pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MORAVIAN MANORS INC**
LEGAL ENTITY

To operate **MORAVIAN MANOR**
NAME OF FACILITY OR AGENCY

Located at **300 WEST LEMON STREET, LITITZ, PA 17543**
(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 **25**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 **August 11, 2026** until **February 11, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **321761**

ISSUING OFFICER

Juliet Marsala
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 628P – 04/.23

Pennsylvania
Department of Human Services

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

Moravian Manors, Inc.
[redacted]

RE: Moravian Manor
300 West Lemon Street
Lititz, Pennsylvania 17543
License/COC #: 321761

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on March 31, 2026, April 1, 2026, April 2, 2026, June 23, 2026 and June 24, 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 REVOKES your certificate of compliance License #32176 dated June 28, 2026, until June 28, 2027 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from AUGUST 11, 2026 to FEBRUARY 11, 2027.

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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
15(a)	III	11	$3	$33	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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: *MORAVIAN MANOR* **License #**: *32176* **License Expiration**: *06/28/2026*

Address: *300 WEST LEMON STREET, LITITZ, PA 17543*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MORAVIAN MANORS INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 1* **Date**: *01/09/1975* **Issued By**: *L&I*

Type: *I 2* **Date**: *09/13/2017* **Issued By**: *Borough of Lititz*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/03/2026*

Inspection Dates and Department Representative

03/31/2026 On Site: [redacted]
04/01/2026 On Site:
04/02/2026 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *11*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

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

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

Have Mobility Need: *9* **Have Physical Disability**: *0*

Inspections / Reviews

03/31/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2026*

05/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/09/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/19/2026*

05/21/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/09/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/12/2026*

07/15/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/09/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], Staff Person A witnessed Resident [redacted] sitting on [redacted] bed, nude from the waist up. Resident [redacted] was also observed in the bedroom, standing in front of Resident [redacted] with [redacted] pants and underwear down. However, this incident was not reported to the local Area Agency on Aging.

Repeated Violation [redacted], et al.

Plan of Correction ***Accept [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Clinical Coordinator to to educate staff on what is abuse and what is reportable.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coirdinator will will educate staff that both the Administrator and Clinical Coordinator need to be notified in case of suspected abuse so an investigation can immediately be launched, with a completion date of 05/25/2026.

Effective 05/11/2026 the adminstrator/clinical coordinator will perform daily audits of on going, through 05/25/2026 to maintain ongoing compliance with immediately reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21 —15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons. On going process and Administrator and Clinical Coordinator will review and file all reports within 2 hours of the report of suspected abuse or medication errors. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Act 13 completed 5/15/2026 and AAA called and initial report given. Waiting on a call back.
Task added to TAR in Point Click Care to monitor behaviors every shift and to report any sexual behaviors to administrator or clinical coordinator. This will also allow Administrator or Clinical Coordinator to check daily.

Licensee's Proposed Overall Completion Date: *05/25/2026*

Not Implemented [redacted] 07/15/2026)

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).

16c Written Incident Report *(continued)*

Description of Violation

On [redacted] taff Member A witnessed Resident [redacted] sitting on [redacted] bed, nude from the waist up. Resident [redacted] was also observed in the bedroom, standing in front of Resident [redacted] with [redacted] pants and underwear down. However, this incident was not reported to the Department.

Resident [redacted] was prescribed [redacted], give 1 tablet by mouth one time a day. On [redacted] and [redacted], Resident [redacted] was not administered [redacted] due to this medication not being available in the home. The home did not report this medication error to the Department until [redacted]

Plan of Correction ***Accept [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Clinical Coordinator to to educate staff on what is abuse and what is reportable.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will will educate staff that both the Administrator and Clinical Coordinator need to be notified in case of suspected abuse so an investigation can immediately be launched, with a completion date of 05/25/2026.
Effective 05/11/2026 the adminstrator/clinical coordinator will perform daily audits of on going, through 05/25/2026 to maintain ongoing compliance with immediately reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701 10225.707) and 6 Pa. Code § 15.21 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons. On going process and Administrator and Clinical Coordinator will review and file all reports within 2 hours of the report of suspected abuse or medication errors. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Education provided to staff on 5/8/26 of what are reportable incidents.
Incident report completed 5/18/26, 5/15/26 AAA was contacted and report given on incident, done by Administrator.
Daily audits are following up on the behaviors that staff are documenting on each shift. This is a task added to the TAR in PCC for reporting and auditing

Licensee's Proposed Overall Completion Date: *05/25/2026*

Not Implemented [redacted] - 07/15/2026)

25b - Contract Signatures

3. Requirements

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

Description of Violation

The resident home contract, dated [redacted] for Resident [redacted] was not signed by the resident or the designated representative.

25b - Contract Signatures *(continued)*

Plan of Correction ***Accept (- 05/20/2026)***

In response to the violation on by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Admission coordinator to Contract signing added to the admission checklist that it needs to be completed within 24 hours of resident moving into facility.

To enhance the currently compliant operations, on 05/11/2026 the Admission Coordinator will ensure that contract is signed within 24 hours of admission by either the resident or designated representative. If there is an issue with signing Admission Coordinator will notify Social Services Director/Administrator/Clinical Coordinator for assistance, with a completion date of 12/31/2026.

Effective 05/11/2026 the Assigned Designee will perform weekly audits of on going, through 12/31/2026 to maintain ongoing compliance with Having contract signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Audits were completed 5/19/26, by Denise Geib and Resident signed contract 5/19/26 and Marci Hoover, Admissions Coordinator obtained signature on aree

Licensee's Proposed Overall Completion Date: *05/19/2026*

Implemented - 07/15/2026)

26b - Quality Management Plan Content

4. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management reviews dated completed through and through did not address reportable incident and condition reporting procedures, complaint procedures, staff person training, licensing violations and plans of correction, resident or family councils. Staff Member B confirmed only falls, medication errors, wounds, and call bells are reviewed for quality management.

Plan of Correction ***Directed - 05/20/2026)***

In response to the violation on by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/04/2026 by the Administrator to Immediate action taken on 5/4/26 Administrator updated Qapi report to include: reportable incident and condition reporting procedures, complaint procedures, staff person

26b - Quality Management Plan Content (continued)

training, licensing violations and plans of correction, resident or family councils, falls, medication errors, wounds, and call bells are reviewed for quality management.

2. on [ ] by the [ ] to [ ]

To enhance the currently compliant operations, on 05/04/2026 the Administrator will Administrator to do monthly and quarterly checks to make sure all information is entered and correct , with a completion date of 12/31/2026.

Effective 05/04/2026 the Administrator will perform quarterly audits of To ensure all information is entered correctly, through 12/31/2026 to maintain ongoing compliance with Having a quality management plan that address the periodic review and evaluation of reportable incident and condition reporting procedures, complaint procedures, staff person training, licensing violations and plans of correction, if applicable, and resident or family councils, or both, if applicable. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Clinical Coordinator was educated on required information for the QAPI report on 4/30/26 and report was updated on 4/30/26

(Directed)
In addition to the above plan of correction:

- *A quality management review will be conducted no later than 6/5/26 and will include all required areas in accordance with 2600.26(b).*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/05/2026*

Implemented [redacted] - 07/15/2026)

42b - Abuse

5. 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] is diagnosed with [redacted] and [redacted]. Resident [redacted]s initial medical evaluation, dated [redacted], indicated the resident had fair cognitive functioning. Resident [redacted] most recent medical evaluation, dated [redacted], indicates a [redacted], [redacted], and a requirement for assistance with all decision making. Staff reported to agents of the Department that Resident [redacted] requires redirection "throughout the day" and "constant reminders" of "what [redacted] supposed to be doing and when [redacted] supposed to be doing it". Staff also reported that Resident [redacted] requires constant supervision due to sexual behaviors.

Resident [redacted] is diagnosed with [redacted] and [redacted] Resident [redacted]s initial medical evaluation, dated [redacted], indicated the resident had fair cognitive functioning. Resident [redacted] most recent medical evaluation, dated [redacted] indicates a [redacted] and [redacted]. Staff reported to agents of the Department that Resident [redacted] is cognitively oriented with "periods of disorientation" and independent with ADLs.

42b - Abuse (continued)

Interviews with staff indicated Resident [redacted] exhibits sexual behaviors, specifically towards Resident [redacted] Resident [redacted] was described as "touchy" and staff have witnessed Resident [redacted] attempting to hug, kiss, and hold hands with residents of the opposite sex. Documentation of Resident [redacted] psychiatry visit, dated [redacted], indicates hypersexuality was reported by staff. Resident [redacted] has referred to Resident [redacted] as [redacted] "second [redacted]", requiring redirection and reorientation by staff. When staff intervene, Resident [redacted] has become [redacted], and has [redacted]

Staff Member A reported to agents of the Department that on [redacted] Resident [redacted] was found in Resident [redacted] room. Resident [redacted] was observed sitting on the edge of the bed, topless. Resident [redacted] was observed standing in front of Resident [redacted] with [redacted] pants and underwear pulled down. Staff Member A asked the residents to separate, and Resident [redacted] left the room. After the incident Resident [redacted] apologized and requested that Staff Member A "not tell anyone".

Resident [redacted] becomes upset and frustrated with Resident [redacted] behavior. Resident [redacted] reported to agents of the Department that Resident [redacted] wants to be in a relationship with [redacted] but it's "not gonna happen". Resident [redacted] also reported that Resident [redacted] will follow [redacted] sit as close to [redacted] as possible, and that Resident [redacted] " makes it uncomfortable", "If I'm over here, [redacted] right behind me". A stop sign was affixed to Resident [redacted] door to deter Resident [redacted] from entering.

During interviews conducted by agents of the Department, neither resident, recalled being undressed in Resident [redacted] bedroom. There is no documentation in either Resident [redacted] or [redacted] records indicating their ability to consent to sexual contact, and the home has not had either resident evaluated by a medical professional to determine the residents' ability to consent.

Plan of Correction ***Directed [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Clinical Coordinator to Coordinate of investigations in the future.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will will complete investigation, obtain new orders from PCP for Psych Service and place referral, notify family as well.If need be resident may need to be moved to another household, if other interventions to not work, with a completion date of 05/25/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform daily checks of on going process, through 12/28/2026 to maintain ongoing compliance with not neglecting, intimidating, physically or verbally abusing, mistreating, subjecting to corporal punishment or disciplining residents in any way. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Tasks were added to the TAR for staff to monitor behaviors and document type of behavior so Admin or CC can follow up and monitor.
Both Residents are being seen by Psych services and behaviors monitored. There have been no further incidents and neither has any recall of what happened
Resident 1 has been started on medication ordered by psych in 10/25.

42b - Abuse (continued)

Resident [redacted] did not start to see psych services till 3/26 and has medications prescribed by them.

(Directed)
In addition to the above plan of correction:

- *The administrator or designee will review Resident [redacted] and [redacted]s behaviors and supervision needs to determine if the home can continue to meet their needs safely; updates will need to be made to each resident's assessment and support plan as applicable to ensure resident safety by 6/8/26.*

Directed Completion Date: *06/08/2026*

Implemented [redacted] - 07/15/2026)

63a - First Aid/CPR Training

6. 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.

Description of Violation

On [redacted] and [redacted] from 11PM to 7AM, 11 residents were present in the home. During this time, there were no staff persons present in the home who were certified in first aid.

Plan of Correction ***Accept [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *on 05/02/2026 by the Administrator/Scheduler to ensure All staff member are in the process of being trained in CPR, however there is a nurse that is on 11pm-7am and is CPR/First Aid certified and covers both PC and AL units. There was a nurse on all nights listed above. Both staff members that work 11-7 in the PC unit completed CPR/first aid training on 4/10/26.*
2. *To ensure that facility compliant with operations, on 05/04/2026 the Administrator will make sure new staff that are hired and are not CPR/First Aid certified, they will be scheduled in the next available class being taught, with a completion date of 12/31/26.*

Effective 05/02/2026 the Administrator/Scheduler will perform daily audits of ongoing audits until all staff are trained in CPR/First Aid, through 07/31/2026 to maintain ongoing compliance with ensuring at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR is present in the home at all times. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
5/19/26-education provided to scheduler that under each license there must be at least one CPR/First Aid certified on every shift.
Audit of staff records show that all staff are currently certified in CPR/First Aid as of 4/10/26.
Going forward all new staff must show proof of CPR/First Aid training and if they do not have will be scheduled in the next monthly CPR/First Aid Class and will be scheduled with another staff member that is CPR/First Aid

63a - First Aid/CPR Training (continued)

Certified until they have completed their training.
5/19/26-staff scheduler will be responsible

Licensee's Proposed Overall Completion Date: *05/19/2026*

Not Implemented [redacted] 07/15/2026)

65a - FS Orientation 1st Day

7. 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:

Description of Violation

Staff Member D, whose first day of work was [redacted], did not receive orientation on general fire safety and emergency preparedness prior to or during the first work day.

Plan of Correction ***Directed [redacted] - 05/20/2026)***

emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.
emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.
4/21/26 staff member received Fire Safety training and emergency preparedness.
Audit to be complete of all training records by 6/5/26 and to be completed by Administrator and Clinical Coordinator.
Will add an additional day of orientation to make sure all areas are covered and are within compliance. This will be completed by 6/5/26

(Directed)
In addition to the above plan of correction:

- *Education will be provided to the staff member(s) responsible for providing orientation to newly hired staff prior to or during the first workday. Education to be completed y 6/5/26.*
- *Beginning 6/1/26, the administrator or designee will audit all newly hired staff orientation within 1 day of the staff member's start date to ensure compliance in accordance with 2600.65(a) for 3 months.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/05/2026*

Not Implemented [redacted] 07/15/2026)

65b - Rights/Abuse 40 Hours

8. 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:

65b - Rights/Abuse 40 Hours *(continued)*

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

Description of Violation

Staff Member D completed [redacted] 40th scheduled work hour by [redacted]. However, Staff Member D did not complete training in the following topics until [redacted] resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/18/2026 by the Administrator/Designee to have Relias classes updated and to be added to all new staff and to be started the 2nd day of orientation. Orientation check lists updated to show these 40 hours of training and to have it checked off when done with date/time and confirmed through Relias.

To enhance the currently compliant operations, on 05/18/2026 the Administrator/Designee will ensure that either the 2nd day of orientation that required training was started and if not, that it is started/completed within the first 40 hours of work, with a completion date of 12/31/2026.

Effective May 18 the Administrator/designee will perform monthly audits of on going after each monthly orientation, through 12/31/2026 to maintain ongoing compliance with ensuring that within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers will have an orientation that includes, including resident rights, and emergency medical plan, and mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102). Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *05/18/2026*

Not Implemented [redacted] - 07/15/2026)

65e - 12 Hours Annual Training

9. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct Care Staff Member E received only 2.25 hours of annual training in 2025.

65e - 12 Hours Annual Training *(continued)*

Plan of Correction ***Directed [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/06/2026 by the Administrator, who created a checklist was made for in the front of the training binder for each year, including 2026, to ensure that all required trainings have been completed within the 12 months.

To enhance the currently compliant operations, on 05/06/2026 the Administrator/Designee will follow up each month to ensure that compliance is being met, with a completion date of 12/31/2026.

Effective 05/06/2026 the Administrator/Designee will perform monthly audits of trainings , through 01/31/2027 to maintain ongoing compliance with ensuring direct care staff persons have at least 12 hours of annual training relating to their job duties. For the remainder of this year 2 topics will held starting in June to make sure Compliance is met. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Staff training audits to be completed by 5/26/26 and any staff that has been found to be out of compliance will be scheduled for missing trainings and those trainings will be completed by 6/5/26

(Directed)
In addition to the above plan of correction:

- *Staff Member E will receive 9.75 hours of education by 6/5/26-these hours will be in addition to the required 12 hours of training for 2026.*
- *An audit of all other staff members training records will be completed to ensure each staff member received 12 hours of annual training during training year 2025. Any staff person found to be out of compliance will receive the missing education hours by 6/5/26-these training hours will be in addition to the required 12 hours of annual training for training year 2026.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/05/2026*

Not Implemented [redacted] - 07/15/2026)

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics *(continued)*

Description of Violation

Direct Care Staff Member E did not receive training on the following topics during the 2025 training year:
-Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
-Care for residents with dementia and cognitive impairments.
-Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
-Personal care service needs of the resident.
-Safe management techniques.

Plan of Correction ***Accept (05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Clinical coordinator/clinical Educator to remind staff to complete their monthly trainings.
Staff training audits will be completed by 5/25/26 and any staff member found out of compliance will have the required education by 6/5/26

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will monitor required education that staff complete online with Relias and will give reminders for them to complete each month. Follow up as to why they are unable to complete, with a completion date of 12/28/2026.

Effective 05/11/2026 the Adminstrator/Clinical Cordinator will perform monthly audits of ongoing process, through 11/30/2026 to maintain ongoing compliance with ensuring training topics for the annual training for direct care staff persons include, including instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and care for residents with dementia and cognitive impairments, and infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, and personal care service needs of the resident, and safe management techniques. If unable to complete training online by end of November each year, because of being away at school, a paper copy of education will be forwarded to them for completion by end of year. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Not Implemented (07/15/2026)

65g - Annual Training Content

11. 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:

65g Annual Training Content *(continued)*

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff Members E and Staff Person F did not receive training on the following topics during the 2025 training year:
Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
Emergency preparedness procedures and recognition and response to crises and emergency situations.
Resident rights.
The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
Falls and accident prevention.
New population groups that are being served at the home that were not previously served, if applicable.

Staff Member G did not receive training in Fire Safety, completed by a fire safety expert or by a staff person trained by a fire safety expert, during the 2025 training year.

Plan of Correction ***Accept[redacted] - 05/20/2026)***

In response to the violation on[redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Designee to create a quick reference for all required training and associated documents.

To enhance the currently compliant operations, on 05/11/2026 the Designee will orient staff with checklist and initial with them that all areas have been reviewed on their first shift, with a completion date of 12/28/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform monthly audits, as this will be an going process with new hires monthly, through 12/28/2026 to maintain ongoing compliance with ensuring direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers are trained annually in, including fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, or videos prepared by a fire safety expert and accompanied by an onsite staff person trained by a fire safety expert, and emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), and falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable. They will then complete the online training. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Staff Training record audit will be completed by 5/25/26 and anyone found to be out of compliance will have educations completed by 6/5/26

Licensee's Proposed Overall Completion Date: *06/05/2026*

Not Implemented[redacted] - 07/15/2026)

65i - Training Record

12. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of annual training for Staff Member E does not include the length of each course.

Plan of Correction ***Accept [redacted] - 05/20/2026)***

After clarification during survey, Administrator and Designee will document time in which it took them to cover topic. Education was provided by Administrator to Clinical Coordinator on creating and maintaining education records. 6/8/26 will be first quarterly meeting with Administrator and Clinical Coordinator to review training records to make sure all areas of required training are present and correct any missing information will be corrected.

Licensee's Proposed Overall Completion Date: *06/08/2026*

Not Implemented [redacted] - 07/15/2026)

81b - Resident Personal Equipment

13. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident [redacted] has a hospital bed with bilateral half-rails. On [redacted] at 10:47 AM, zip ties were fastened to the bed rails and bedframe to lock them in a down position, however the rails were not secure and moved 5 inches when lifted.

Plan of Correction ***Directed [redacted] 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Designee to to have all beds with "secured" half rails inspected for compliance and remove rails if the resident is not care planned to have them on their bed.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Designee will will perform routine checks on any bedrails and have maintenance remove if not needed or tighten to meet standards, with a completion date of 06/01/2026.

Effective [ ] the [ ] will perform monthly inspections of on going inspections, through 12/31/2026 to maintain ongoing compliance with ensuring wheelchairs, walkers, prosthetic devices and other apparatus used by residents are clean, in good repair and free of hazards. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Bilateral half rails were resecured by Maintenance.
5/18/26 Clinical Coordinator started monthly inspection.

81b Resident Personal Equipment (continued)

(Directed)
In addition to the above plan of correction:

- *Resident [redacted] will be assessed by the home to determine if the resident requires the use of bilateral half rails by 6/5/26. If the resident does not utilize them, the rails will be removed entirely by 6/5/26. If the resident is determined to be in need of the bilateral half rails, the physician will be contacted to verify that [redacted] recommends the bedrail use. The resident's medical evaluation record will be updated, as applicable, by 6/5/26. The resident will be assessed to ensure the resident can raise and lower the bilateral bed rails independently. If the resident is unable to raise and lower the rails independently, then the home will assess the resident for an alternative bedside mobility device. These steps will be implemented for each resident in the home who utilizes a bedrail by 6/5/26.*
- *Documentation of completed education, audits and updates to resident records will be kept by the home and available for use by the Department.*

Directed Completion Date: *06/05/2026*

Implemented [redacted] - 07/15/2026)

91 - Telephone Numbers

14. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephones located in Residents [redacted] or [redacted] bedrooms.

Plan of Correction ***Accept [redacted] 05/12/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/06/2026 by the Administrator to maintain compliance with posting of the emergency phone numbers in each residents room. 4x6 clear frames were ordered that have adhesive on the back so they can be secured to the back of the door.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Designee will print out the emergency phone numbers and use the clear frames, to secure them to the back of each room door, with a completion date of 05/15/2026.

Effective 05/25/2026 the Administrator/Disignee will perform weekly audits of on going audits, through 12/31/2026 to maintain ongoing compliance with posting telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline on or by each telephone with an outside line. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

91 - Telephone Numbers *(continued)*

Licensee's Proposed Overall Completion Date: *05/25/2026*

Implemented [redacted] - 07/15/2026)

107d - Procedure Emergency Management Agency Submission

15. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were submitted to the local emergency management agency in 2024 and not again until [redacted]; the emergency procedures were not submitted to the local emergency management agency in 2025.

Plan of Correction ***Accept ([redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *on 05/01/2026 by the Administrator to on 5/1/2026 administrator added a recurring calendar appointment to to calendars of the Administrator, Director of Health and Wellness, for January 1st every year going forward, to remind them to send the Emergency Procedures binder to the EMA.*
2. *on 05/01/2026 by the Administrator to Recurring reminder on calendar of Administrator, Maintenance Director and Director of Health and Wellness for January 1st every year starting January1, 2027. This is in place to remind them to send the Emergency Procedures to the Emergency Management Agency for approval.*

To enhance the currently compliant operations, on 01/01/2027 the Designated staff will The designated staff member will sign off on the log when they sent it to EMA and when it was returned from EMA. They will initial and date each time, with a completion date of 01/08/2027.

Effective 01/01/2027 the Administrator, Director of Health and Wellness, Maintenance Director will perform annual audits of to be done the first of every year and is ongoing., through 01/31/2027 to maintain ongoing compliance with reviewing, updating and submitting annually, to the local emergency management agency, written emergency procedures. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
5/1/26 Administrator educated Director of Health and Wellness and Director of Maintenance of Procedure to review Emergency Plans in November and once review is completed, by January 1st, the EMA will be contacted to review the Emergency Plan. This log for review will be kept in the front of the Emergency plan so it can be initialed and dated when complete.

Licensee's Proposed Overall Completion Date: *05/20/2026*

Implemented [redacted] - 07/15/2026)

121a - Unobstructed Egress

16. 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] the Fire Commissioner of the Warwick Emergency Services Commission identified the Personal Care Unit courtyard as a fire safe area. On [redacted] at 9:30 AM, a magnetic lock prevented immediate egress from the home to the courtyard. Staff Member B was unable to open the door utilizing the wall-mounted keypad.

On [redacted] at 9:31 AM, the rear double doors of the Personal Care Unit were observed with an illuminated "EXIT" sign, indicating it as an egress route. However, there were a 5 pieces of paper taped to the doors that read: "NOT AN EXIT", "DO NOT OPEN THIS DOOR", and "PLEASE DO NOT GO OUT THIS DOOR. IT LEADS TO THE KITCHEN. PLEASE TURN AROUND".

Plan of Correction ***Directed [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/04/2026 by the Maintenance Department to The magnetic door locks on the courtyard and the back door, release when the fire system is activated, so that residents and staff can freely evacuate into the courtyard and the back door. This has been tested by Maintenance Dept and the mag locks drop without incident.As for the signs on the back door stating, "This is not an exit" they were removed 4/2/2026.

To enhance the currently compliant operations, on 05/11/2026 the Maintenance will do regular audits to make sure maglocks are working and report/fix any issues that may occur, with a completion date of 12/31/2026.

Effective 06/11/2026 the All Staff will perform daily inspections of ongoing monitoring, through 12/31/2026 to maintain ongoing compliance with ensuring stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed during fire drills. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Keypad in dining room that leads to the courtyard has requested to be disabled and to be completed by 6/12/26. Maintenance is working on this.
Regular audits are monthly when fire drills are performed.

(Directed)

- *Education will be provided to all staff in the home on ensuring each exit is not locked or marked as "not an exit" by 6/5/25.*
- *Beginning no later than 6/5/26, weekly audits will be completed in the home to ensure each exit is clearly marked as an exit and unobstructed. Weekly audits will continue for a minimum of 1 month and then monthly thereafter.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/12/2026*

121a - Unobstructed Egress *(continued)*

Not Implemented [redacted] - 07/15/2026)

121b - Locking Device Approval

17. Requirements

2600.
121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

The double doors at the rear of the Personal Care Unit, is used as an egress route. These doors lead to an interior hallway, with an exit door leading to the exterior of the building. However, the door leading to the exterior is equipped with a magnetic lock with a push-button release mounted to the wall, preventing immediate egress from the building. The home does not have written approval or a variance from the Department of Labor and Industry, the Department of Health or the local building authority for use of this magnetic lock.

On [redacted] the Fire Commissioner of the Warwick Emergency Services Commission indicated the Personal Care Unit courtyard as a fire safe area. The courtyard doors are equipped with magnetic locks with a push-button release located in the nurse's station, preventing immediate egress from the building. The home does not have written approval or a variance from the Department of Labor and Industry, the Department of Health or the local building authority for use of this magnetic lock.

Plan of Correction ***Directed [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/04/2026 by the Maintenance Department to The magnetic door locks on the courtyard and the back door, release when the fire system is activated, so that residents and staff can freely evacuate into the courtyard and the back door. This has been tested by Maintenance Dept and the mag locks drop without incident. As for the signs on the back door stating, "This is not an exit" they were removed 4/2/2026.

To enhance the currently compliant operations, on 05/11/2026 the Maintenance will do regular audits to make sure maglocks are working and report/fix any issues that may occur, with a completion date of 12/31/2026.
Effective 06/11/2026 the All Staff will perform daily inspections of ongoing monitoring, through 12/31/2026 to maintain ongoing compliance with ensuring stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed during fire drills. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Keypad in dining room that leads to the courtyard has requested to be disabled and to be completed by 6/12/26. Maintenance is working on this.

Regular audits are monthly when fire drills are performed.
The push button wall mount is not in the household but in the back hallway that leads to the loading dock area. Can this be replaced with a keypad?

121b Locking Device Approval (continued)

(Directed)

In addition to the above plan of correction:

- *The home will disengage the push button wall mount lock by 6/5/26.*
- *If the home decides to install an acceptable lock as identified in the Chapter 2600 Regulations, the home will assess all current residents on their ability to utilize the keypad on the locked door to the courtyard. Resident assessments will be updated to include their ability to utilize the locked door. This process will continue with any new admissions to the home. If at least one resident is unable to independently utilize the acceptable lock, then the lock will immediately be disengaged. Additionally, the home will obtain a written approval or variance from the Department of Labor and Industry, Department of Health or an appropriate local building authority for the use of the lock.*
- *Education will be provided to the administrator on 2600.121(b) as well "Egress: Obstructions, Locks and Courtyards Not Located in a Secured Dementia Care Unit" located in the 2600 Regulatory Compliance Guide by 6/5/26.*
- *An initial audit of all egresses in the home will be completed by the administrator or designee to ensure compliance in accordance with 2600.121(a) and 2600.121(b) by 6/5/26.*
- *Beginning 6/5/26, the administrator or designee will complete monthly audits of the home for a minimum of 3 months to ensure ongoing compliance.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/12/2026*

Not Implemented [redacted] 07/15/2026)

123b - Emergency Procedures Posted

18. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On [redacted] and [redacted] the home's emergency procedures were not posted in a conspicuous and public place in the home. The procedures were stored in a cabinet located in the nurse's station.

Plan of Correction ***Accept ([redacted] - 05/20/2026)***

On 4/3/26 the Emergency Procedure binder was placed on the front counter by the sign in/out book. Weekly checks for the first month, which were started 4/10/26 through 5/1/26 then will be monthly, for June and July and then bi monthly till January 2027.

Staff were educated on 4/10/26 at staff meetings and explained the requirements and why it is to be kept out in open area. Administrator provided education to staff.

Licensee's Proposed Overall Completion Date: *05/19/2026*

Implemented ([redacted] - 07/15/2026)

130h - Inoperable Smoke Detector

19. Requirements

130h - Inoperable Smoke Detector *(continued)*

2600.
130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction ***Accept [redacted] - 05/12/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *on 05/05/2026 by the Director of Health and Wellness to Immediate action was taken to create a policy for emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.*

5/6/2026 staff to be educated on new policy and policy will be added to the Emergency Preparedness binder, by Director of Health and Wellness, with a completion date of 05/31/2026.

Effective 05/05/2026 the Administrator, Director of Health and Wellness, Director of Maintenance will perform annual reviews. Fire Commissioner will review yearly, starting 01/01/2027 to maintain ongoing compliance with Ensuring the home's emergency procedures indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable. This will be reviewed yearly by Fire Commissioner when the Emergency Preparedness Binder is reviewed. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] - 07/15/2026)

132b - Safety Inspection/Fire Drill

20. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

A fire drill observed by a fire safety expert was conducted on [redacted]. The following fire drill observed by a fire safety expert was not conducted until [redacted]

Plan of Correction ***Accept [redacted] - 05/20/2026)***

132b - Safety Inspection/Fire Drill (continued)

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/04/2026 by the Administrator to In response to the violation on 03/31/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 5/4/26 by the Administrator to add a calendar reminder to November 2026, 2027 and 2028 to message the Fire Commissioner to schedule annual drill observation for January of every year going forward.

To enhance the currently compliant operations, on 05/05/2026 the Administrator will Administrator will follow up in November to schedule observed fire drill for January of the next year and to make sure it is not past the 365 day mark, with a completion date of 12/31/2026.

Effective 05/05/2026 the Administrator will perform annual inspections of Schedule in Novemeber for Annual inspection for January, through 12/31/2026 to maintain ongoing compliance with Ensuring a fire safety inspection and fire drill conducted by a fire safety expert is completed annually, and to keep documentation of each fire drill and fire safety inspection. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
4/3/26 when tag was reviewed by BHSL, Administrator was educated that is had to be every 12 months. Administrator is the staff person that schedules the fire expert annually and will contact at least 2 month ahead of last observation.

Licensee's Proposed Overall Completion Date: *05/19/2026*

Implemented [redacted] - 07/15/2026)

132e - Fire Drill Sleeping Hours

21. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

On [redacted], a fire drill was conducted during sleeping hours. The previous sleeping hours fire drill was conducted on [redacted]

Plan of Correction ***Accept [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *on 05/05/2026 by the Administrator to In response to the violation on 03/31/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 5/5/2026 by the Administrator to to educate the Director of Facility Operations on the regulation of sleeping hour drills, and that sleeping drills must be schedule every 6 moths.*
2. *Director of Facility Operations schedules the fire drill, they and the Maintenance Director and Administrator will schedule drills together to make sure dates are in compliance of regulations, with a completion date of 11/30/2026.*

132e Fire Drill Sleeping Hours (continued)

Effective 05/05/2026 the Administrator will perform annual reviews of reviewed annually and as needed to make sure compliance is met, through 09/30/2026 to maintain ongoing compliance with Holding a fire drill during sleeping hours once every 6 months will be reviewed annually and as needed to make sure drills are completed every 6 months. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Next scheduled drills are 9/18/26 in PC and 9/24 in AL

Licensee's Proposed Overall Completion Date: *05/20/2026*

Implemented [redacted] - 07/15/2026)

141a - Medical Evaluation

22. 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.

Description of Violation

The medical evaluation for Resident [redacted] was not complete within 60 days prior to admission or within 30 days after admission of the resident. Resident [redacted] was admitted to the home on [redacted] and the medical evaluation was not completed until [redacted]

Plan of Correction ***Accept [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Adminsitrator/Clinical Coordinator to Created an Admission checklist for the admission process from beginning to end. Listing the DME as the first item on list.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will ensure that all documents are collected before the admission can be completed. Goal is to have the DME completed no more than 30 days before admission, with a completion date of 05/18/2026.

Effective 05/11/2026 the Adminsitrator/Clinical Coordinator will perform weekly audits of on going weekly audit to make sure we are in compliance, through 12/28/2026 to maintain ongoing compliance with ensuring each resident has 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. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Audit was completed by Clinical Coordinator 5/13/26
Administrator and Clinical Coordinator will be reviewing and auditing all medical evaluations instead of Admission Coordinator.

141a - Medical Evaluation *(continued)*

Licensee's Proposed Overall Completion Date: *05/19/2026*

Implemented [redacted] - 07/15/2026)

141b1 - Annual Medical Evaluation

23. Requirements

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

Description of Violation

Resident [redacted] medical evaluation was completed on [redacted]. The medical evaluation form did not indicate if the resident's needs can be met safely at the Personal Care Home.

Plan of Correction ***Accept[redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/08/2026 by the Admnistrator/Clinical Coordinator to ensure that all DME's have complete information are to be reviewed by the Administrator or Clinical Coordinator.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will review the DME to make sure all information is included and there are no incomplete areas, with a completion date of 08/31/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator will perform monthly audits of on going process, through 12/29/2026 to maintain ongoing compliance with ensuring each resident has a medical evaluation at least annually and all documents will be reviewed every 11 months instead of annually so designated staff can make sure all information is captured for the yearly medical exam and no information is missing. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
5/12/26 Medical Evaluation was updated
5/25/26 Clinical Coordinator will complete audit of all resident medical evaluations and any found to be out of compliance, the physician will be contacted to make corrections by 6/5/26
5/12/26 this education was completed by the Administrator to the Clinical coordinator and the Admission Coordinator.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Not Implemented ([redacted] - 07/15/2026)

171b4 - Staff Training

24. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

171b4 - Staff Training *(continued)*

4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff Member H and Staff Member I transport residents independently. However, neither Staff Member has successfully completed the Department-approved direct care training course.

Plan of Correction ***Accept (- 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/30/2026 by the Director of Facility Operations to inform the Director of Facility Operations that all staff transporting residents must complete the Direct Care Training.

To enhance the currently compliant operations, on 05/11/2026 the Director of Facility Operations will will complete training before transporting any residents, with a completion date of 05/18/2026.

Effective 5/18/26 the Administer will perform monthly audits of on going process with new hires needing trained, through 12/30/2026 to maintain ongoing compliance with ensuring at least one staff member transporting or accompanying the residents has completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation). Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
H and I are completing the trainings and have been removed from transporting residents. This was delayed as their immediate supervisor has been out on leave,

Licensee's Proposed Overall Completion Date: *06/05/2026*

Implemented (- 07/15/2026)

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident [redacted] is prescribed [redacted] subcutaneously one time a day. However, the pharmacy label for Resident [redacted] provided instructions for "18u subcutaneously once daily".

Plan of Correction ***Accept - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Designee to Change label was placed on medication 4/2/2026. Nursing staff was verbally educated/reminded that they are responsible for the Change stickers.

184a Resident's Meds Labeled (continued)

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Designee will will educate Nursing staff of their responsibility to place Change stickers on a medication that has had a dosage change and the nurse doing the chart check for this order will double check to make sure there is change sticker on the medication, with a completion date of 05/11/2026.

Effective 05/11/2026 the Adaministrator/Designee will perform daily audits of ongoing process of audits, no end date, through 12/31/2026 to maintain ongoing compliance with ensuring the original container for prescription medications will be labeled with a pharmacy label that includes, including the prescribed dosage and instructions for administration and place change stickers on any medication that has had a dosage change, such as insulin. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
5/11/26 a cart audit was completed by Clinical Coordinator to ensure that all labels match orders(dosage, instructions).

Licensee's Proposed Overall Completion Date: *05/19/2026*

Not Implemented [redacted] - 07/15/2026)

185a - Implement Storage Procedures

26. 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 3:00 PM, Resident [redacted] glucometer was not calibrated to the correct date or time. The resident's April 2026 Medication Administration Record (MAR) indicated the resident's blood glucose was [redacted] on [redacted] at 10:24 AM. However, the glucometer indicated this blood glucose reading was taken on August 9th at 3:27 AM. The MAR indicated the resident's blood glucose was [redacted] on [redacted] at 7:01 AM. However, the glucometer indicated this blood glucose reading was taken on August 9th at 12:04 AM.

Resident [redacted] is prescribed Accuchecks before meals and at bedtime. The blood glucose value on the glucometer did not match the number transcribed on the resident's March 2026 MAR as follows:
Glucometer reading on [redacted] at 7:35 AM was [redacted] The number documented in the MAR states blood glucose is [redacted]
Glucometer reading on [redacted] at 7:28 PM was [redacted] The number documented in the MAR states blood glucose is [redacted]
Glucometer reading on [redacted] at 3:41 PM was [redacted] The number documented in the MAR states blood glucose is [redacted]
Glucometer reading on [redacted] at 11:18 AM was [redacted] The number documented in the MAR states blood glucose is [redacted]
Glucometer reading on [redacted] at 7:44 AM was [redacted] The number documented in the MAR states blood glucose is [redacted]
Glucometer reading on [redacted] at 7:45 PM was [redacted] The number documented in the MAR states blood glucose is [redacted]
Glucometer reading on [redacted] at 11:09 AM was [redacted] The number documented in the MAR states blood glucose is [redacted]

Plan of Correction ***Accept ([redacted] - 05/20/2026)***

185a - Implement Storage Procedures (continued)

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/03/2026 by the Administrator to to correct the storage issue with the glucometer and glucose monitoring tools. Staff were educated that the glucometer and all tools needed to monitor blood glucose, need to be kept in the storage pencil box, labeled with the residents name.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will perform weekly audit to make sure all items are stored correctly and that glucometer readings match the computer, with a completion date of 05/25/2026.

Effective 05/11/2026 the Adminstrator/Clinical Coordinator will perform weekly audits of On going process to maintain compliance, through 12/28/2026 to maintain ongoing compliance with ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
4/2/26 glucometer was calibrated and this in done nightly on 11-7 staff and recorded in log book. Both high and low controls are being completed.(This is our only glucometer at this time in this household)
4/2/26 staff were educated on each resident only gets one glucometer and and that they are to be kept separate in the boxes with the residents name, so glucometers do not get cross contaminated and each resident has their own glucometer.
Glucometers started being audited 5/11/26 and we are auditing, date, time, control readings as well as the glucose reding to make sure all are correct and entered into PCC correctly as well.

Licensee's Proposed Overall Completion Date: *05/19/2026*

Not Implemented [redacted] 07/15/2026)

187a - Medication Record

27. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
4. Strength.

Description of Violation

Resident [redacted] is prescribed [redacted], give 1 capsule by mouth one time a day. However, Resident [redacted]s March 2026 Medication Administration Record does not indicate the strength.

Plan of Correction ***Directed ([redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Designee to correct the missing strength, by contacting pharmacy.

To enhance the currently compliant operations, on 05/11/2026 the Nursing/Administrator/Designee will enter strength of medication and if no strength is associated with it in the system, to contact pharmacy, with a completion date of 05/18/2026.

187a Medication Record (continued)

Effective 05/18/2026 the Administrator/Designee/Nursing will perform daily audits of 2nd or 3rd shift nurse doing chart checks should monitor this. On going process., through 12/31/2026 to maintain ongoing compliance with keeping a medication record, for each resident for whom medications are administered, that includes, including strength, and nurse doing the chart checks will make sure there is a strength is associated with the medication. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
5/22/26 audit of all MAR's will be completed and any order out of compliance will be corrected.
Administrator/Clinical Coordinator to complete the audit.
New orders are being audited to ensure that correct dosage/dosage are included in the order.

(Directed)

- *An initial audit of all other resident Medication Administration Records be completed by 6/8/26 to ensure they are documented in accordance with 2600.187(a).*
- *Education will be provided to all staff members who administer medications to residents on 2600.187(a) by 6/5/26.*
- *Beginning no later than 6/5/26, the administrator or designee will audit all resident Medication Administration Records monthly for a minimum of 6 months.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/08/2026*

Not Implemented ([redacted] - 07/15/2026)

187d - Follow Prescriber's Orders

28. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted], give 1 tablet by mouth one time a day. However, this medication was not administered to Resident [redacted] on [redacted] or [redacted] because the medication was not available in the home.

Resident [redacted] is prescribed [redacted], inject [redacted]s subcutaneously one time a day, give 4 units with breakfast, hold if FBS < 120. On [redacted] at 6:36 AM Resident [redacted] blood glucose was [redacted], requiring the administration of medication; however the resident's March 2026 Medication Administration Record indicates this medication was held.

Plan of Correction ***Accept ([redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/11/2026 by the Administrator/Clinical Cordinator to educate Medication Tech's that they must notify the nurse on duty regarding any missing medications or insulins that need to be held because of a low blood sugar reading.

187d - Follow Prescriber's Orders (continued)

To enhance the currently compliant operations, on 05/18/2026 the Med Tech will will notify the nurse on duty so the nurse can make every effort to get the medication or to let the Med Tech know to hold insulin or not, with a completion date of 05/18/2026.

Effective 05/11/2026 the Administrator/Clinical Coordinator/Nurse will perform daily audits of daily missed medication reports, on going process, through 12/31/2026 to maintain ongoing compliance with ensuring the home must follow the directions of the prescriber and having nursing guidance on holding a medication, such as insulin or if a medication is missing the nurse will attempt to get from pharmacy or pull from Cubix, if available. Nursing will notify the Administrator/Clinical Coordinator so a DHS reportable can be completed if medication could not be obtained. Administrator to run daily missed medication reports. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
4/7/26 at staff meeting Administrator reviewed with the staff the importance of checking the pharmacy packs when they arrive to make sure medications are in packs and if not to contact the nurse so the medications can be obtained from pharmacy. or from the Cubix.
5/8/26 the nursing staff was educated on and dosage changes that a CHANGE sticker need to be applied to the packaging to alert staff of the change.
5/8/26 staff are to keep the medication packet for Clinical coordinator to review. They are to compare the order to the packet and once they confirm medication and dose are correct put a check mark through it and once this has been completed for each medication in the packet, if not notify the nurse. If all is complete the initial and date for review.

Licensee's Proposed Overall Completion Date: *05/19/2026*

Not Implemented [redacted] - 07/15/2026)

190a - Completion Medication Course

29. 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 Member C completed the online exam portion of the Department-approved medication administration course on [redacted] However, Staff Member C did not complete the 4 medication administration observations required within 30 days of passing the exam. Remediation was also not completed, however, Staff Person C administered medications to residents to include the following:
- On [redacted] and [redacted] at 7:00 AM, Staff Member C administered [redacted] to Resident [redacted]
- On [redacted] at 5:21 AM, Staff Member C administered [redacted] to Resident [redacted]

190a - Completion Medication Course (continued)

Plan of Correction ***Directed [redacted] - 05/20/2026)***

Staff member C completed course on 8/12/24 and did observation on 9/1/24, 9/18/24, 9/19/24 and 9/19/24, has been removed from medication cart and will redo the medication administration course and complete within compliance.
Staff member E completed course on 8/18/25 with observations being 8/7/25, 8/12/25, 8/18/25 and 8/25/25.
Clinical Coordinator and Administrator to monitor together to make sure everyone is in compliance with monitoring and re-mediation

Audit of all med tech documenting and records will be completed by 5/29/26 and anyone found not in compliance will repeat Med Tech course.

(Directed)

- *Immediately, Staff Members C and E will be removed from administering medications to residents until they have successfully completed the Department-approved medication administration training course and have obtained proper documentation from the training course that all sections of the training have been successfully completed.*
- *Education will be provided to staff responsible for medication administration training records on the required completion and documentation for successful completion of medication administration training (both initial and annual records). Education will be completed by 6/8/26.*
- *Beginning 6/1/26, the administrator or designee will complete quarterly audits on current staff medication administration training records.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *06/08/2026*

Not Implemented [redacted] - 07/15/2026)

225a - Assessment 15 Days

30. 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] has received hospice services since [redacted]. However, the resident's initial assessment, completed on [redacted], does not include the residents' services received by hospice.

Repeated Violation - [redacted], et al.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept [redacted] 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/06/2026 by the Administrator/Clinical Coordinator to 5/11/26 Administrator and Clinical Coordinator will both review resident records ahead of time to make sure complete information is captured on assessment form.

To enhance the currently compliant operations, on 05/11/2026 the Administrator/Clinical Coordinator will will review medical and physical needs prior to assessment and then review assessment together, to make sure all physical, behavioral, outside services and care needs are included in the assessment form, with a completion date of 05/25/2026.

Effective 05/11/2026 the Admnistrator/Clinical Coordinator will perform weekly audits of on going process with new admissions, through 12/31/2026 to maintain ongoing compliance with ensuring each resident has 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. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Assessment for resident 5 was updated on 4/1/26 by [redacted] RN
All audits will be completed by 6/5/26 by RN, Clinical Coordinator or Administrator

Proposed Overall Completion Date: 06/05/2026

Licensee's Proposed Overall Completion Date: *06/05/2026*

Not Implemented [redacted] 07/15/2026)

225c - Additional Assessment

31. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] most recent assessment, completed on [redacted] indicated the resident ambulates independently. However, Resident [redacted] has ambulatory dysfunction with a history of falls requiring the use of a walker to adhere to fall precautions. The resident's assessment has not been updated to reflect the residents change in need.

Resident [redacted] most recent assessment, completed on [redacted] indicated no behavioral or cognitive needs related to [redacted], or [redacted]. However, Resident has a history of angry outbursts, agitation, irritability, verbal aggression, negative comments, and mood swings. As a result of these behaviors, Resident [redacted] was referred to psychiatric services, and [redacted] medication was altered. The resident's assessment was not updated to reflect these behavioral/cognitive needs.

Resident [redacted] assessment, dated [redacted] indicated a dietary need of NAS. However, on [redacted], Resident [redacted] received

225c - Additional Assessment (continued)

orders for a mechanical soft diet. Resident [redacted] assessment was not updated to reflect the change in dietary need.

Plan of Correction ***Accept [redacted] - 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/06/2026 by the Administrator/Clinical Coordinator/RN to was to review all resident support plans and make corrections, fill in care needs, behavioral health needs assistive devices and dietary needs and services required and plan to meet those needs.

To enhance the currently compliant operations, on 06/01/2026 the Administrator/Clinical Coordinator will review all support plans quarterly and as needed to make sure any deficits are corrected and up to date, and all care needs are being met, with a completion date of 06/15/2026.
Effective 06/01/2026 the Administrator/Clinical Coordinator will perform quarterly and as needed audits, through 12/31/2026 to maintain ongoing compliance with Documenting in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Resident 1 was updated and completed on 4/8/26 by [redacted] RN
Resident 3 was updated on 5/19/26 by Administrator
Resident 7 was updated on 4/8/26 by [redacted] RN

Education to staff will be completed by 6/5/26

Licensee's Proposed Overall Completion Date: *06/05/2026*

Not Implemented [redacted] - 07/15/2026)

227d - Support Plan Medical/Dental

32. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

227d - Support Plan Medical/Dental *(continued)*

Description of Violation

Resident [redacted] assessment, completed on [redacted], indicated the resident has a personal care need related to personal hygiene and requires some physical assistance. However, the resident's support plan does not include a plan to meet this service need as these areas was left blank.

Plan of Correction ***Accept [redacted] 05/20/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 04/06/2026 by the Administrator/Clinical Coordinator/RN to was to review all resident support plans and make corrections, fill in care needs and services required and plan to meet those needs.

To enhance the currently compliant operations, on 06/01/2026 the Administrator/Clinical Coordinator will review all support plans quarterly and as needed to make sure any deficits are corrected and up to date, and all care needs are being met, with a completion date of 06/15/2026.

Effective 06/01/2026 the Administrator/Clinical Coordinator will perform quarterly and as needed audits, through 12/31/2026 to maintain ongoing compliance with Documenting in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
5/11/26 initial review of all support plans was started by designated nurse and will be completed by completed on 6/5/26.
4/7/26 staff were updated at staff meeting the importance documentation and reporting changes in residents conditions so support plans can be updated.
The second Monday of every month Clinical Coordinator, Administrator, Activities, Therapy and Dining will meet to discuss support plans that are due that month and update at that time.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Not Implemented [redacted] - 07/15/2026)

254c - Records Storing

33. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

On [redacted] at 9:20 AM, resident records were unlocked, unattended and accessible in the nurse's station; the nurse's station does not have a door. Resident record information included:

- *Resident [redacted] prescreen dated [redacted] indicating level of supervision and mobility needs, medical evaluation*

254c - Records Storing (continued)

dated [redacted] indicating the resident's diagnoses and prescriptions.

- *A daily care log containing the following:*

-Resident [redacted] care- exit cueing, requires extra cueing in am/care, monitor behaviors with males
-Resident [redacted] care cue, mild assist, cue with showers and room number
-Resident [redacted] care cue and reminders
-Resident [redacted] care mod assist accu check, FBS, noon BS, and room number
-Resident [redacted] resident is to be encouraged to do care and walk as much as [redacted] could
-Resident [redacted] care independent, weights Monday, Wednesday, Friday and room number
-Resident [redacted] care independent, reminder to do colostomy care

On [redacted], at 9:21 AM, the following resident information was unlocked, unattended and accessible in the kitchenette:
- Resident [redacted] current dietary order of mechanical soft with thin liquids, ordered [redacted]
- Resident [redacted] s current dietary order of a low residue diet, followed by a note that read "This will help avoid having more issues with [redacted] [redacted] & [redacted]

Plan of Correction ***Accept [redacted] - 05/12/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *on 03/31/2026 by the Administrator/Director of Health and Wellness to Immediate action was taken 3/31/26 at 1730pm by administrator and Director of Health and Wellness. Cabinets in the locked medication were cleaned out and resident charts and daily log book were moved to locked medication room.Also on 3/31/26 at 1800pm the resident items posted in the kitchenette, were removed from plain sight and placed in binder in cabinet. Kitchenette is a locked room, when staff are not serving meals.*
2. *on [ ] by the [ ] to [ ]*

To enhance the currently compliant operations, on 04/01/2026 the Administrator will Provided written education to staff that medical records and all personal information regarding residents needs to placed in the locked medication room and any dietary orders are not to be posted on the walls or cabinets in the kitchenette, but to be placed in the binder in the cabinet, with a completion date of 04/03/2026.

Effective 05/04/2026 the Administrator/Clinical Coordinator will perform daily checks of Make sure all resident information is secured properly, through 09/30/2026 to maintain ongoing compliance with Storing records in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging. Administrator/Clinical Coordinator will do spot checks throughout the day, on different shifts, to monitor ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] 07/15/2026)