audit will be kept in the Executive Directors office.

Training: The Regional Director of Operations conducted a training on regulation 2600.25b for the Executive Director and the Sales Director on July 13, 2026. A record of this training will be kept in accordance of 2600.65i.

Ongoing:

Effective July 13,2026, The Executive Director will review all new admissions using the resident file checklist to verify that the resident-home contract is fully completed and signed before the resident's admission file is finalized.

Audits of newly admitted residents' records will be conducted once a month for the next three months to ensure all required signatures are present and documentation is complete, the Executive Director. A review of these audits will be completed during the home's monthly QA meeting for the next three months starting in August 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

25b - Contract Signatures *(continued)*

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

41e - Signed Statement

5. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.
Repeated violation 7/30/25.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: The residents lease to include statement signed by the resident acknowledging receipt of a copy of resident rights and complaint procedures, was reviewed with resident #1 on July 13,2026 and signatures were obtained at that time by the Executive Director.

July 13, 2026, the facility's notice of new admission list was revised to include verification that the resident-home contract has been signed before the admission process is considered complete. The facility's lease contains documentation informing residents of resident rights.

Training: The Regional Director of Operations provided re-education to the Executive Director, Sales Director and Director of Nursing on the admission process, specifically on regulation 2600.41e. A record of this training will be kept in accordance of 2600.65i.

Ongoing:

Effective July 13, 2026 The Administrator will review all new admissions using the admission checklist to verify that the resident-home contract is fully completed and signed before the resident's admission file is finalized.

July 31, 2026, monthly audits of newly admitted residents' records will be conducted once a month for the next three months to ensure all required signatures are present and documentation is complete, the Executive Director.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

65g - Annual Training Content

6. Requirements

2600.

65g - Annual Training Content *(continued)*

65.g. 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.

Description of Violation

Staff persons A and B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 2025 training year. Staff person B did not receive training in emergency preparedness during the 2025 training year.
Repeated violation 7/30/25.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: Prior to the inspection on July 9, 2026 the facility conducted Fire safety training with a Fire Safety Expert on July 6, 2026. The home has completed the annual requirement. A record of this training is in the home's fire safety binder.

On July 10, 2026 the home confirmed that staff person B has completed the annual emergency preparedness training requirement for 2026. An audit of all staff training records was completed on July 10, 2026 by the Executive Director. In addition, the home confirmed that the 2026 Training Plan includes annual training on Emergency Preparedness to ensure compliance with regulation 2600.65g.

Training: The Executive Director conducted training on regulation 2600.65g with the Maintenance Director and the Administrative Assistant on 7/10/26. A record of this training will be kept in accordance with regulation 2600.65i.

Ongoing: Effective August 1, 2026 The Executive Director will maintain a record of annual training dates to ensure emergency preparedness training is completed and that fire safety training is scheduled and completed prior to the annual due date each year.

The home will review this regulation and the findings of the training audit at the next monthly QA meeting on August 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

82a - Poisonous Materials

8. Requirements

82a Poisonous Materials *(continued)*

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At 9:50 a.m. there was an unlabeled spray bottle containing a clear liquid found in the laundry area of the 200 Hall. Repeated violation 7/30/25.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: Executive Director immediately removed the bottle during the inspection on July 9, 2026 and properly discarded.

On July 6,2026 all other laundry rooms and storage areas were checked by Executive Director to ensure no other unlabeled bottles were present and that all solutions were in their original container.

TRAINING: All staff received training on regulation 2600.82a on July 15th and July 16th 2026. Training was conducted by the Director of Nursing. A record of this training will be kept in accordance with regulation 2600.65i.

Ongoing: Effective July 31, 2026 Maintenance Director or Executive Director will check all laundry rooms and storage areas every week for 3 months to ensure compliance with regulation 2600.82a. A record of these audits will be kept and findings will be reviewed during the home's monthly QA meetings for the next 3 months starting in August 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

82c Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At 3:00 p.m., Sensodyne toothpaste with a manufacture's label indicating " If more than used for brushing is accidentally swallowed, get medical help or Contact a Poison Control Center ", was unlocked, unattended, and accessible in resident #1's bathroom. Also Febreze Heavy Duty Air Freshener with a manufacture's label indicating " If eye contact occurs rinse well with water and if irritation persists, get medical attention ", was unlocked, unattended, and accessible in resident #1's bathroom. Resident #1 has been assessed as unable to safely use or avoid poisons. Repeated violation 7/30/25.

82c Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept (- 08/07/2026)***

Action: All products identified in resident #1 room were immediately removed and properly stored pending further clarification from the Primary Care Physician (PCP). PCP was contacted on July 9, 2026 for clarification. On July 13, 2026 PCP responded to facility in writing that resident CAN safely use or avoid poisonous materials. Resident's DME was corrected for the error and resident was given products back to use freely in room on July 13, 2026.

An audit of all residents DME's and RASP will be completed by Director of Nursing by August 7, 2026. A record of this audit will be kept in the administrator's office.

TRAINING: A training was conducted by the Executive Director for the Director of Nursing on July 10, 2026 to review regulation 2600.82c. Additionally, a training was conducted for all staff on regulation 2600.82c on July 15th and July 16th by The Director of Nursing. A record of this training will be kept in accordance with regulation 2600.

Ongoing: Effective August 1, 2026, following the completion of the DME by the Director of Nursing, the Executive Director will review the DME to ensure accuracy and that is matches the RASP, prior to being filed.

A review of the audit findings and regulation 2600.82c will be reviewed at the home's next QA meeting starting on August 19, 2026 for the next three months.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

91 - Telephone Numbers

10. 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

At 9:30 a.m. the sticker with the required emergency telephone numbers for the phone in the 300 Hall kitchenette was torn and the numbers were illegible.

Plan of Correction ***Accept (- 08/07/2026)***

The illegible emergency phone numbers were removed and replaced with new, clearly printed and easy to read emergency contact information immediately upon discovery on July 9, 2026 by the Executive Director.

A complete audit of all emergency phones with an outside line will be conducted by the Maintenance Director by August 6,2026 to ensure all emergency numbers are present and legible. A record of this audit will be kept in the administrator's office.

TRAINING: The Administrator will conduct a training with all staff on regulation 2600.91 by August 14, 2026. A record of this training will be kept in accordance with regulation 2600.65i.

91 - Telephone Numbers (continued)

Ongoing: Effective Aug 6, 2026 The Administrator, Maintenance Director or Resident Care Coordinator will complete a monthly audit for three months to ensure all emergency numbers are in place and that the information is legible. These audits will be kept in the Administrator's office and will be reviewed at the home's next three QA meetings, starting on August 19, 20262026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

132a - Monthly Fire Drill

12. Requirements

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

Description of Violation

An unannounced fire drill was not held during the month of October 2025. The fire drill documented on the home's 2025 fire drill log for 10/19/25 at 4:00 a.m. was an incident in which the fire alarm was activated but evacuation time for the incident was not observed and accurately documented.

Plan of Correction ***Accept (- 08/07/2026)***

Action: The leadership team, which includes the maintenance director, Director of Nursing, Sales Director, Resident Care Coordinator, Life Enrichment Coordinator, Dining Services Director, and the Administrative Assistant were instructed by the Executive Director July 9, 2026 that accidental alarm activations may not be substituted for required scheduled fire drills.

Training: The Executive Director trained all staff on regulation 2600.132a by August 14, 2026. The Executive Director did a separate training with the Maintenance Director on July 9, 2026 on the requirement of keeping drills unannounced and ensuring that true emergencies and/or accidental alarms were not recorded as drills. A record of these trainings will be kept in accordance with regulation 2600.65i.

Ongoing: Effective July 9, 2026, The Executive Director will review all fire drill documentation monthly for accuracy and completeness. Any discrepancies will be addressed immediately. A review of regulation 2600.132a and all future fire drill logs will be reviewed during the home's monthly QA meetings starting in August 19,2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

133.1 - Exit Signs

13. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

133.1 Exit Signs *(continued)*

Description of Violation

At 9:55 a.m. there was no exit sign over the door leading to the unenclosed outdoor patio area in 200 Hall. The home currently serves 50 residents.

Plan of Correction ***Accept (- 08/07/2026)***

Action: The missing exit sign was replaced on July 10, 2026 by the home's Maintenance Director.

The Maintenance Director replaced all over the door exit signs on July 14, 2026 that are currently in a picture frame with an adhesive Exit sign to prevent Exit sign from falling off.

TRAINING: A training on regulation 2600.121a was completed by the Administrator for the Maintenance Director on July 14, 2026. A record of this training will be kept in accordance with regulation 2600.65i.

Ongoing: The home's Maintenance Director will conduct an audit on all exit doors monthly for the next three months to ensure compliance with regulation 2600.121a. A record of these audits will be kept in the administrator's office.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's medical evaluation dated does not include the resident's weight, pulse rate, blood pressure or temperature.

Plan of Correction ***Accept (- 08/07/2026)***

Action: The resident's medical evaluation was immediately reviewed, by the Executive Director and Director of Nursing. The resident's physician was contacted, and a complete medical evaluation, including weight, pulse rate,

141a 1-10 Medical Evaluation Information (continued)

blood pressure, and temperature, was obtained and placed in the resident #2's record, by the Director of Nursing on July 9, 2026 at the time of the survey.

The DON will conducted an audit of all resident medical evaluations to ensure that all required components, including weight, pulse rate, blood pressure, and temperature, are documented. Any identified omissions were corrected by obtaining updated documentation from the resident's healthcare provider. This will be completed by August 7, 2026.

Training: The Executive Director conducted training with the Director of Nursing on July 31, 2026 on regulation 260.141a. A record of this training will be kept in accordance with regulation 2600.65i.

Ongoing: The Executive Director will review all DME's prior to filing to ensure DME's are competed in their entirety. If any missing information is noted, the Executive Director will notify the Director of Nursing to ensure correct information is obtained and documented prior to considering DME complete.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

162c - Menus Posted

15. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 7/09/26 at approximately 9:15 a.m., the menu for the week of 7/05/26 to 7/11/26 was posted. However, the weekly menu for the upcoming week of 7/12/26 to 7/18/26 was not posted.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: The upcoming week's menu was posted immediately during survey on July 9, 2026 upon identification of the deficiency in the designated area accessible to residents by the Dietary Manager.

Training: The menu posting requirement has been reviewed with cooks and Dietary manager on 7/10/26, by the Executive Director. A record of this training will be kept in accordance with regulation 2600.65i.

Ongoing: Effective July 10, 2026 The Dietary Manager or designee will verify weekly that the current and upcoming week's menus are posted as required. Compliance will be documented as part of the facility's routine dietary oversight weekly for 90 days. Findings will be reviewed on August 19, 2026 at the Quality managers meeting.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

171b5 - First Aid Kit

16. Requirements

171b5 - First Aid Kit *(continued)*

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

At approximately 1:15 p.m., the home's transportation vehicle did not have a first aid kit in the vehicle.

Plan of Correction ***Accept (- 08/07/2026)***

Action: The first aid kit was immediately restocked and returned to the facility van by the Maintenance Director on July 9, 2026 at the time of the survey. The contents were verified to ensure the kit was complete and readily available for resident transportation.

Ongoing: Effective August 1, 2026 The Maintenance Director will inspect all facility first aid kits including the van's, to verify that required first aid kits are present, fully stocked, and readily accessible weekly for 90 days. Any deficiencies will be corrected immediately and documented. Findings will be reviewed at the Quality manager meeting on Aug 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

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

Resident #3 is prescribed Carboxymethyl eye drops, one drop in both eyes 4 times a day as needed. The home did not have the eye drops available to administer if needed.

Plan of Correction ***Accept (- 08/07/2026)***

Action: The resident's physician's order was reviewed, and the prescribed PRN eye drops were obtained from the pharmacy and made available for administration by the Director of Nursing on July 10, 2026. A cart audit was conducted on July 16, 2026. Findings will be discussed at Quality Manager Meeting on Aug 19th.

Training:

The Executive Director conducted a training for the Director of Nursing on July 10,2026 to review regulation 2600.185a.

An education was provided on July 15th and 16th 2026 by DON, to all staff responsible for medication administration, on Regulation 2600.185a and the importance of having all ordered medications available including PRN medications ordered by physicians. A record of these trainings will be kept in accordance with regulation 2600.65i.

Ongoing: Effective July 16, 2026, Director of Nursing will conduct a cart audit every week for 90 days to ensure all current residents medications are available. Documentation of findings will be kept, and any discrepancies will be addressed immediately. Findings will be reviewed at the Quality Management Meeting on August 19, 2026.

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

187b - Date/Time of Medication Admin.

18. Requirements

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

Description of Violation

At 9:40 a.m. staff person C carried medications to resident #4 and was observed administering the medications to the resident in their room. After administering the medications, staff person C stated that they had already initialed the medications as administered on the resident's Medication Administration Record

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: Staff Member C was immediately counseled regarding the requirement to document medication administration only after the resident has received and taken the medication on July 10, 2026 by DHS surveyors. Formal counseling was conducted on July 16,2026 by [redacted] DON. All staff members responsible for administering medications were re-educated on safe medication administration practices on July 15th and 16th by [redacted] DON.

TRAINING Training on 2600.187 Medication Administration was conducted with all med tech staff on July 15 and 16, 2026 by [redacted] Director of Nursing.

Ongoing: Effective August 1, 2026 A certified medication administration trainer, practicum observer, or Licensed nurse will conduct random weekly observation of at least one medication administration weekly on random shifts for 90 days. Any discrepancies related to correct medication administration as outlined by the Department will be immediately addressed and documented. Findings will be discussed at quality manager meeting on Aug 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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

191 - Resident Right to Refuse

19. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1 was admitted to the home on [redacted] and has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: The residents lease to include statement signed by the resident acknowledging education to the residents right to refuse medication if the resident believes that there may be a medication error, was reviewed with the resident on July 13,2026 and signatures were obtained at that time by the Executive Director.

An audit of all resident charts will be conducted and completed by Aug 7,2026 ensuring all residents contracts

191 Resident Right to Refuse (continued)

have been signed or noted, when appropriate, that resident is unable to sign.

The facility's notice of new admission list was revised to include verification that the resident home contract has been signed before the admission process is considered complete. The facility's lease contains documentation of education provided to the resident of the right to question or refuse medication if the resident believes that there may be a medication error.

Training: The Regional Director of Operation provided re education to the Executive Director on regulation 2600.191 on July 10, 2026. A record of this training will be kept in accordance with regulation 2600.65i.

Ongoing:

The Executive Director will review all new admissions using the admission checklist to verify that the resident home contract is fully completed and signed before the resident's admission file is finalized for the next 90 days. Findings will be discussed at the quality managers meeting on Aug 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

225a - Assessment 15 Days

20. 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

Resident #1's initial assessment dated [redacted] documents no problems with the resident's ability to use and avoid poisonous materials: however, the medical evaluation dated [redacted] documents the resident can not safely use or avoid poisonous materials.
Repeated violation 7/30/25

Plan of Correction ***Accept (- 08/07/2026)***

Action: The Director of Nursing contacted the resident's provider for clarification. On 7/13/26 clarification was received that the resident can safely use and avoid poisonous material. Residents DME has been updated. An audit of all current DME's and RASP's will be completed by Aug 19, 2026. Findings will be discussed at quality manager meeting on Aug 19, 2026.

Training: Executive Director reeducated the Director of Nursing regarding ensuring DME and RASP match need, on regulation 2600. 225a on July 10,2026. (see attached training)

Ongoing: Beginning July 10, 2026, The Executive Director and Director of Nursing will both review DME's and RASPs for consistency prior to considering documents completed and filed.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/31/2026)

234a - Admission Support Plan

21. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #4 was admitted to the home's Secured Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Action: The resident's support plan was completed and reviewed to ensure it accurately reflected the resident's assessed needs, preferences, and services on July 8, 2026. On July 10, 2026 a review of all current resident records and recent admissions was completed to verify that support plans were completed within the required 72-hour timeframe with no further deficiencies noted on July 10, 2026 by the Director of Nursing.

Training: Training was conducted with Director of Nursing on July 10, 2026 on regulation 2600.234a by Executive Director.

Ongoing: Effective July 10, 2026 The Executive Director will audit all admissions, to a secured dementia care unit weekly for three (3) months to verify that support plans are completed within 72 hours of admission. Any identified noncompliance will be addressed immediately through corrective action and additional staff education as needed. Audit findings will be reviewed through the facility's Quality Assurance process on August 19, 2026.

Licensee's Proposed Overall Completion Date: *08/31/2026*

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