pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CARE HSL BELLE REVE OPCO LLC**
LEGAL ENTITY

To operate **BELLE REVE SENIOR LIVING CENTER**
NAME OF FACILITY OR AGENCY

Located at **404 EAST HARFORD STREET, MILFORD, PA 18337**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **86**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 12, 2026** until **December 12, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **225132**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/.23

Pennsylvania
Department of Human Services

Sent via email to [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 11, 2026

[redacted]
CARE HSL BELLE REVE OPCO LLC
[redacted]

RE: Belle Reve Senior Living Center
404 East Harford Street,
Milford, PA 18377
License: 225132

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 18, 2026, February 20, 2026, February 24, 2026, February 25, 2026, May 5, 2026, May 6, 2026, and May 12, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on the directed plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from JUNE 12, 2026 to DECEMBER 12, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: [redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *BELLE REVE SENIOR LIVING CENTER* **License #**: *22513* **License Expiration**: *06/12/2026*

Address: *404 EAST HARFORD STREET, MILFORD, PA 18337*

County: *PIKE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL BELLE REVE OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/31/2022* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *81* **Waking Staff**: *61*

Inspection Information

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

Reason: *Complaint, Provisional, Incident, Interim* **Exit Conference Date**: *05/22/2026*

Inspection Dates and Department Representative

05/05/2026 - On-Site: [redacted]
05/06/2026 - On-Site: [redacted]
05/12/2026 - On-Site: [redacted]
05/15/2026 - Off-Site: [redacted]
05/18/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *86* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *40* **Residents Served**: *17*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*

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

Have Mobility Need: *24* **Have Physical Disability**: *1*

Inspections / Reviews

05/05/2026 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/20/2026*

06/29/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/18/2026*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

Description of Violation

On [redacted] at 10:15 a.m., an agent of the Department requested access to 6 staff records. The records were not provided until 9:00 a.m. on [redacted]

Plan of Correction ***Directed[redacted] - 06/29/2026)***

IImmediate Corrective Action – The new Administrator worked diligently to gather and provide the requested records to the Department. However, during the transition of ownership and management from Heritage Senior Living to Viva Management, access to several record-keeping platforms and historical documentation was not immediately available. Upon obtaining access, the Administrator promptly worked to retrieve, organize, and submit the requested information.

Additional Corrective Action – The Business Office Manager has been hired. Staff records are being inputted into new platforms provided by Viva. Audits have been put into place to ensure all employee records are intact and in compliance.

Ongoing Corrective Action – All new and previous employees will be inputted into a shared file to be monitored by the Administrator, RDO, and RBOM, as well as for continued compliance.

Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, The administrator will ensure that agents of the Department have immediate access to the home, records, and residents upon request. The home will designate a staff person to act as administrator designee at all times the administrator is not present in the home. The designee will have access to all staff and resident records. The staff schedule will indicate who is acting as administrator designee on all shifts.
The home's written policy regarding record storage and access requirements will be reviewed and updates will be made, as necessary. The policy will state that there will be a designated staff person to act as administrator at all times the administrator is not present in the home. All staff will be educated on the policy. Documentation of the education shall be kept.
The administrator and all staff in the home will be educated on 2600.5(a)(1). Education will include providing access to all areas within the licensed setting including all areas of the basement and locked rooms.

Directed Completion Date: *07/20/2026*

17 - Record Confidentiality

2. Requirements

2600.

17 - Record Confidentiality *(continued)*

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

On [redacted] at approximately 4:13 p.m., the 2rd floor medication room door was open, unlocked, unattended and contained an unlocked laptop that was able to access resident records.

Plan of Correction ***Directed ([redacted] - 06/29/2026)***

Immediate Action – We ensured all doors to medication rooms were shut and locked while not being occupied by med techs. Old doors did not have proper commercial door closers installed.

Additional Actions – New commercial door closers were purchased and added to all medication rooms. Staff education is scheduled to ensure all employees make sure doors are shut when not in use or unattended. Daily audits of medication room checks are being added to the daily round checklist.

Ongoing Corrective Action – The daily round checklist will be audited by managers for compliance and reviewed by the Administrator during morning stand-up.
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction,
The administrator will review and update the policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records that ensures that all resident records will be confidential and stored in a manner that protects confidentiality that is consistent with this chapter education shall be kept.
All staff persons will be educated on the confidentiality of resident records and the procedures for maintaining resident records in a secure location. Documentation of the training will be kept.

Directed Completion Date: *07/20/2026*

25c2 - Fee Schedule

3. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

The home charges specified amounts for individual personal needs services. Resident [redacted] transitioned from personal care to secured dementia care on [redacted] and Resident [redacted] transitioned from personal care to secured dementia care on [redacted] Neither of the residents' contracts were updated with the new fee schedule of the actual amounts charged for the available services as of [redacted].

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – An audit was completed, and residents who were not notified of the change in fee were contacted by the RBOM.

25c2 - Fee Schedule (continued)

Additional Action – A BOM has been hired and inserviced on the correct procedures when a change of rent/fee is to be added to the contract on file.

Ongoing Corrective Action – The admission checklist will be updated to include any new schedule of fee forms to be signed.
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, the administrator or designee will audit 4 records weekly to ensure proper rent/fee schedule is part of the resident record.

Directed Completion Date: *07/20/2026*

51 - Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

On [redacted], staff person A, hired on [redacted], did not have a criminal background check completed.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – Staff in question had proper background checks completed through the EPatch software in compliance with PA regulations.

Additional Action – An audit of all new hires/rehires using EPatch was conducted to ensure that all files included compliant criminal background checks. The RBOM is rerunning all background checks for compliance.

Ongoing Corrective Action – The community will continue to utilize the EPatch platform to obtain criminal background checks for all newly hired employees. The onboarding documentation checklist will be updated and utilized to include positive affirmation that a compliant background check from the PSP is completed prior to hire. The ED/designee will monitor for compliance during regular one-on-one meetings with the BOM.
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, all staff involved in the hiring and initiating and documenting criminal background checks on employees will be educated in the requirements of this chapter.

Directed Completion Date: *07/20/2026*

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted], the home had an in-house census of 48 residents including 14 residents in the Secured Dementia Care

60a - Staff/Support Plan (continued)

Unit that would require constant supervision in the event of an emergency. In total there were 24 residents with mobility needs, including 12 residents that require the assistance of 2 staff members to transfer. The home had only 3 staff persons working in the building between the hours of 11:00 p.m. to 7:00 a.m. 3 staff persons would not be enough to safely evacuate the residents in the event of an emergency.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – An additional PCA was added to the ongoing schedule to ensure compliance in the event of an emergency.

Additional Action – Ongoing schedules now reflect the additional PCA to maintain the correct resident/staff ratio as defined by DHS.

Ongoing Action – The Administrator/designee will sign off on the upcoming staff schedule weekly prior to posting to ensure it reflects the correct resident/staff ratio as defined by DHS.
Proposed Overall Completion Date: 06/30/2026

Directed: in addition to the above plan of correction, The administrator or designee will review the staff schedule 7 days in advance to ensure that there is enough staff scheduled for each day based upon the current home census and current resident needs. If any staff member calls off, fails to show, or leaves their scheduled shift early the administrator or designee will replace the staff member immediately. The administrator will document by initialing staff schedules to verify that they have been reviewed.

Directed Completion Date: *07/20/2026*

65a - FS Orientation 1st Day

6. 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.
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.

Description of Violation

Staff person B, whose first day of work was [redacted], staff person C, whose first day of work was [redacted], and staff person D, whose first day of work was [redacted], did not receive orientation in 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.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

65a - FS Orientation 1st Day (continued)

7. Telephone use and notification of emergency services.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – A procedure was developed that includes an audit of all new employees to ensure they have received all required training to meet the requirements of 65A.

Additional Action – A checklist has been implemented to be completed at the time of hire by HR, which includes all training required by DHS for the first day.

Ongoing Action – The ED/designee will sign off on all new hire orientation tools before the employee completes orientation. The BOM/ED will review during weekly one-on-one meetings.
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, Staff person B, C, and D will be removed from the schedule and not work in the home until the required orientations have been completed.
All staff person's involved in the hiring and scheduling of employees will be educated in the required 1st day orientation topics.

Directed Completion Date: *07/20/2026*

65b - Rights/Abuse 40 Hours

7. 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 person A completed their 40th scheduled work hour on [redacted] staff person B completed their 40th scheduled work hour on [redacted] staff person C completed their 40th scheduled work hour on [redacted], and staff person D completed their 40th scheduled work hour on [redacted]. These staff persons did not complete orientation in the following topics: resident rights, emergency medical plan, OAPSA, and reporting of reportable incidents and conditions.

Plan of Correction ***Directed ([redacted] - 06/29/2026)***

Immediate Action – A procedure was developed that includes an audit of all new employees to ensure they have received all required training to meet the requirements of 65B.

Additional Action – A checklist has been implemented to be completed at the time of hire by HR, which includes all training required by DHS for the first day.

Ongoing Action – The ED/Designee will sign off on all new hire orientation tools before the employee completes orientation. The BOM/ED will review during weekly one-on-one meetings.
Proposed Overall Completion Date: 06/30/2026

65b - Rights/Abuse 40 Hours (continued)

Directed: In addition to the above plan of correction, Staff person A, B, C, and D will be removed from the schedule and not work in the home until the required orientations have been completed.
All staff person's involved in the hiring and scheduling of employees will be educated in the required orientation topics to be completed in the employees first 40 hours of work in the home..

Directed Completion Date: *06/30/2026* **Not Implemented- [redacted] - 7/14/26)**

65g - Annual Training Content

8. Requirements

2600.
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.

Description of Violation

Staff person E did not receive fire safety training by a fire safety expert during training year 2025.

Repeated Violation: [redacted]

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – The employee in question will be trained by a fire safety expert to comply with regulations.

Additional Action – The community has implemented a training compliance checklist to track all required annual trainings, due dates, completion dates, and supporting documentation for all direct care staff, ancillary staff, substitute personnel, and regularly scheduled volunteers. The checklist will be reviewed routinely to ensure required trainings are completed prior to their due dates.

Ongoing Actions – The ED/BOM will monitor the training compliance checklist on a monthly basis, with the BOM verifying that annual training remains current. Any upcoming expirations will be identified in advance and staff will be scheduled for training prior to due dates.
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, Audits will be completed by the administrator, or designee will be completed at the end of each month on all trainings provided to staff that month. These audits will be documented with date of audit, person completing the audit, and training audited. Any staff that missed the scheduled training will have a make-up date rescheduled for the missed training to be completed in compliance with 65g requirements.

Directed Completion Date: *06/30/2026* **Not Implemented- [redacted] 7/14/26)**

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

On [redacted] at approximately 11:34 a.m., in the unlocked first floor Maintenance Office, a can of Ecosmart Flying

82c - Locking Poisonous Materials (continued)

Insect Killer aerosol spray with a manufacturer's label instructing if swallowed, call a Poison Control Center or doctor for treatment advice, was unlocked, unattended and assessable to residents of the home. Not all the residents of the home, including resident [redacted], have been assessed capable of recognizing and using poisons safely.

On [redacted] at 9:26 a.m., the home's 2nd floor housekeeping cart containing Lysol Disinfectant Spray and Lysol toilet bowl cleaner with a manufacturer's label instructing if swallowed, get medical help or contact a Poison Control Center, was unlocked, unattended and assessable to residents of the home. Not all the residents of the home, including resident [redacted], have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – All carts in question were moved behind closed doors to maintain compliance. The maintenance office door was closed immediately.

Additional Actions – An in-service with the Maintenance Director/housekeepers on the importance of doors remaining locked at all times was completed by the ED on 05/15/26.

Ongoing Corrective Action – The daily round checklist will be audited by managers for compliance and reviewed by the Administrator during morning stand-up.
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, the administrator or designee will complete checks 3 times weekly for 3 weeks for any unlocked poisonous materials.

Directed Completion Date: *07/20/2026*

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On [redacted] at 9:15 a.m., ice cream cups were observed in the 2nd floor freezer. They were opened and uncovered.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – Uncovered ice cream was immediately discarded.

Additional Actions – A kitchen/food storage checklist was implemented to ensure all food items are properly covered, labeled, and stored in accordance with regulations.

Ongoing Actions – The ED/designee will sign off on the checklist to verify compliance with food storage. All staff will be inserviced by 06/25. FSD will monitor for compliance and review with ED at weekly meeting
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, the administrator or designee will complete daily checks on storage of food.

Directed Completion Date: *07/20/2026*

130a - Smoke Detector 15 ft Bedroom

11. Requirements

2600.
130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

On [redacted], the smoke detector that was closest to room [redacted] was 17 ft. away.

Plan of Correction ***Directed [redacted] 06/29/2026)***

Immediate Corrective Action – Maintenance was notified and reviewed the hallway near Room [redacted]. The area was checked to ensure resident safety while corrective action was arranged.

Additional Corrective Action – A smoke detector was purchased and placed to meet the required 15 feet of Room 303.

Ongoing Corrective Action – Smoke detector placement will be checked during routine monthly maintenance rounds and reviewed by fire and life safety upon vist. MD to review checklist with ED/Designee monthly
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, all staff will be educated in the requirements of this regulation.

Directed Completion Date: *07/20/2026*

132g - Fire Drills Days/Times

12. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home was routinely scheduling 3 staff members on the overnight shift in April 2026 based on a review of staff schedules, payroll records, and interviews with staff. On [redacted] at 1:57 a.m., a fire drill was conducted while there were five staff present in the home. The number of staff present for the fire drill was not reflective of their normal staffing levels in the home.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Corrective Action – The Administrator reviewed Regulation 132.G with the Maintenance Director to ensure compliance with regulatory requirements.

Additional Corrective Action – Fire drill scheduling procedures were revised to ensure drills are conducted on varied days and times consistent with typical staffing patterns.

Ongoing Corrective Action – The Administrator/designee will review fire drill schedules prior to execution to ensure compliance with regulations. Fire drills will be tracked for time, day, and staffing levels to confirm compliance. Ongoing compliance will be monitored by the ED/designee at monthly meetings.
Proposed Overall Completion Date: 06/30/2026

132g - Fire Drills Days/Times (continued)

Directed: In addition to the above plan of correction, the administrator or designee will review fire drill records after completion of the drill and ensure staff participating in the drill was reflective of staffing provided for the 2 weeks leading up to the drill at that time of day.

Directed Completion Date: *07/20/2026*

141a 1-10 Medical Evaluation Information

13. 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

On [redacted], resident [redacted]s initial medical evaluation, dated [redacted] and resident [redacted]initial medical evaluation, dated [redacted] did not indicate if their needs could be met in the personal care home.

Plan of Correction ***Directed[redacted] - 06/29/2026)***

Immediate Action – Reviewed resident file for missing or incomplete medical evaluations. Updated evaluations were obtained from providers.

Additional Action – All DME upon admission and annually will be reviewed by the ED/RDO or designee to ensure compliance.

Ongoing Action – Conduct monthly chart audits for compliance by clinical leads. Weekly clinical meetings will also review any DME from the prior week and scheduled move-ins.

Proposed Overall Completion Date: 06/30/2026

Directed: in addition to the above plan of correction, the administrator or designee will audit all current DME's for all required information. Any missing information will be added within 3 days of discovery. All staff that are involved in securing or reviewing completed DME's will be educated in the requirements of this regulation.

Directed Completion Date: *07/20/2026*

141b1 - Annual Medical Evaluation

14. Requirements

141b1 - Annual Medical Evaluation *(continued)*

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

Description of Violation

Resident [redacted] annual medical evaluation, dated [redacted], did not indicate that their needs could be met in the personal care home.
Resident [redacted] annual medical evaluation, dated [redacted], did not include the residents' temperature or a signature by a medical professional. Resident [redacted]s current medical evaluation was completed on [redacted]. The previous medical evaluation was completed on 5/16/24.
Resident [redacted] annual medical evaluation was missing the following information: temperature, date of in person evaluation, health status, cognitive function, and if the residents' needs can be met in a personal care home.

Repeated Violation.[redacted]

Plan of Correction ***Directed ([redacted] - 06/29/2026)***

Immediate Action – Reviewed resident file for missing or incomplete medical evaluation. Updated evaluations were obtained from providers.

Additional Action – All DME upon admission and annually will be reviewed by the ED/RDO or designee to ensure compliance. Clinical leads were inserviced and educated on the process of DME review.

Ongoing Action – Conduct monthly chart audits for compliance by clinical leads. Weekly clinical meetings will also review any DME from the prior week and scheduled move-ins.

Proposed Overall Completion Date: 06/30/2026

Directed: in addition to the above plan of correction, the administrator or designee will audit all current DME's for all required information. Any missing information will be added within 3 days of discovery. All staff that are involved in securing or reviewing completed DME's will be educated in the requirements of this regulation.

Directed Completion Date: *07/20/2026*

181c - Self-administration Assessment

15. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

On [redacted] resident [redacted] was identified to self-administer medications to include a nighttime sleep aid. Resident [redacted] most recent medical evaluation dated [redacted] indicates that the resident cannot self-administer medications.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

IImmediate Action – Resident [redacted] was reassessed by PCP regarding ability to self-administer medication, including nighttime sleep aid use. A new written order has been obtained clarifying the resident's current medication

181c - Self-administration Assessment (continued)

self-administration status.

Additional Actions – Self-administered medication will be stored in a secured, locked area in the room with a key provided for resident access.

Ongoing Actions – A checklist was created to conduct monthly audits to assess residents' ability to self-administer medication. Medication will be monitored by the clinical lead for storage per DHS guidelines to also be reviewed by ED/Designee monthly
Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, the administrator or designee will conduct an audit of records of residents who desire to self-administer medications that [redacted] has been assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders. Assistance with medication administration identified through the self-administration assessment will be provided by qualified staff persons

Directed Completion Date: *07/20/2026*

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] [redacted] tablets prescribed for resident [redacted], were in the home's personal care medication cart; however, the medication was discontinued on [redacted]
On [redacted], [redacted] prescribed for resident [redacted], were in the home's personal care medication cart; however, the medication was discontinued on [redacted].

Plan of Correction ***Directed[redacted] - 06/29/2026)***

Immediate Actions – All medication carts were immediately inspected. The discontinued medications ([redacted] for Resident [redacted] and [redacted] for Resident [redacted] were removed from the active medication cart and quarantined for proper disposal in accordance with pharmacy return and controlled substance destruction procedures.

Additional Corrective Actions – A full medication reconciliation audit was initiated for all residents to verify that each medication stored on site matches current physician orders.

Ongoing Actions – Weekly medication cart audits are conducted and signed off by the ED/designee to ensure compliance. These are also reviewed in weekly clinical meetings by clinical leads

Proposed Overall Completion Date: 06/30/2026

Directed: In addition to the above plan of correction, all staff who assist with administration of medications will receive education on this regulation. Documentation of the staff education will be kept and made available to the Department for review.

Directed Completion Date: *07/20/2026*

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 [redacted] receives [redacted] on a sliding scale 3 times daily at 7:00 a.m., 11:00 a.m. and 4:00 p.m. The residents' blood glucose readings are checked prior to administration of the medication. On [redacted] at 4:00 p.m., the resident had a blood glucose reading of [redacted] documented on the medication record that was not found in the resident's glucometer. Resident [redacted]s glucometer was calibrated to 12:04 p.m. with a date of [redacted] on [redacted] at 11:19 a.m. Resident [redacted] has a PRN order for [redacted] solution. The medication was not available in the medication cart on [redacted].

Repeated Violation: [redacted]

Plan of Correction ***Directed ([redacted] - 06/29/2026)***

Immediate Action – All med techs were inserviced on 05/20/26 for correct procedures on recording blood glucose levels and accurately documenting on the eMAR. Weekly cart checks are now in place to ensure all medications are in the cart. The glucometer batteries were changed, which caused a lapse in date/time; this was immediately corrected.

Additional Actions – Med techs will document at the end of each shift any medication changes, new orders, or reorders and relay this information for proper follow-up. Clinical leads will monitor monthly for compliance, and findings will be reviewed with the ED/designee.

Ongoing Actions – Weekly medication cart audits are conducted and signed off by the ED/designee to ensure compliance. These are also reviewed in weekly clinical meetings.
Proposed Overall Completion Date: 06/30/2026

Staff who assist with taking, reading and recording of blood glucose levels shall be educated on the importances of properly transcribing the blood glucose levels and times of the blood glucose checks. Documentation of the education shall be kept and made available to the Department for review.
Completion date [___]

Directed: In addition to the above plan of correction, the Administrator or designee will conduct weekly audits of glucometer calibration to date/time and of the actual readings on the residents' glucometers and compare with the documented glucose readings. Documentation of the audits will be kept and made available for review by the Department.

Directed Completion Date: *07/20/2026*

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.

187b - Date/Time of Medication Admin. *(continued)*

Description of Violation

Resident [redacted] is prescribed [redacted] and [redacted] to be administered daily at 8:00 p.m. Resident [redacted]'s May 2026 medication administration record does not include the initials of the staff person who administered the medications on 5/2/26 at 8:00 p.m.
Resident [redacted] is prescribed [redacted] to be administered daily at 10:00 p.m. Resident [redacted] May 2026 medication administration record does not include the initials of the staff person who administered the [redacted] on [redacted] at 10:00 p.m.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – Upon investigation, the med tech was deemed not to be meeting expectations and was removed from medication administration duties.

Additional Actions – An in-service training was conducted by the clinical team for all medication administration staff to reinforce proper medication pass procedures.

Ongoing Actions – To ensure compliance, ongoing eMAR audits have been implemented as part of the weekly clinical meetings and will be reviewed by the ED/designee.
Proposed Overall Completion Date: 06/30/2026

Directed: in addition to the above plan of correction, the administrator or designated staff person shall audit all resident MAR's weekly to ensure accuracy and completeness.
A monthly analysis of the medication reviews will be part of the home's quality management agendas and review.

Directed Completion Date: *07/20/2026*

187d - Follow Prescriber's Orders

19. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] on a sliding scale daily at 7:00 a.m., 11:00 a.m., 4:00 p.m. and receives blood glucose checks prior to administering the medication. However, staff did not check the resident's blood glucose prior to administering the medication on [redacted] at 4:00 p.m.
Resident [redacted] is prescribed one [redacted] tablet with instructions to administer at 6:00 p.m. daily: however, on [redacted] the resident did not receive the medication.
Resident [redacted] is prescribed one [redacted] tablet with instructions to administer at 6:00 p.m. daily: however, on [redacted] staff person G administered one [redacted] tablet in error.
Resident [redacted] was prescribed [redacted] compression stockings on [redacted] with instructions to apply topically in the morning and removed before sleep. The resident's Care Tracking Form indicates the compression stockings were not applied on the morning of [redacted], [redacted] or [redacted].

Repeated Violation: [redacted].

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Immediate Action – Retraining was completed for all med techs. Resident [redacted] staff were immediately re-educated on the requirement to obtain and document blood glucose readings prior to medication administration. Resident [redacted] PCP was notified of a missed medication and a reportable was submitted on site. An immediate eMAR review and medication pass retraining was completed with involved staff.

Additional Actions – All staff were re-educated on following prescriber orders as written, including medications and ordered treatments such as insulin administration and compression socks. The care team will not be responsible for placement of compression stockings; they will be added to the eMAR for med tech administration and ongoing compliance.

Ongoing Action – The clinical lead will audit eMARs weekly for compliance, with findings reviewed with the ED/designee at weekly clinical meetings.

Proposed Overall Completion Date: 06/30/2026

Directed: in addition to the above plan of correction, the administrator or designated medication trained staff shall observe 3 medication passes each week for two weeks and then at least once weekly thereafter. Documentation of the observations shall be kept.
The administrator or designee shall interview at least 3 residents weekly for two weeks and then monthly thereafter to ensure they are receiving all medications as prescribed. Documentation of the interviews shall be kept.

Directed Completion Date: *07/20/2026*

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

Facility Information

Name: *BELLE REVE SENIOR LIVING CENTER* **License #:** *22513* **License Expiration:** *06/12/2026*

Address: *404 EAST HARFORD STREET, MILFORD, PA 18337*

County: *PIKE* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL BELLE REVE OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *01/31/2022* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *121* **Waking Staff:** *91*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *03/12/2026*

Inspection Dates and Department Representative

02/18/2026 - On-Site: [redacted]
02/20/2026 - On-Site:
02/24/2026 - On-Site:
02/25/2026 - On-Site:
02/23/2026 - Off-Site:
02/27/2026 - Off-Site:
03/12/2026 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *86* **Residents Served:** *72*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *3rd floor* **Capacity:** *40* **Residents Served:** *40*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *72*

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

Have Mobility Need: *49* **Have Physical Disability:** *0*

Inspections / Reviews

02/18/2026 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/09/2026*

04/09/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/29/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2026*

04/17/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/29/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/30/2026*

07/14/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/29/2026*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted] at 9:30 a.m. an agent of the Department requested multiple resident records for review. A portion of the resident records were provided at approximately 1:30 p.m. The home was unable to provide immediate access to the resident records.

On [redacted] at 9:50 a.m. agents of the Department requested access to the facility's electronic records. This was obtained [redacted] at 10:00 a.m.

On [redacted] at 9:50 a.m. the facility was asked about their census, mobility needs, how many residents were sent to the hospital on [redacted] how many have returned and what hospitals they were sent to. On 2/20/26 at 11:48 a.m. the facilities mobility needs information was received.

Plan of Correction ***Directed [redacted] - 04/17/2026)***

·Immediate Action
Executive Director or designee to provide immediate access to records as requested by agents of the department timely.
.
Ongoing Corrective Action
ED and Department Heads were in-services on 4/8/26 providing records access, census, and mobility needs to agents of the department timely. · Resident's mobility needs will be entered on admission and change of condition per DME by Clinical Coordinator or Memory Care Director.

Ongoing Monitoring Actions
· Mobility needs list will be printed on Wednesdays and reviewed be clinical care coordinator Memory Care director. ED will review and sign off on mobility needs list weekly on after clinical care meetings on Wednesdays to ensure compliance.

Proposed Overall Completion Date: 04/29/2026

(Directed)
Effective immediately the administrator will ensure the Department has immediate access to the home, records, and residents upon request. The home will designate a staff person to act as administrator designee at all times the administrator is not present in the home. The designee will have access to all staff and resident records. The staff schedule will indicate who is acting as administrator designee on all shifts for 3 months.

Directed Completion Date: *04/20/2026*

Not Implemented [redacted] - 05/15/2026)

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

Resident [redacted] has an order for [redacted] tablet, take daily on an empty stomach at 6:00 a.m. The resident did not receive this medication from [redacted] through [redacted]. The medication error was not reported to the Department.

Resident [redacted] has an order for [redacted] 3 times daily on a sliding scale at 7:00 a.m., 11:00 a.m., and bedtime. On [redacted] Resident [redacted] blood glucose was not tested at 7:00 a.m. or 11:00 a.m. and the resident was not given [redacted]. The medication error was not reported to the Department.

On [redacted], the Department of Health notified the the Administrator of one resident case of invasive group A [redacted] This communicable disease was not reported to the Department.

On [redacted] the facility had an exterior natural gas leak, prompting the facility to enact their emergency preparedness plan, and notifying UGI and the local fire department. The fire department responded to the facility. This was not reported to the Department until [redacted].

On [redacted] Resident [redacted] had a fall, was sent to the hospital for hip pain. The resident had an unspecified fracture of the right femur. This injury was not reported to the Department until [redacted].

Plan of Correction ***Accept [redacted] - 04/17/2026)***

Immediate Plan of Correction:
·Incident reports were completed and sent to the department by the Executive Director

Ongoing Corrective Action
RDO inserviced Executive Director & Departments Heads on Pennsylvania Personal Care Home Regulation 16c. Incident Reporting by 04-08.2026

MC & CC will inservice all care staff and medication techs on Pennsylvania Personal Care Home Regulation 16c. Incident Reporting by 4/17/26.

Ongoing Monitoring Actions
· Incident and Observation Center to be audited daily by Executive Director to identify potential reportable incidents and ensure a follow up note is written within 24 hours

Proposed Overall Completion Date: 04/17/2026

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan dated [redacted] for Resident [redacted] indicates the resident requires total physical assistance with incontinence care and staff will assist with all incontinence care as needed. Staff of the home stated that incontinence checks are to be completed every 2 hours for residents in the secured dementia care unit. However, on the morning of [redacted] a staff person reported arriving to the home and finding Resident [redacted] saturated with urine. The staff person noted the resident's sheets and bedding were also saturated with urine. The resident did not receive assistance with incontinence care as required by the resident's assessment and support plan.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

Immediate Corrective Action
Resident [redacted] was discharged to from Belle Reve on 3/05/2026 as per the family's preference. Residents with incontinence issues will have these programs reviewed by the Clinical Coordinator and Memory Care to ensure PRN Care documentation expectations are consistent with the support plans by 04/29/2026.

Ongoing Corrective Actions
Resident Care Staff will be inserviced by the Executive Director/designee, Clinical Coordinator and Interim Memory Care Director on expectations of communication of resident's changing needs and documentation of change in care on by April 7, 2026. The resident care staff will document PRN care in the electronic medical record starting 04/08/2026.

Ongoing Monitoring Actions
The Clinical Coordinator and Memory Care Director will monitor the PRN Care Documentation daily for compliance. The PRN Care Documentation will be reviewed weekly in the Weekly Clinical Meeting by the Clinical Care Coordinator and Memory Care Director and signed off by the Executive Director to monitor for compliance.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident [redacted] was admitted to the personal care home on [redacted]. Based on the home's own internal screening form the home was aware the resident would be admitted with a diagnosis of [redacted] and [redacted]. Through interviews with staff, it was noted that the resident flooded their apartment multiple times by placing items in the sink.

42b - Abuse (continued)

Multiple staff of the home confirmed that after the resident flooded their personal care apartment on [redacted], the resident was moved to the home's secured dementia care unit in an attempt to increase the resident's level of supervision by staff. Multiple staff persons confirmed the resident remained on the secured dementia care unit since that date, and the resident did not have a room on the unit until [redacted]. Staff stated the resident was found sleeping on the recliners, benches and couches as a result.

Medical evaluations were completed for the resident on [redacted] and [redacted] however neither medical evaluation listed a diagnosis of [redacted]. The home did not have an assessment or support plan in place for the resident to indicate to staff how the resident's care needs could be met until being evaluated for hospice services on [redacted] The hospice evaluation notes state that a prescription for [redacted] would be ordered for the resident however upon review of the resident's medication record on [redacted] it was determined that the resident had no current orders for any medications.

On [redacted] at approximately 2:05 p.m. Resident [redacted] was observed walking barefoot in the dining area of the secured dementia care unit of the home with thick big yellowing toenail measuring approximately 2 inches in length. The toenails were growing perpendicular to the resident toe in a "L" shape which appeared to hinder the resident from wearing shoes or socks. The residents remining toenails were ¾ of an inch long and bent downwards toward the ground. Through interviews with staff, it was noted that the home was aware of the resident's need for podiatry care however the resident had not been evaluated by a podiatrist since being admitted to the home.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 04/17/2026)***

Immediate Plan of Correction
Resident [redacted]s support plan was updated was updated by the former Resident Care Director on_02/21/2026, Medication orders were processed by the former resident care director beginning 02/09/2026. Podiatrist was contacted and services were provided to the resident by [redacted] March 2, 2026.

Ongoing Plan of Correction
·Clinical Coordinator and Memory Care Director to review any residents with Podiatry needs weekly during the weekly clinical meeting. Medication Exception Reports to be reviewed daily identify any residents who do not have medication orders processed. Support plans were audited by 03/12/2026 and were updated by April 10, 2026. The Resident care staff were inserviced on 04/07/2026 by the Clinical Coordinator or Memory Care communicating regarding resident's changing needs and documenting changing needs. Medical Evaluations will be reviewed by Executive Director/designee, Clinical Coordinator, or Memory Care Director 48 hrs. prior to admissions to ensure diagnosis information is included from the admission assessment and prescreening for admission form.
Ongoing Monitoring Actions
· Executive Director/designee to review and sign off after weekly Clinical Meeting to ensure that residents with podiatry needs, medication orders are processed, medical evaluations for new admissions from the prior week and support plans have been updated to reflect the needs of the residents. Executive Director to monitor for compliance

Licensee's Proposed Overall Completion Date: *04/29/2026*

42b - Abuse *(continued)*

Implemented [redacted] 05/15/2026)

60a - Staff/Support Plan

6. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted] there were 79 residents present in the home, 40 of whom reside in the home's secured dementia care unit due to cognitive impairment. 9 residents require the assistance of 2 staff to evacuate, and 11 residents require the assistance of 1 staff person to evacuate in the event of an emergency. 3 staff persons worked in the building between the hours of 11:15 p.m. to 5:23 a.m. on [redacted]. 3 staff persons are not enough staff to evacuate residents in the event of an emergency.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

Immediate Corrective Action
The Executive Director added staff to schedule beginning February 20, 2026 including agency staff as needed to ensure staffing meets the needs of the residents as per assessment and support plans. The Clinical Coordinator and Memory Care Director scheduled the added staff starting February 20, 2026

Ongoing Corrective Actions
Clinical Coordinator and Memory Care Director to review schedule daily. RDO in-serviced ED and Clinical Coordinator and memory care director on staffing calculator on 4/8/26. The Executive Director/designee will sign off on the schedule daily and review staffing for the prior comparing it to the staffing calculator to ensure staffing meets the needs of the residents as per their medical evaluation and assessment by 04/29/2026 The staffing calculator will be updated with change in census and changes in the resident condition as per the DME and RASP by the Executive Director/designee by 04/29/2026

Ongoing Monitoring Actions
Executive Director will sign off on past and current schedules weekly after Weekly clinical care meeting to ensure staffing provided by the community meets the needs of the residents as per assessment and support plan. The Executive Director/designee will ensure compliance.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Not Implemented [redacted] - 05/15/2026)

63a - First Aid/CPR Training

7. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

63a - First Aid/CPR Training *(continued)*

Description of Violation

On [redacted], from 7:30 a.m. to [redacted] at 7:00 a.m., 79 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 6:00 p.m. to 11:00 p.m., 78 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 6:00 p.m. to [redacted] at 7:00 a.m., 79 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted] from 3:30 p.m. to 11:00 p.m., 79 residents were present in the home. During this time, 0 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 3:00 p.m. to 11:00 p.m., 77 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted] from 9:00 p.m. to 11:00 p.m., 67 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 11:00 p.m. to [redacted] at 7:00 a.m., 72 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 3:00 p.m. to [redacted] at 7:00 a.m., 71residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 6:00 p.m. to 11:00 p.m., 70 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted] from 6:00 p.m. to 11:00 p.m., 71 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted], from 6:00 p.m. to [redacted] at 7:00 a.m., 67 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

On [redacted] from 3:00 p.m. to 11:00 p.m., 67 residents were present in the home. During this time, 1 staff person was present in the home who was certified in First Aid and CPR.

Plan of Correction ***Directed[redacted] - 04/17/2026)***

Immediate Action

CPR certification for staff was scheduled on and completed on March 19, 2026 for the staff with expired or no certifications. Certifications were received and uploaded to the HRIS System ('Paylocity") for recordkeeping. First Aid class to be scheduled by April 29, 2026_ to ensure resident care staff are first aid certified. The First Aid

63a - First Aid/CPR Training (continued)

certifications received after the class for staff will be uploaded to the HRIS system ("Paylocity") for recordkeeping.
Ongoing Corrective Actions
CPR expiration dates will be entered into the HRIS System ('Paylocity", for Business Office Manager to monitor weekly by 04/29/2026_to ensure CPR and first aid certifications do not expire and renewed timely by pulling a report from the HRIS system (Paylocity). Additionally, the Business Office Manager and Staff will receive a notification 45 days prior to expiration to ensure staff and management are aware of the expiration date and recertification classes are scheduled prior to expiration.
Ongoing Monitoring Actions
The Executive Director to ensure compliance with reviewing and signing off on the certification report from the HRIS system ("Paylocity") weekly_ after the weekly Clinical Meeting to ensure CPR and First Aid Certifications remain current by 04/29/2026

Proposed Overall Completion Date: 04/29/2026

(Directed)
Effective immediately the Administrator will review the schedules to ensure the required staff certified in first aid and CPR are present in the home at all times. The Administrator will initial the schedule on a weekly basis to ensure coverage is maintained for 3 months.

Directed Completion Date: *04/20/2026*

Implemented [redacted] - 05/15/2026)

82c - Locking Poisonous Materials

8. 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

On [redacted], at approximately 11:34 a.m. in the unlocked first floor Maintenance Office, a 180 fluid ounce container of Honeywell Eyesaline Concentrate with a manufacturer's label instructing if swallowed, get medical help or contact a Poison Control Center, was unlocked, unattended and accessible to residents of the home. Not all the residents of the home, including Resident [redacted], have been assessed capable of avoiding and using poisons safely.

On [redacted], at approximately 9:15 a.m. in the unlocked first floor Maintenance Office, a 180 fluid ounce container of Honeywell Eyesaline Concentrate with a manufacturer's label instructing if swallowed, get medical help or contact a Poison Control Center, was unlocked, unattended and accessible to residents of the home. Not all the residents of the home, including Resident [redacted] have been assessed capable of avoiding and using poisons safely.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

Immediate Corrective Action
The Maintenance Director closed and locked the maintenance office door at the time of inspection. The Maintenance Director changed the lock to a keypad lock automatic closure on the Maintenance Director office door on March 7,

82c - Locking Poisonous Materials (continued)

2026. The department heads made rounds at the time of inspections to identify and remove any additional poisonous materials at the time of inspections.

Ongoing Corrective Action
Department Heads were in-serviced on 4/8/26 on daily environmental audits, which included Manager on Duty on weekends and holidays to ensure poisonous materials are locked and inaccessible to residents. Department Heads and Managers on duty will conduct daily environmental audits to identify potential environmental issues, any findings identified will be corrected immediately.

Ongoing Monitoring Actions
The Executive Director will ensure compliance by reviewing the audit and signing off environmental daily audit form weekly after the weekly Clinical Meeting by 04/29/2026 after 60 days with no findings identified from the daily environment audit the form will be continued daily and reviewed during morning stand up report with Executive Director/designee continuing to ensure compliance after the 60 days period of no findings, and reviewing the audit for during morning standup meeting.
continued and reviewed with morning report

Licensee's Proposed Overall Completion Date: *04/29/2026*

Not Implemented [redacted] - 05/15/2026)

90b - Staff Communication

9. Requirements

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in the event of an emergency. On [redacted], the home served 72 residents. Staff interviews indicated the facility radios were not working and the facility provided iPhones were all being utilized on the 1st and 2nd floors. The 3rd floor did not have a method of communication at this time.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

The communication equipment within the community was audited on 2/27/26 by the former Resident Care Director/designee to ensure there are enough devices and the devices are operable for the staff to use within the community on each floor. A monthly audit will be conducted by the Executive Director/designee by April 29, 2026 to ensure there are enough devices and they are operable.
Ongoing Corrective Action
Department Heads were inserviced by the Regional Director of Operations on 04/08/2026 regarding daily environmental rounding to include Manager on Duty weekends. Communication equipment was added to the daily environmental rounding form and the Regional Director of Operations inserviced Departments Heads including Manager on Duty during weekends on the daily environmental rounding. The Department Heads will conduct daily

90b - Staff Communication (continued)

environmental roundings including Manager on Duty weekends to identify environmental issues. Any findings from the daily environmental rounding audit will be corrected.
Ongoing Monitoring Actions
The Executive Director to ensure compliance by reviewing and signing off on the daily environmental a audit form weekly after the weekly Clinical meeting by April 29, 2026, after 60 days with no findings form will the continued and reviewed with morning standup meeting.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

121a - Unobstructed Egress

10. 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

On [redacted], at approximately 11:38 a.m., a Poly Sleigh Shovel was laying across a portion of the sidewalk outside of the first-floor side emergency exit door obstructing the egress route of the building.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 04/17/2026)***

The shovel was removed from 1st Floor Emergency Door egress by the maintenance director at the time inspections. During the subsequent inspections, the Maintenance Director ensure that the egress continued not to be unblocked at the 1st floor emergency door.
Ongoing Corrective Actions
Department Heads were inserviced by the Regional Director of Operations on 04/08/2026 regarding daily environmental rounding to include Manager on Duty weekends. Unblocked egress was added to the daily environmental rounding form and the Regional Director of Operations inserviced Departments Head on the updated daily environmental rounding form to include Managers on Duty for weekend coverage. The Department Heads will conduct daily environmental roundings including Manager on Duty weekends, to identify environmental issues. Any findings from daily environmental rounding audit will be corrected
Ongoing Monitoring Actions
The Executive Director to ensure compliance by reviewing and signing off on the daily environmental a audit form weekly after the weekly Clinical meeting by 04/29/2026 after 60 days with no findings form will the continued and reviewed with morning standup meeting.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

132c - Fire Drill Records

11. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drills conducted on [redacted] at 2:55 p.m. and [redacted] at 4:07 p.m. does not include the time it took to complete the fire drill in seconds. Both fire drills were recorded as having a completion time of 5 minutes. Staff interviews indicated the fire drills were not exactly 5 minutes long.

Plan of Correction ***Accept[redacted] - 04/17/2026)***

Immediate Plan of Correction
The Executive Director corrected the fire drill record to include the seconds that were documented on an audit form for the 10/16/2025 and 11/20/2025 fire drill, at the time of inspection.

Ongoing Corrective Action
Maintenance Director initiated new fire drill documentation form on December 19 2026. The Executive Director to in-service Maintenance Director by 4/10/26 regarding Pennsylvania DHS Personal Care Home 2600 Regulation 132c. The Maintenance Director will be responsible to document fire drills on the Pennsylvania DHS Personal Care Home Fire Drill Record to include minutes and seconds. Maintenance Director will be responsible for maintaining the fire drill records monthly
Ongoing Monitoring Actions
To ensure compliance, The Executive Director will audit monthly starting with the April 2026 fire drill, and sign off on the fire drill record to ensure the timing of the drills are documented to include minutes and seconds.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented ([redacted] - 05/15/2026)

132g - Fire Drills Days/Times

12. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 4 staff persons on the overnight shift. The sleeping hours fire drill conducted on [redacted] at 5:43 a.m. 7 staff persons participated. The sleeping hours fire drill conducted on [redacted] at 11:21 p.m. 10 people participated. The sleeping hours fire drills are being conducted when more staff are available.

Plan of Correction ***Directed [redacted] - 04/17/2026)***

Immediate Corrective Actions
Fire Drill scheduled for 11-7 will be audited by the Executive Director to ensure scheduled staff only attended the inservices

132g - Fire Drills Days/Times (continued)

• Fire Drills will be scheduled at times where minimal staff are scheduled as per Pennyslvania DHS Personal Care Home Regulations 2600, 132 and the Regulatory Compliance Guide for the 2600 regulation 132g. Maintenance Director to be inserviced by the Executive Director on Pennyslvania DHS Personal Care Home Regulations 2600, 132g and the Regulatory Compliance Guide for the 2600 regulation 132g by -4/10/2026

Ongoing Monitoring Actions
• The Executive Director to review and sign off on 11-7 fire drills beginning May, 2026 to ensure compliance.

Proposed Overall Completion Date: 04/29/2026

(Directed)
The home will conduct a sleeping hours fire drill by 4/24/26 during a time when only third shift staff are in the building. The administrator will initial and review the fire drill logs monthly for 6 months to ensure fire drills are conducted on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Directed Completion Date: *04/24/2026*

Not Implemented [redacted] - 05/15/2026)

141a 1-10 Medical Evaluation Information

13. 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 [redacted] initial medical evaluation dated [redacted] does not include the resident's weight.

Resident [redacted] medical evaluation does not include the date of evaluation or form completion, is not signed by a medical professional, weight, pulse, medical information pertinent to diagnosis or treatment, special health or dietary needs, immunization history, medications, body positioning, and health status.

Resident [redacted]'s initial medical evaluation dated [redacted] does not include the resident's blood pressure.

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction ***Accept [redacted] - 04/09/2026)***

Immediate Corrective Action

• All DME's were audited by 3/18/26 include residents weight, DME to include resident's BP and or DME to fully completed

Ongoing Corrective Action

The Executive Director, CCC and MCD to be in serviced on 4/8/26 by Regional DIrector of Operations on Pennsylvania DHS Personal Care Home Regulations 2600 141a1-10. Admission checklist will be completed by the Clinical Coordinator or Memory Care Director.

Ongoing Monitoring Action

• Admission Checklist to be completed prior to admission by the Clinical Coordinator and Memory Care Director hen audited within 48 hrs. after new resident admissions to ensure compliance All new admission check lists will be reviewed and signed off by the Executive Director on at the weekly clinical meeting,

Licensee's Proposed Overall Completion Date: *04/17/2026*

Not Implemented [redacted] - 05/15/2026)

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed [redacted]

Repeat violation [redacted]

Plan of Correction ***Accept [redacted] - 04/09/2026)***

Immediate

• Resident's [redacted] annual DME was completed on 2/4/26.

Ongoing Corrective Actions

ED, CCC, and MD inservice by RDO on Pennsylvania DHS Personal Care Home Regulations 2600, 141b1 on 4/8/26. Compliance documents report will be run on the last Wednesday of each month and reviewed for upcoming month at weekly clinical meeting.

Ongoing Monitoring Actions

• The Executive Director will sign off of weekly clinical meeting after review of compliance documentations report to ensure compliance.

141b1 - Annual Medical Evaluation *(continued)*

Licensee's Proposed Overall Completion Date: *04/17/2026*

Not Implemented [redacted] - 05/15/2026)

183a - Original Containers and Injections

15. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On [redacted] at 12:20 p.m. there was a cup of medications in the top drawer of the medication cart. Staff person A stated they had pre-poured Resident [redacted]'s 8:00 p.m. medications.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

Staff member #2 was in serviced on prepouring medications on 2/25/26 by the Resident Care Director/designee.

Ongoing Corrective Actions
The Clinical Coordinator and Memory Care Director to be inserviced by the Executive Director/Deisgnee by 04/29/2026 on Pennsylvania DHS Personal Care Home Regulations 2600, 183a. Medication Technicians will continue to complete regulatory training as required and as needed by the Memory Care Director beginning. Memory Care Director to conduct observations of Medication Technicians as required by regulation by 04/29/2026

Ongoing Monitoring Actions:
To ensure compliance, the Executive Director will review and sign off regulatory training and observations of Medication Technician upon completion as required by regulation beginning 04/29/2026

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] at 5:07 p.m. Resident [redacted]'s [redacted] tablets were on top of a filing cabinet in the medication room on the 3rd floor. The medication was discontinued on [redacted]

On [redacted] at 5:07 p.m. Resident [redacted]s [redacted], were on top of a filing cabinet in the medication room on the 3rd floor. The medication was discontinued on [redacted].

183d - Prescription Current (continued)

On [redacted] at 5:07 p.m. Resident [redacted] tablets were on top of a filing cabinet in the medication room on the 3rd floor. The medication was discontinued on [redacted].

On [redacted] at 5:07 p.m. Resident [redacted] tablets and [redacted] capsules were on top of a filing cabinet in the medication room on the 3rd floor. The resident passed away on the residents date of death.

On [redacted], at approximately 2:53 p.m., Resident [redacted] tablets were in the home's medication cart. The medication was discontinued on [redacted].

On [redacted], at approximately 2:52 p.m., three medication multipacks including [redacted] tablets prescribed for Resident [redacted] were in the home's medication cart. The medication was discontinued on [redacted]

On [redacted] at approximately 2:52 p.m., two medication multipacks including [redacted] tablets prescribed for Resident [redacted] were in the home's medication cart. The medication was discontinued on [redacted].

Plan of Correction ***Directed ([redacted] - 04/17/2026)***

Discontinued Medications were disposed of on 2/27/26 by the former Resident Care Director at the time of inspection. An audit was conducted of medication carts by the _____ to ensure compliance with this regulation.

Proposed Overall Completion Date: 04/29/2026

(Directed)
The home will train all medication trained staff on the homes policy on what to do with discontinued medications for residents living in the home and residents that are no longer living in the home. The home will audit the medication carts to ensure only medications in the cart are current. The home will create an auditing tool to ensure the policy is being followed weekly for 3 months then monthly for 3 months. Documentation of the training and audits will be kept for the Department to review upon request.

Directed Completion Date: *04/29/2026*

Not Implemented [redacted] - 05/15/2026)

183e - Storing Medications

17. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 2/25/26, at approximately 3:07 p.m., Resident #11's Lantus Solstar Pen was open and undated. According to the manufacturer's instructions, Lantus insulin must be discarded 28 days after opening.

183e - Storing Medications (continued)

Plan of Correction ***Accept [redacted] 04/09/2026)***

Immediate Corrective Action
Resident [redacted] was disposed of by 2/27/26.

Ongoing Corrective Action:
Cart audits to be completed weekly for any expired medications by the Clinical Coordinator /designee and Memory Care Director/designee. The results of cart audits to be presented during weekly clinical meeting and after meeting the audits will be reviewed and signed off on by the Executive Director to ensure compliance

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented [redacted] - 05/15/2026)

185a - Implement Storage Procedures

18. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [redacted], at approximately 12:02 p.m., one oxygen tank was sitting directly on the floor next to the medication cart in the third-floor medication room and was not secured per manufacturer's instructions.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

185
Immediate Corrective Actions
Oxygen tank was removed and relocated to the O2 holder in the PPE Storage Room by the Executive Director and Maintenance Director at the time of inspection on 02/18/2026.

Ongoing Corrective Actions:
The Department Heads and to include Manager on Duty for weekends were inserviced to conduct daily environmental rounds beginning March 31, 2026. The daily environmental round audit sheet was updated by the Executive Director/designee on April 8, 2026 to include proper O2 storage. The Department Heads, including Manager on Duty for weekends were inserviced regarding the updated daily environmental rounds sheet by April 9, 2026
Ongoing Monitoring Actions
The Executive Director will ensure compliance by reviewing the audit and signing off environmental daily audit form weekly after the weekly Clinical Meeting starting on 04/15/2026, after 60 days with no findings identified from the daily environment audit the form will be continued daily and reviewed during morning stand up report with the Executive Director continuing to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 07/14/2026)

187b - Date/Time of Medication Admin.

19. 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 [redacted] has an order for [redacted] take 1 tablet orally at 6:00 a.m. The medication has been unavailable since [redacted]. On [redacted], and [redacted], the medication administration record incorrectly indicates the medication was administered.

Plan of Correction ***Accept [redacted] - 04/09/2026)***

Immediate Corrective Actions
Resident [redacted] was received by the community on 2/25/26.

Ongoing Corrective Actions
Medication Exception Report audited daily by the Clincial Coordinator and Memory Care Director. The Medication Techs, Clinical Coordinator and Memory Care Director to be inserviced 3/27/26-4/1/26 regarding documentation of medication administration.

Ongoing Monitoring Actions
The Executive Director to review and sign off on Medication Exception report after weekly Clinical Meeting q Wednesday

Licensee's Proposed Overall Completion Date: *04/17/2026*

Not Implemented [redacted] 05/15/2026)

187d - Follow Prescriber's Orders

20. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] has an order for [redacted] mcg tablet, take daily on an empty stomach at 6:00 a.m. The resident did not receive this medication from [redacted] through [redacted]

Resident [redacted] has an order for [redacted], inject 3 times daily on a sliding scale at 7:00 a.m., 11:00 a.m., and bedtime. On [redacted] Resident [redacted]'s blood glucose was not tested at 7:00 a.m. or 11:00 a.m. and was not given [redacted].

Resident [redacted] is prescribed [redacted] tablet one tablet daily every 8 hours, hold if systolic blood pressure is greater than [redacted]. On [redacted] at 2:04 p.m. the residents systolic blood pressure was [redacted] the medication was withheld and should have been administered.

Resident [redacted] is prescribed [redacted] take one tablet orally two times a day. On [redacted] at 11:56 p.m. the medication was not administered.

187d - Follow Prescriber's Orders (continued)

Repeat violation: [redacted]

Plan of Correction ***Accept ([redacted] - 04/09/2026)***

Immediate Corrective Actions:
MARS were audited by the Executive Director on 2/27/26.

Ongoing Corrective Actions
Medication Exception Report to be audited daily by the Clinical Coordinator and Memory Care. The Clinical Coordinator and Memory Care Director will inservice the Medication Technicians on Pennsylvania DHS Personal Care Home Regulations, 187b by 04/17/2026

Ongoing Monitoring Actions
The Executive Director to review and sign off on Medication Exception report after weekly Clinical Meeting q Wednesday

Licensee's Proposed Overall Completion Date: *04/17/2026*

Not Implemented ([redacted] - 05/15/2026)

188b - Medication Error Reporting

21. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [redacted] has an order for [redacted] tablet, take daily on an empty stomach at 6:00 a.m. The resident did not receive this medication from [redacted] through [redacted]. This medication error was not reported to the resident, their designee or the prescriber.

Resident [redacted] has an order for [redacted], inject 3 times daily on a sliding scale at 7:00 a.m., 11:00 a.m., and bedtime. On [redacted], Resident #3; s blood glucose was not tested at 7:00 a.m. or 11:00 a.m. and the resident did not receive [redacted]. The medication error was not reported to the resident, their designee or the prescriber.

Plan of Correction ***Accept ([redacted] - 04/09/2026)***

Immediate Corrective Actions
The medication errors were Resident [redacted] and Resident [redacted] were reported to the prescriber or family by the Executive Director.

Ongoing Corrective Actions

188b - Medication Error Reporting (continued)

Medication Exception Report audited daily by CC and MC. Medication Techs, CC and MC to be inserviced on Pennsylvania DHS Personal Care Home Regulations 2600. 188b by 4/17/26.

Ongoing Monitoring Actions
• ED to review and sign off on Medication Exception Report after weekly Clinical Meetings q Wednesday.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented [redacted] - 05/15/2026)

190a - Completion Medication Course

22. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person B passed the Department approved Medication Administration Course on [redacted]. An annual practicum has not been completed since passing the initial course. On [redacted] Staff Person B administered [redacted] to Resident [redacted].

Staff Person C passed the Department approved Medication Administration Course on [redacted] An annual practicum has not been completed since passing the initial course. On [redacted] Staff Person C administered [redacted] to Resident [redacted].

Staff Person D passed the Department approved Medication Administration Course on [redacted]. An annual practicum has not been completed since passing the initial course. On [redacted] Staff Person D administered [redacted] [redacted] tablet to Resident [redacted]

Staff person E passed the Department approved Medication Administration Course on [redacted]. An annual practicum has not been completed since passing the initial course. On [redacted] Staff Person E administered [redacted] [redacted] to Resident [redacted]

Plan of Correction ***Accept ([redacted] - 04/09/2026)***

Immediate Correction
The Medication Technicians were removed off the cart, and courses were completed successfully by the Medication Technicians.

Ongoing Corrective Actions
The expiration dates of certifications will be entered into Paylocity for BOM and staff to receive and reminders to be sent 45 days prior to expiration date.

Ongoing Monitoring Actions
BOM will run monthly report on the first Wednesday of each month out of Paylocity and ED will ensure course and

190a - Completion Medication Course (continued)

or training are completed, ED will review and sign off on report as an acknowledgement and ensure compliance

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented [redacted] - 05/15/2026)

224a - Preadmission Screen Form

24. Requirements

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

Description of Violation

Resident [redacted] was admitted to the facility on [redacted], the home did not complete a preadmission screening.

Resident [redacted] was admitted to the facility on [redacted] the home did not complete a preadmission screening.

Plan of Correction ***Accept [redacted] - 04/09/2026)***

Immediate corrective actions:
All residents prescreen were audited by 3/5/26.

Ongoing Corrective Actions:
Executive Director, Clinical Care Coordinator and Memory Care Director were in-service on 4/8/26, on Pennsylvania DHS Personal Care Regulations 2600, 225a, by Regional Director of Operations. An admission check list will be followed for each admission starting 4/08/26
Ongoing Monitoring: Admission check list will be completed prior to admission and audited within 48 hours of admission to Personal Care and MC. Executive Director will review and sign off on new admission checklists weekly after Weekly Clinical Meeting q Wednesday.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented [redacted] - 05/15/2026)

225a - Assessment 15 Days

25. 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 [redacted] medical evaluation dated [redacted] indicates the resident requires a secure dementia care unit. The resident's initial assessment and support plan dated [redacted] indicates they are a resident of the secure dementia care unit. However, the resident resides in the personal care home section of the home.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept [redacted] - 04/17/2026)***

All residents assessments were audited by the former Resident Care Coordinator by 3/5/26. The current RASPs for residents with initial assessments were completed the designee of the Executive Director by 04/09/2026
Ongoing Corrective Actions: Executive director, Clinical Care Coordinator and Memory Care Director was in-serviced on 4/8/26, Pennsylvania DHS Personal Care Regulation 2600, 225a, by Regional Director of Operations. A compliance report will be pulled weekly and reviewed by the Clinical Coordinator/designee at the weekly Clinical Meeting to ensure RASPs are being completed within the 15 days of admission
Ongoing Monitoring:
Executive Director to review and sign after weekly Clinical Meeting to ensure that initial assessment are completed timely within the 15 days of admission to ensure compliance by 04/29/2026

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

231b - Medical Evaluation

26. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the facility's secure dementia care unit on [redacted]. Resident [redacted]s medical evaluation dated [redacted] indicates the resident does not require placement in a secure dementia care unit.

Resident [redacted] moved into the facility's secure dementia care unit on [redacted]. The resident does not have a medical evaluation completed by a medical professional that indicates the resident requires to be in a secure dementia care unit.

Plan of Correction ***Accept [redacted] - 04/17/2026)***

Immediate Corrective Actions:
All residents medical evaluations were audited by 03/05/2026 by the former Resident Care Coordinator/designee. Resident [redacted] and Resident [redacted] medical evaluations were revised to reflect each of the resident's needs to be in a memory care unit.

[redacted]

Ongoing Corrective Actions:
Executive Director, Clinical Care Coordinator and Memory Care Director were in-serviced on 04/08/2026, on Pennsylvania DHS Personal Care Regulations 2600, 231b by Regional Director of Operations. An admission check list will be completed each admission starting 4/08/26 by the Clinical Coordinator/designee and Memory Care Director to ensure DME's are appropriate to the level of care where the resident is being placed.
Ongoing Monitoring:

231b - Medical Evaluation (continued)

Admission check list will be completed prior to admission and audited within 48 hours of admission to Personal Care or Memory Care Unit by the Clinical Coordinator/designee or Memory Care Director/designee by April 29, 2026. Executive Director will sign off on the admissions checklist within the first 72 hours and then weekly after the weekly meeting to ensure compliance by April 29, 2026.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

231c - Preadmission Screening

27. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the facility's secure dementia care unit on [redacted] The resident did not have a cognitive preadmission screening completed.

Resident [redacted] moved into the facility's secure dementia care unit on [redacted]. The resident does not have a cognitive preadmission screening completed.

Resident [redacted] moved into the facility's secure dementia care unit on [redacted]. The resident's cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept [redacted] - 04/17/2026)***

All residents cognitive prescreens were audited by the former Resident Care Director on 03/05/2026. The prescreens for residents [redacted] and [redacted] were completed by the Executive Director.

Ongoing Corrective Actions:
Executive director, Clinical Care Coordinator and Memory Care Director was in-service on 4/8/26, Pennsylvania DHS Personal Care Home Regulations 2600 225a, by Regional Director of Operations. An admission check list will be followed for each admission starting 4/08/26 to ensure cognitive prescreens are being completed.

Ongoing Monitoring:
Admission check list will be completed prior to admission by the Clinical Coordinator or Memory Care Director and audited within 48 hours of admission to the Personal Care or Memory Care Community. The Executive Director will review and sign off on the new admission checklist weekly after weekly Clinical Meeting to ensure compliance by 04/29/2026

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] - 05/15/2026)

231e - No Objection Statement

28. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the secure dementia care unit on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept[redacted] - 04/17/2026)***

IImmediate corrective actions:
Current residents on the memory care unit will have their residency agreements audited by the Executive Director/designee by 04/29/2026 to ensure the responsible party and resident have signed that they are aware of placement in a secured memory care unit, and have no objection to the placement.
Ongoing Corrective Actions:
The Executive Director/designee will be inserviced by the Regional Director of Operations by 04/29/2026 that the responsible party and resident have signed as being aware of being placed in a secured memory unit, or have no objection to it during the residency agreement signing process prior to admission to the secure memory care unit. A new admission checklist will be completed starting with a new admission or transfer to the memory care unit by the Clinical Coordinator and Memory Care Director prior to admission to ensure that the responsible party and resident are aware of being placed in a secure dementia unit, and no objection statement is fully signed by both the responsible party and the resident during the residency agreement signing process prior to admission.
Ongoing Monitoring:
Executive Director/designee will sign off on the admissions checklist within the first 72 hours after admission and then weekly after the weekly Clinical meeting to ensure compliance by 4/29/2026

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented [redacted] 05/15/2026)

234a - Admission Support Plan

29. 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 [redacted] was admitted to the secure dementia care unit on [redacted]. The resident's initial support plan was not completed.

Resident [redacted] moved into the facility's secure dementia care unit on [redacted] The resident does not have a completed support plan.

234a - Admission Support Plan *(continued)*

Plan of Correction ***Accept [redacted] - 04/09/2026)***

Immediate corrective actions:
All current resident RASPs were updated and revised as of March 31st, 2026. All expiration dates entered in electronic charting system.

Ongoing Corrective Actions:
Compliance of due dates entered into the electronic chart system will be printed and review at morning meeting Monday through Friday each week
Ongoing Monitoring:
Executive director will review and sign off on each morning meeting with the exceptions of vacation and sick days.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented [redacted] - 05/15/2026)

234d - Support Plan Revision

30. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

On [redacted] Resident [redacted] most recent support plan was completed on [redacted].

Plan of Correction ***Accept [redacted] 04/09/2026)***

Immediate corrective actions:
All current resident RASPs were updated and revised as of March 31st, 2026. All expiration dates entered in electronic chart system.
Ongoing Corrective Actions:
A monthly compliance report will be printed by the Clinical Coordinator or Memory Care Director for upcoming month to ensure support plan documentation is completed timely.
Ongoing Monitoring:
Residents with upcoming expired rasps for the following month will be reviewed at the weekly clinical meeting. Executive Director to review and sign after weekly Clinical Meeting to ensure that rasps are completed timely.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented [redacted] - 05/15/2026)