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

August 17, 2026

[redacted], REGIONAL ADMINISTRATOR
CRANBERRY PLACE
1201 CUMBERLAND ROAD
[redacted]
PITTSBURGH, PA, 15237

RE: CUMBERLAND CROSSING MANOR
1201 CUMBERLAND ROAD
PITTSBURGH, PA, 15237
LICENSE/COC#: 44616

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/14/2026, 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**: *CUMBERLAND CROSSING MANOR* **License #**: *44616* **License Expiration**: *06/30/2027*

**Address**: *1201 CUMBERLAND ROAD, PITTSBURGH, PA 15237*

**County**: *ALLEGHENY* **Region**: *WESTERN*

## Administrator

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

## Legal Entity

**Name**: *CRANBERRY PLACE*

**Address**: *1201 CUMBERLAND ROAD,* [redacted] *, PITTSBURGH, PA, 15237*

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

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *10/09/1998* **Issued By**: *L&I*

## Staffing Hours

**Resident Support Staff**: *43* **Total Daily Staff**: *159* **Waking Staff**: *119*

## Inspection Information

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

**Reason**: *Renewal, Complaint* **Exit Conference Date**: *07/15/2026*

## Inspection Dates and Department Representative

*07/14/2026 - On-Site:* [redacted]

*07/15/2026 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *115* **Residents Served**: *73*

### Special Care Unit

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

### Hospice

**Current Residents**: *12*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *73*

**Diagnosed with Mental Illness**: *0* **Diagnosed with Intellectual Disability**: *2*

**Have Mobility Need**: *43* **Have Physical Disability**: *0*

# Inspections / Reviews

### 07/14/2026 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/30/2026*

### 07/31/2026 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *08/15/2026*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/04/2026*

## Inspections / Reviews *(continued)*

**08/05/2026 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *08/15/2026*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/17/2026*

**08/17/2026 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *08/15/2026*

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

## 17 Record confidentiality

**1. Requirements**

2800.
17. Confidentiality of Records - 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**

*On 7/14/26 at approximately 10:47 a.m., empty boxes of prescription medication were found unlocked, unattended, and accessible on top of the 3rd Floor North medication cart located outside of the medication room in the North Hallway with confidential and protected health information to include:*

- *Resident #1's Breo Ellipta 100mcg/25mcg inhaler*
- *Resident #2's Diclofenac Sodium Gel*

*REPEAT VIOLATION 6/10/25 et. al.*

**Plan of Correction** ***Accept ([redacted] - 08/05/2026)***

*1. The medication cart found on 3rd floor outside of nurse's station was unattended while Medication Technician was assisting resident's apartment. On return from resident's room, Med Tech secured medications and protected health information and locked cart. Resident Support Coordinator immediately reviewed the necessity to secure medication cart before leaving to address resident care need with Medication Technician.*

*2. All medication passers(Licensed staff and medication technicians have been re-educated by the Resident Support Coordinator(RSC) and/or designee on importance of securing medication cart during shift. Specifically, the need to lock all aspects of cart during the medication pass and when unattended. Education was completed by 7/17/2026. Documentation of completion of training will be kept in accordance with 2800.65(l).*

*3. The RSC and/or designee will conduct random audits of medication carts to ensure locked while unaccompanied and during medication pass daily for 2 weeks and weekly for 2 months to ensure compliance. Audits are to begin within 3 business days of the receipt of the accepted plan of correction.*

*4. Audit findings will be reviewed by the Administrator and/or designee. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 54a Direct care staff quals

**2. 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**

*Direct care staff person A, hired [redacted], did not have a United States high school diploma, GED or active status on*

## 54a Direct care staff quals (continued)

*the Pennsylvania nurse aide registry.*

**Plan of Correction** ***Accept ( - 07/31/2026)***

*1. Staff person A, hired did not have a US high school diploma, GED or active status on the PA nurse registry. Staff person A non-US high school diploma, transcripts, and work status was verified at time of hire by Certiphi (credential service). Staff person A is currently enrolled in LPN program.*
*2. CCM applied for PA DHS waiver to 2800.54.(a) on 7/17/2026 for staff person A, waiver approval was received 7/29/2026 for staff person A.*
*3. Regional Administrator reviewed 54.(a) with administrator, as designee, to review new hire Direct Care Staff for education requirement to ensure compliance. Documentation of completion of training will be kept in accordance with 2800.65(l)*
*4. Audit of all existing employees was conducted to measure compliance. All new-hire Direct Care Staff persons who do not have US high school diploma will warrant Waiver request for qualifications prior to first day of employment.*
*5. Audit findings will be reviewed by the Administrator and/or designee monthly as part of the weekly Staffing meeting with Human Resources and will be ongoing.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ( - 08/17/2026)***

## 63a First Aid/CPR 1:35

**3. Requirements**

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

**Description of Violation**

*On all overnight shifts from 10:30 p.m. until 7:00 a.m. on dates ranging from 7/1/26 through 7/15/26 the residence census exceeded a total of 67 residents and only one staff person was certified in first aid and obstructed airway techniques and Cardiopulmonary resuscitation (CPR), the other staff persons working during those dates and times had only received "Basic Life Support" training that did not include First Aid.*

**Plan of Correction** ***Accept ( - 07/31/2026)***

*1. Overnight shifts from 7/1/26 through 7/15/2026 exceeded 67 residents and only one staff person was certified in first aid and obstructed airway techniques and Cardiopulmonary resuscitation(CPR), the other staff persons working during those dates and times had only received "Basic Life Support" training that did not include First Aid.*
*2. Overnight shifts from 7/1/26 through 7/15/2026 have Licensed Practical Nurse scheduled with Direct Care Staff persons. Review of all staff CPR/First Aid certification revealed curriculum did not include First Aid training with CPR certification.*
*3. Administrator has provided education to RSC specific to 2800.63(a) First Aid/CPR, 1 per 35 residents. This was completed on 7/15/26. Documentation of education will be kept in accordance with 2800.65(l)*
*4. Audit of existing Direct Care Staff for First Aid/CPR certification prompted 2 scheduled training classes. Complete course of both First Aid/CPR for certification is scheduled 7/31/26 and 8/7/26.*
*5. Audits of direct care staff First aid/CPR will be conducted by RSC and/or designee will be conducted upon hire and within 60 days of expiration of certification.*
*6. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days*

## *63a First Aid/CPR 1:35 (continued)*

*of receipt of the accepted plan of correction and will continue monthly for 6 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.*

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

***Implemented ( - 08/17/2026)***

## 65j Annual training content

**4. 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.

**Description of Violation**

*Direct care staff person A, hired , did not receive required annual training for the 2025 training year to include:*

*(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 reasponse to crises and emergency situations.*

**Plan of Correction** ***Accept ( - 08/05/2026)***

*1. Training by fire safety expert, McCandless Fire Marshall, was conducted on 07/09/2026 for all staff. Direct Care Staff A has been trained by fire safety expert. Documentation of training will be kept in accordance with 2800.65 (j).*
*2. The Regional Director has educated the facility administrator on 7/30/2026 that direct care staff, ancillary staff, substitute personnel and regularly scheduled volunteers shall be trained annually in fire safety by a fire safety expert or by a staff person trained by a fire safety expert. Documentation for completion of the training will be kept in accordance with 2800.65 (j).*
*3. The Administrator and/or designee will audit all employee 2026 annual training transcripts to ensure that annual Fire Safety training has been offered and completed.*
*4. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 6 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.*

**Licensee's Proposed Overall Completion Date:** *08/23/2026*

***Implemented ( - 08/17/2026)***

## 103f Fridge/Freezer Temps

**5. Requirements**

2800.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

## 103f Fridge/Freezer Temps *(continued)*

**Description of Violation**

*On 7/14/26 at approximately 11:58 a.m., the freezer portion of the General Electric refrigerator and freezer in the residence's activity room measured 6 degrees Fahrenheit. The temperature was re checked at 2:14 p.m. and measured 10 degrees Fahrenheit.*

*On 7/14/26 at 1:27 p.m. there was no thermometer in the ice cream chest freezer in the residence's kitchen to the right of the dry storage room.*

**Plan of Correction** ***Accept ( [redacted] - 07/31/2026)***

*1. On 7/14/26 at approximately 11:58 a.m., the freezer portion of the General Electric refrigerator and freezer in the residence's activity room measured 6 degrees Fahrenheit. The temperature was re checked at 2:14 p.m. and measured 10 degrees Fahrenheit. On 7/14/26 at 1:27 p.m. there was no thermometer in the ice cream chest freezer in the residence's kitchen to the right of the dry storage room.*
*2. A thermometer was immediately placed in the chest freezer. Additionally, the setting was lowered in the Activity Room freezer to ensure compliance.*

*3. Thermometer audits will be conducted 2x per day by the Dietary manager or chef on duty at the beginning and end of each day for the chest freezer. For the Activity Room freezer, a daily log will be conducted.*

*4. Education provided by Administrator and/or designee to Dietary manager and Activities Coordinator, who conduct temperature logs, to the standard procedure for repair/maintenance when logs do not meet parameters stated for refrigerators and freezers. Documentation of education will be kept in accordance with 2800.65(l)*

*5. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 2 months or until substantial compliance is achieved.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ( [redacted] - 08/17/2026)***

## 103g Storing food

**6. Requirements**

2800.
103.g. Food shall be stored in closed or sealed containers.

**Description of Violation**

*On 7/14/26 at approximately 1:30 p.m. in the residence's dry storage area there was an uncovered plastic container with what appeared to be homemade Caesar salad croutons that was not fully covered with plastic wrap.*

*On 7/4/26 at approximately 1:32 p.m., there was a ten pound bag of rainbow color ice cream sugar sprinkles that was found open and unsealed underneath multiple other bags of sealed ice cream bar ingredients and was approximately three quarters full of sprinkles.*

**Plan of Correction** ***Accept ( [redacted] - 07/31/2026)***

*1. On 7/14/26 at approximately 1:30 p.m. in the residence's dry storage area there was an uncovered plastic container with what appeared to be homemade Caesar salad croutons that was not fully covered with plastic wrap.*

## *103g Storing food (continued)*

*On 7/14/26 at approximately 1:32 p.m., there was a ten-pound bag of rainbow color ice cream sugar sprinkles that was found open and unsealed underneath multiple other bags of sealed ice cream bar ingredients and was approximately three-quarters full of sprinkles.*

*2. Croutons and Sprinkles were immediately discarded. Dry good storage containers were purchased for items such as Croutons and Ice Cream Sprinkle to ensure freshness in dry storage areas.*

*3. Dietary Director, or designee, conducted education for Dietary Manager, and all cooks. Education provided specific to Storing: Set up, maintenance and Compliance was conducted by designee 7/29/2026. Documentation of training will be kept in accordance with 2800.65 (l).*

*4. To ensure that all food is properly stored, labeled, dated, and covered audits will be conducted 2x per day by the manager or chef on duty after meal preparation to monitor proper food storage.*

*5. These audits will be conducted for two months beginning three business days following acceptance of the Plan of Correction.*

*6. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 6 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 103i Outdated food

**7. Requirements**

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

**Description of Violation**

*On 7/14/26 at approximately 1:36 p.m. there was an unlabeled and undated bag of what appeared to be pre-breaded chicken cordon bleu with six pieces within found on the shelving in the residence's walk-in freezer.*

*On 7/14/26 at approximately 1:36 p.m. there was an unlabeled and undated bag of what appeared to be hot dogs that contained nine individual hot dogs found on the shelving in the residence's walk-in freezer.*

**Plan of Correction** ***Accept ([redacted] - 07/31/2026)***

*1. On 7/14/26 at approximately 1:36 p.m. there was an unlabeled and undated bag of what appeared to be pre-breaded chicken cordon bleu with six pieces within found on the shelving in the residence's walk-in freezer. On 7/14/26 at approximately 1:36 p.m. there was an unlabeled and undated bag of what appeared to be hot dogs that contained nine individual hot dogs found on the shelving in the residence's walk-in freezer.*

*2. Unlabeled food products were immediately discarded.*

## 103i Outdated food (continued)

*3. Dietary Director, or designee, conducted education for Dietary Manager, and all cooks. Education provided specific to Storing: Set up, maintenance and Compliance was conducted by designee 7/29/2026. Documentation of training will be kept in accordance with 2800.65 (l).*

*4. To ensure that all food is properly stored, labeled, dated, and covered audits will be conducted 2x per day by the manager or chef on duty after meal preparation to monitor proper food storage.*

*5. These audits will be conducted for two months beginning three business days following acceptance of the Plan of Correction.*

*6. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 6 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 132b Safety inspection/fire drill

**8. Requirements**

2800.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

**Description of Violation**

*The most recent fire safety inspection and fire drill conducted by a fire safety expert was held on 5/20/26, and the previous fire safety inspection and fire drill conducted by a fire safety expert was held on 4/2/25.*

**Plan of Correction** ***Accept ([redacted] - 08/05/2026)***

*1. The most recent fire safety inspection and fire drill conducted by a fire safety expert was held on 5/20/26, and the previous fire safety inspection and fire drill conducted by a fire safety expert was held on 4/2/25.*

*2. A Fire Safety Inspection and Drill were conducted on 5/20/2026 by a Fire Safety Expert. Documentation of Inspection and Drill were provided by fire safety expert. Annual Inspection and Drill for 2027 has been scheduled with McCandless Fire Marshall on 4/13/2027. Furthermore, we have registered CCM Maintenance director for PA Fire Safety Train the Trainer Course taking place 9/23/2026 to ensure compliance.*

*3. The Regional Director has educated the facility Administrator that fire safety inspection and drill must be conducted annually by a fire safety expert. Education was completed 7/30/26. Documentation for completion of the training will be kept in accordance with 2800.65 (l).*

*4. Audits of fire safety inspections and drill are to occur quarterly, reviewing dates of upcoming inspections/drills and historical events with Fire Safety Expert to ensure compliance. Audits are performed by Administrator, and/or designee.*

## 132b Safety inspection/fire drill (continued)

*5. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 12 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 141a Medical evaluation

**9. Requirements**

2800.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.

**Description of Violation**

*Resident #3's initial medical evaluation, dated [redacted], did not include a general physical exam and fields for height, weight, pulse rate, blood pressure and temperature were all left blank.*

**Plan of Correction** ***Accept ([redacted] - 08/05/2026)***

*1. Resident #3's initial medical evaluation, dated [redacted], did not include a general physical exam and fields for height, weight, pulse rate, blood pressure and temperature were all left blank.*

*2. Resident Support Coordinator(RSC) was educated on 7/17/2026 to specific blank sections on initial Medical Evaluation. Documentation of education will be kept in accordance with 2800.65 (l). RSC completed missing field data for resident #3 and initialed on 7/31/26 and submitted for physician review.*

*3. RSC performed audit for new admissions in past 30 days for completion to achieve compliance. Random audit of 2 admissions per month for the next 3 months for Medical Evaluation fields including resident height, weight, pulse rate, blood pressure, and temperature will be conducted by RSC and/or designee.*

*4. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 3 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management Committee meeting.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 141b1 Annual medical evaluation

**10. Requirements**

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

## 141b1 Annual medical evaluation *(continued)*

**Description of Violation**

*Resident #4's annual medical evaluation, dated [redacted] was missing the resident's height, that area of the form was left incomplete.*

**Plan of Correction** ***Accept ([redacted] - 08/05/2026)***

*1. Resident #4's annual medical evaluation, dated [redacted] was missing the resident's height, that area of the form was left incomplete.*

*2. Resident Support Coordinator(RSC) was educated on 7/10/2026 to specific blank sections on initial Medical Evaluation. Documentation of education will be kept in accordance with 2800.65 (l). RSC completed resident height for resident #4 and initialed on 7/31/26 and submitted for physician review.*

*3. RSC performed audit for new admissions in past 30 days for completion to achieve compliance. Random audit of 2 admissions per month for the next 3 months for Medical Evaluation fields including resident height will be conducted by RSC and/or designee.*

*4. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 3 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management meeting.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 182b Prescription medication

**11. Requirements**

2800.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2800.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

**Description of Violation**

*Numerous staff interviews indicated that assisted living care aides without medication administration training required under 2800.190(a) had administered treatments to residents of the assisted living residence to include Voltaren External Gel 1% to resident #4 on dates to include:*

- *7/1/26 at approximately 9:45 p.m.*
- *7/5/26 at approximately 10:00 p.m.*
- *7/6/26 at approximately 10:30 p.m.*
- *7/7/26 at approximately 9:45 p.m.*
- *7/13/26 at approximately 10:00 p.m.*

**Plan of Correction** ***Accept ([redacted] - 07/31/2026)***

*1. Numerous staff interviews indicated that assisted living care aides without medication administration training required under 2800.190(a) had administered treatments to residents of the assisted living residence to include*

## *182b Prescription medication (continued)*

*Voltaren External Gel 1% to resident #4 on dates to include:*
*7/1/26 at approximately 9:45 p.m.*
*7/5/26 at approximately 10:00 p.m.*
*7/6/26 at approximately 10:30 p.m.*
*7/7/26 at approximately 9:45 p.m.*
*2. All medication passers (Licensed staff and medication technicians) have been educated by the Resident Support Coordinator(RSC) and/or designee on importance of performing treatments as licensed or certified professionals. Education included directive that only Medpassers can administer and document topicals with active medication ingredient. Education was completed 7/17/2026.*

*3. Personal Care Assistants will also be educated on their role specific to administration of medications and treatments. Education will be complete by 8/15/2026. Documentation of completion of training will be kept in accordance with 2800.65(l).*

*4. The RSC and/or designee will conduct random audits of Treatment Administration Record daily for 2 weeks and weekly for 2 months to ensure compliance. Audits are to begin within 3 business days of the receipt of the accepted plan of correction.*

*5. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue weekly for 2 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management meeting.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 183b Medications and syringes locked

**12. 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 7/14/26 at approximately 10:47 a.m., the residence's 3rd Floor North medication cart was found unlocked, unattended and accessible in the North Hall outside of the medication room and to the left of the 3rd Floor South medication cart with the bottom drawer to the cart left open and numerous medications within for all of the residence's 3rd Floor North residents to include but not limited to:*

- *Resident #1*
- *Resident #2*
- *Resident #3*
- *Resident #5*

## 183b Medications and syringes locked *(continued)*

**Plan of Correction** ***Accept ( [redacted] - 08/05/2026)***

*1. The medication cart found on 3rd floor outside of nurse's station was unattended while Medication Technician was assisting resident's apartment. On return from resident's room, Med Tech secured medications and protected health information and locked cart. Resident Support Coordinator immediately reviewed the necessity to secure medication cart before leaving to address resident care need with Medication Technician.*

*2. All medication passers(Licensed staff and medication technicians have been educated by the Resident Support Coordinator(RSC) and/or designee on importance of securing medication cart during shift. Specifically, the need to lock all aspects of cart during the medication pass and when unattended. Education was completed 7/17/2026. Documentation of completion of training will be kept in accordance with 2800.65(l).*

*3. The RSC and/or designee will conduct random audits of medication carts to ensure locked while unaccompanied and during medication pass daily for 2 weeks and weekly for 2 months to ensure compliance. Audits are to begin within 3 business days of the receipt of the accepted plan of correction.*

*4. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue weekly for 2 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management Meeting.*

**Licensee's Proposed Overall Completion Date:** *08/22/2026*

***Implemented ( [redacted] - 08/17/2026)***

## 185a Storage procedures

**13. 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 #3 is prescribed blood glucose testing before meals and at bedtime. However, the resident's blood glucose readings were incorrectly entered onto the residents July 2026 medication administration record (MAR) as follows:*

- *7/10/26 at approximately 11:00 a.m., there was no reading in the resident's Accu-Chek glucometer; 137mg/dL was entered on the MAR.*
- *7/10/26 at approximately 8:00 p.m., there was no reading in the resident's Accu-Chek glucometer; 123mg/dL was entered on the MAR.*
- *7/11/26 at approximately 11:00 a.m., there was no reading in the resident's Accu-Chek glucometer; 121mg/dL was entered on the MAR.*
- *7/11/26 at 8:28 p.m., resident #3's Accu-Chek glucometer indicated a reading of 169mg/dL; 163mg/dL was entered on the MAR.*
- *7/12/26 at 7:20 a.m., resident #3's Accu-Chek glucometer indicated a reading of 153mg/dL; 159mg/dL was entered on the MAR.*
- *7/13/26 at approximately 11:00 a.m., there was no reading in the resident's Accu-Chek glucometer; 126mg/dL was entered on the MAR.*

## 185a Storage procedures (continued)

*Resident #5 is prescribed blood glucose testing twice daily. However, the resident's blood glucose readings were incorrectly entered onto the residents July 2026 medication administration record (MAR) as follows:*

- *7/3/26 at 3:58 p.m., resident #5's FreeStyle Lite glucometer indicated a reading of 139mg/dL; 132mg/dL was entered on the MAR.*
- *7/7/26 at 7:43 a.m., resident #5's FreeStyle Lite glucometer indicated a reading of 151mg/dL; 157mg/dL was entered on the MAR.*
- *7/8/26 at 7:34 a.m., resident #5's FreeStyle Lite glucometer indicated a reading of 159mg/dL; 151mg/dL was entered on the MAR.*

*REPEAT VIOLATION 6/10/25 et. al.*

**Plan of Correction** ***Accept ([redacted] - 07/31/2026)***

*1. Resident #3 and Resident #4 had blood glucose readings incorrectly entered onto the MAR. Review of licensed staff schedule determined this to be conduct of one specific employee.*

*2. As new glucometer devices are implemented, staff will review processes specific to the operation of the glucometer to ensure readings used for medication administration align with the MAR notation.*
*3. All diabetic residents with glucose checks ordered will have their own pre coded glucometer which is labeled with their name and room number and stored in their room. The schedule will be determined by the MD including frequency and sliding scale coverage for the reported measurement. The actual reading will be checked against the glucometer used to perform the test. Documentation of reading will in turn be checked for accuracy when entering.*
*4. The Nurses and Medication Technicians will be educated by the Resident Support Coordinator(RSC) and/or designee on the process to add a note to the glucometer reading used for the medication administration and aligning with the MAR notation. Education will be completed by 8/15/2026. Documentation for completion of the training will be kept in accordance with 2800.65 (l).*
*5. The Resident Support Coordinator and /or designee will complete a weekly audit of glucometer readings compared to the medication administration record for all residents with glucometers. Audits will begin within 3 business days of the receipt of an approved plan of correction and continue weekly for three months.*
*6. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management meetings.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 187a Medication record

**14. Requirements**

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.

## 187a Medication record *(continued)*

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

**Description of Violation**

*Resident #4 is prescribed Valtoco Nasal Spray 10mg, Use 1 spray in the nose once as needed for seizure lasting more than 5 minutes. However, resident #4's July 2026 medication administration record did not contain an area to document the administration of the resident's Valtoco Nasal Spray.*

*REPEAT VIOLATION 6/10/25 et. al.*

**Plan of Correction** ***Accept ([redacted] - 07/31/2026)***

*1. Resident #4 is prescribed Valtoco Nasal Spray 10mg, Use 1 spray in the nose once as needed for seizure lasting more than 5 minutes. However, resident #4's July 2026 medication administration record did not contain an area to document the administration of the resident's Valtoco Nasal Spray.*
*2. Medication order was added to Medication Administration Record per prescribers order for administration and documentation by medpassers on 7/16/2026.*
*3. Education of all medication technicians and licensed staff will be conducted to ensure accuracy for medication administration and their roles in transcription and reconciliation. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education will be completed by 8/15/2026.*

*4. All orders should be checked for accuracy and upon receiving medication. Discrepancies should be reported by medication passers to pharmacy as identified and submitted to the Resident Support Coordinator(RSC) weekly to rectify any issues.*

*5. RSC and/or designee will conduct random audits of 3-4 resident's MAR's 2 times per month to compare MAR to medication labels to measure compliance.*

*6. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 3 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management meetings.*

**Licensee's Proposed Overall Completion Date:** *08/15/2026*

***Implemented ([redacted] - 08/17/2026)***

## 187d Follow prescriber's orders

**15. Requirements**

2800.

## 187d Follow prescriber's orders *(continued)*

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

**Description of Violation**

*Resident #4 is prescribed Losartan Potassium Oral Tablet 50mg, Give 1.5 tablet by mouth two times daily. However, on 7/12/26 at 8:00 a.m., resident #4 was administered the 50mg tablet of Losartan Potassium and the remaining half tablet was found inside of the resident's pharmacy blister pack of Losartan Potassium on 7/15/26.*

*Resident #4 is prescribed Voltaren External Gel 1%, apply to left hip, neck, shoulders topically three times a day, apply 4 grams lower body and 2 grams upper body. However, there were numerous dates and times throughout 7/1/26 through 7/15/26 that resident #4 was not administered the Voltaren External Gel 1% three times daily to include:*

- *7/2/26*
- *7/3/26*
- *7/6/26*
- *7/8/26*
- *7/13/26*

**Plan of Correction** ***Accept ([redacted] - 08/05/2026)***

*1. Resident #4 was notified by Resident Support Coordinator(RSC) on 7/15/2026 that medication errors occurred. On 7/12/2026, only 1 of the 1.5 tablets prescribed of Losartan Potassium Oral tablet, 50mg were administered. .5(half tab) remained in medication card from 08:00 dose 7/12/2026. Resident #4 was informed that documentation of prescribed Voltaren External Gel 1% was missing from administration record on July 2,3,6,8,13. Resident's [redacted] was informed of medication errors by Administrator 7/15/2026. RSC notified physician of medication errors 7/16/26, no changes or instructions were given due to administration errors. Documentation errors are permanent part of residents Electronic Medication record, MAR and TAR. An incident report for medication errors to Resident #4 was sent to DHS 8/4/26.*

*2. Education of all medication technicians and licensed staff will be conducted to ensure accuracy for medication administration and their roles in transcription and reconciliation. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education will be completed by 8/15/2026.*

*3. All orders should be checked for accuracy and upon receiving medication. Discrepancies should be reported by medication passers to pharmacy as identified and submitted to the Resident Support Coordinator (RSC) weekly to rectify any issues. Missed medication order report will be generated by charge nurse to ensure compliance with incident event reporting.*

*4. RSC and/or designee will conduct random audits of 3 4 residents MAR's 2 times per month to compare EMAR to medication labels to measure compliance. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 3 months or until substantial compliance is achieved. Audits will be reviewed during Quality Management meetings.*

**Licensee's Proposed Overall Completion Date:** *08/22/2026*

***Implemented ([redacted] - 08/17/2026)***