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

November 6, 2026

[redacted], VP OF OPERATIONS
WEST CHESTER PA SENIOR PROPERTY LLC
[redacted]

RE: MERRILL GARDENS AT WEST CHESTER
1201 WARD AVENUE
WEST CHESTER, PA, 19380
LICENSE/COC#: 14912

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/18/2026, 08/19/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MERRILL GARDENS AT WEST CHESTER* **License #**: *14912* **License Expiration**: *11/14/2026*

Address: *1201 WARD AVENUE, WEST CHESTER, PA 19380*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WEST CHESTER PA SENIOR PROPERTY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/21/2017* **Issued By**: *West Goshen Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *105* **Waking Staff**: *79*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/19/2026*

Inspection Dates and Department Representative

08/18/2026 - On-Site: [redacted]

08/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *94* **Residents Served**: *78*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *23* **Residents Served**: *18*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*

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

Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

08/18/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/14/2026*

09/15/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/01/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/25/2026*

Inspections / Reviews *(continued)*

10/27/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/01/2026*

11/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/01/2026*

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

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/19/2026, at 12:22 PM, a resident 24 hour report log book was unlocked, unattended, and accessible in the exam room on the second floor.

Repeated Violation 10/30/2025 and 8/25/2025 et al

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The nursing suite on the second floor has 3 rooms; med room, RCD office and exam room and a desk for staff to sit. The exam room door was closed and when the Surveyor opened the door and turned on the light the 24-hour report log book was on the desk.
The logbook was immediately removed and placed in the locked med room.
The Regional Drector of Health Services verbally in-serviced all care staff on HIPPA and ensuring that resident records and documentation containing resident information must be secured and may not be unlocked and unattended in areas accessible to unauthorized individuals.
GHS/Designee will conduct routine weekly checks to ensure all resident information is secured and inaccessible to unauthorized individuals. 9-14-26 to 12-14-26.
GM will conduct random monthly audits to ensure confidentiality. 9-14-26 to 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

63a - First Aid/CPR Training

3. 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 8/15/2026, from 10 PM to 6 AM, 78 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

Staff member A was on the schedule for NOC shift and had a CPR re-certification card - upon review during the Survey it was identified that staff member A took an on-line recertification course. Staff member A has completed an in-person recertification (see attached)
A full audit was completed by the BOD and RDHS to ensure all staff have had an in-person CPR training. Completed 9-10-26
Staffing schedules to be reviewed by GHS/Designee weekly to ensure adequate staff certified in CPR/First Aid on in the building. 9-14-26 to 12-14-26
GM/Designee will review schedules twice/month 9-14-26 t0 12-14-26

63a First Aid/CPR Training (continued)

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
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 person A did not receive training in 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 during training year 1/1/2025 to 12/31/2025.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

This was an oversight and Staff Person A has completed the Fire Safety Training for 2026. See attached.
The Business Office Director (BOD) will print a list of all staff trainings due at the beginning of each month and give to the appropriate department Directors. Prior to the end of the month the BOD will run a report to ensure staff are in compliance with the training.
The community will utilize a staff roster to ensure all annual fire safety training is complete an no staff member is missed.
The GM shall review the staff roster to ensure all staff have completed the training.
The GM shall review the trainings monthly with each department Director.to verify status of trainings monthly beginning 9 14 26 through 12 14 26.

Licensee's Proposed Overall Completion Date: *09/14/2026*

Implemented ([redacted] - 10/27/2026)

81b - Resident Personal Equipment

5. 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

On 8/18/2026 resident 1 had a thin upside down U shaped bedside mobility device securely attached to [redacted] bed. The device did not require a cover as per FDA guidelines; however, an unsecured white stretchy tube sleeve was

81b - Resident Personal Equipment (continued)

placed on the device which moved freely and did not allow for proper gripping.

Plan of Correction ***Accept (- 09/15/2026)***

The bedside mobility device identified during the inspection was reviewed. The unsecured stretchy sleeve that interfered with proper gripping was removed, and the device was clean, in good repair and free of hazards.
Regional Director of Health Service on site during survey and reminded staff to report and remove any accessory or covering that may interfere with the safe use of resident equipment.
All residents with enabler bars have been checked by GHS and RDHS to ensure coverings are secured and warrant no safety concern to resident gripping the bar.
On-going auditing to ensure compliance and resident safety.

Licensee's Proposed Overall Completion Date: *09/14/2026*

Implemented (- 11/06/2026)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/18/2026 at approximately 10:30 AM, there was no method to dry hands in the Garden House bathroom.

On 8/19/2026 at 11:47 AM, 3 sealed boxes of Boost supplemental drink sat on top of a cardboard bin labeled Biohazard Regulated Medical Waste" in the garden house medication room. There was also one open box of Boost on the floor next to the bin. The bottom of the bin had a large half circle shaped wet spot. Above the bin there was a picture frame with small brown splatters. Also in the room was an orange toolbox the home utilizes as a first aid kit that was sitting on top of a shelf near the ceiling. The front of the box was covered in dark black/brown splatters.

Plan of Correction ***Accept (- 09/15/2026)***

The GHS immediately addressed the identified sanitary conditions in the GHS med room. The Boost nutritional supplements were removed from the Biohazard container, and the open box was removed from the floor. The affected waste container was removed by Maintenance Director. The picture frame and first-aid toolbox identified with visible splatter were cleaned and sanitized by GHS.
Regional Director of Health Services reminded staff that food, nutritional supplements and other resident use items are to be stored in clean, appropriate locations and not to be placed on or adjacent to regulated medical waste containers. Staff were also reminded that bathrooms must have appropriate supplies- toilet paper and that equipment and surfaces must be maintained in a clean and sanitary condition.
To prevent recurrence the GHS/Designee will conduct weekly rounds of the GH Unit to ensure waste storage areas, equipment, and visible environmental cleanliness. Findings will be documented and any identified concerns will be addressed promptly. starting 9-14-26 to 12-14-26.
The General Manager will review the weekly audits and conduct random audits monthly to verify compliance. 9-14 -26 through 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented (- 10/27/2026)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 8/19/2026 at 11:27 AM, there was a large light brown water spot on the ceiling above the door in Garden House medication room.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The identified ceiling tiles with water spots in the Garden House med room, were immediately inspected by the Maintenance Director to determine the source of the water staining. The ceiling tiles were replaced immediately. Garden House medication room and unit will be audited weekly for evidence of moisture, staining, deterioration or other surface concerns. Any identified issue will be and corrected immediately. 9-14-26 to 12-14-26
The General Manager will review the weekly audits and conduct random audits monthly to verify compliance x 3 months 9-14 -26 through 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 2 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The Guest Service Director conducting rounds with the Surveyor immediately addressed resident #2's bedside lighting. Resident #2's bedside lamp was inspected and confirmed to be operable and accessible to the resident. It was determined that this was an isolated incident in which the resident's family had unplugged the lamp in order to plug in another item. Access was promptly restored to the bedside lighting. Resident #2 no longer resides at the community.

The Regional Director of Health Services reviewed with staff that every resident must have an operable lamp or other source of lighting that can be turned on/off at the bedside. Staff were reminded to address any changes to the resident's equipment that could affect required resident accommodations and notify management immediately.
The above information will be reviewed by the Geneal Manager at the next Resident Council Meeting on October 2, 2026
The GM will monitor compliance through routine resident apartment checks by care staff/housekeeping staff and address any identified concerns immediately.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented ([redacted] - 10/27/2026)

102h Toilet Paper

9. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 8/18/2026 at approximately 10:30 AM, there was no toilet paper for the toilet in the garden house public bathroom.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The GHS immediately replenished the toilet paper in the Garden House public bathroom when identified.
The Regional Director of Health Services on site at time of survey reviewed with housekeeping staff and care staff that toilet paper must be available at every toilet at all times.
Staff responsible for environmental and housekeeping rounds will ensure that bathroom supplies are checked and replenished as needed.
The availability of toilet paper and other required bathroom supplies will be incorporated into the routine GH checks to ensure continued compliance. GHS/Designee to conduct audits 9-14-26 to 12-14-26
GM/Designee to conduct monthly random audit to verify compliance 9-14-26 to 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

103i Outdated Food

10. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 8/18/2026 there was an unlabeled, undated and unsealed container of pepperoni and an unlabeled, undated white sauce in the main fridge. There was a tin of parmesan cheese in the main kitchen mini fridge that expired 7/2025.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The identified food items were immediately removed from use and discarded by Sous Chef. The refrigerator areas were audited by the Sous Chef to ensure that food items were properly labeled, dated, sealed, and within the expiration/use by dates.
The Guest Service Director immediately reviewed with the kitchen staff the requirement that food stored in the home must be appropriately labeled and dated and that outdated or spoiled food may not be used. Staff were reminded to routinely check refrigerated and dry-storage areas for expiration dates and to remove any outdated or improperly stored food items immediately.
The Director of Dining/Designee will conduct weekly refrigerator and food-storage checks to verify that food is labeled, dated, properly sealed, and within the applicable expiration/use by date. Any discrepancy identified during the audit will be addressed immediately. 9-14-26 through 12-14-26
The GSD/GM/Designee shall conduct random monthly audits to ensure compliance. 9-14-26 through 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 11/06/2026)

123b - Emergency Procedures Posted

11. 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

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The Emergency Procedures (Crisis Manual) was placed at the front desk during the survey. (see attached)
The Regional Director of Health Services reviewed with the GM that the Emergency Procedures must be available in a public place at all times. The area identified is at the front desk.
The GM will verify that required emergency procedures remain posted at the front desk. As the GM will see the binder upon entering the community and leaving the community.

Licensee's Proposed Overall Completion Date: *09/14/2026*

Implemented ([redacted] - 10/27/2026)

132h - Designated Meeting Place

12. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drills completed on below listed dates, residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. According to provided fire drill documentation, no residents were evacuated.

09/16/25 at 2:00 AM
10/29/25 at 1:00 PM
11/13/25 at 10:17 PM
12/04/25 at 11:00 PM
01/23/26 at 1:22 PM
02/09/26 at 9:19 PM
03/14/26 at 3:06 AM

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

On July 27, 2026, RDHS was on site conducting a review of the community's fire drill records as part of the community's internal review process. During the review the RDHS identified that the previous contracted fire safety corporation had not conducted and documented the fire drills in accordance with the regulatory requirements, including documentation indicating the residents were not evacuated to a designated meeting place. and that the fire alarm or smoke detector is appropriately set off during each fire drill.
The community had stopped using the company and returned to using a reputable company, Fire Safety Solutions, as of April 2026 (see attached drills)
As part of the corrective action. Fire Safety Solutions will provide a copy via email to Regional Director of Health

132h Designated Meeting Place (continued)

Services of each completed fire drill record for review.
The Regional Director of Health Services will review each drill for accuracy and compliance including verification that residents are evacuated to the designated meeting place or appropriate fire safe areas as required. Any discrepancy identified will be addressed immediately with the General Manager, Director of Maintenance and Fire Safety Solutions.
This process will remain in place as an ongoing quality assurance measure to ensure that fire drills are conducted and documented accurately and in accordance with regulatory requirements.

Licensee's Proposed Overall Completion Date: *09/14/2026*

Implemented ([redacted] - 10/27/2026)

132i - Testing Fire Alarm

13. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drills completed on the below listed dates, the fire alarm was not sounded. In its place there was a coded announcement .

09/16/25 at 2:00 AM
10/29/25 at 1:00 PM
11/13/25 at 10:17 PM
12/04/25 at 11:00 PM
01/23/26 at 1:22 PM
02/09/26 at 9:19 PM
03/14/26 at 3:06 AM

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

On July 27, 2026, RDHS was on site conducting a review of the community's fire drill records as part of the community's internal review process. During the review the RDHS identified that the previous contracted fire safety company had not conducted and documented the fire drills in accordance with the regulatory requirements, including documentation indicating the residents were not evacuated to a designated meeting place. and failure to document that the fire alarm was sounded during the drills.
The community had stopped using the company and returned to using a reputable company, Fire Safety Solutions, as of April 2026 (see attached drills)

As part of the corrective action. Fire Safety Solutions will provide a copy via email to Regional Director of Health Services of each completed fire drill record for review.

The Regional Director of Health Services will review each drill for accuracy and compliance including verification that residents are evacuated to the designated meeting place or appropriate fire safe areas as required and that the fire alarm or smoke detector is appropriately set off during each fire drill.
Any discrepancy identified will be addressed immediately with the General Manager, Director of Maintenance and Fire Safety Solutions.

132i Testing Fire Alarm (continued)

This process will remain in place as an ongoing quality assurance measure to ensure that fire drills are conducted and documented accurately and in accordance with regulatory requirements.

Licensee's Proposed Overall Completion Date: *09/14/2026*

Implemented ([redacted] - 10/27/2026)

162c - Menus Posted

14. Requirements

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

Description of Violation

On 8/18/2026 the home's menu for the week of 8/16/2026 8/22/2026 was posted in the garden house dining room. However, the menu for the following week was not posted. Additionally, the menu only detailed the daily specialty dinner option, which was listed as "Lunch". Breakfast and lunch were not posted. Additionally, there was no menu posted for the current and next week in the personal care area.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The Dining Department immediately reviewed the community's menu posting process and ensured that menus are prepared and posted in accordance with regulatory requirements. Menus will identify the specific food items being served at each meal and the current week and next week's menu will be posted.as per regulations.
The Director of Dining/Designee shall conduct a weekly audit to ensure menu's are posted 9 14 26 to 12 14 26
GM/Designee will conduct random monthly audits to ensure compliance. 9 14 26 to 12 14 26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

181c - Self-administration Assessment

15. Requirements

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

Description of Violation

Resident 3 self administers medications to include triamcinolone cream .1%, ; however, resident 3 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

Upon further review of Resident 3's medical record, the home identified a PCP order dated July 2025 stating that the resident may self administer triamcinolone cream. The order did not specify whether the medication was to be administered routinely or on a PRN basis. The resident's PRN order/Emar also identified the medication as self administered.
The home further clarified that the resident's medication administration process involved self administration with

181c Self administration Assessment (continued)

staff assistance. Staff maintained the medication and assisted by preparing the ordered amount of cream and placing it in a cup/container for the resident to apply independently. The resident, rather than staff, applied the cream.
The home also identified an Emar documentation discrepancy in which the medication was identified as self administered, while staff were signing the Emar as though the medication had been administered by staff. The home recognizes the need to ensure that the medication order, Emar instructions, and actual method of medication administration are consistent and accurately documented.
See attached order for resident #3 stating patient may self administer triamcinolone cream and keep at bedside.
The DME has been updated to reflect the self administration of the creams only.
Med Cart audits will be conducted weekly by GHS/Designee beginning 9 14 26 to 12 14 26
Regional Director of Health Service will conduct random monthly audits of med carts to verify compliance 9 14 26 to 12 14 26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

183d - Prescription Current

17. Requirements

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

Description of Violation

On 8/19/2026, polyethylene glycol powder 3350 prescribed for individual resident 4 , was in the home's medication room; however, the medication was discontinued on 7/21/2026.

On 8/19/2026, lubricant jelly that expired 12/2024, skin protectant ointment that expired 12/2022, syringes with safety hypodermic needles that expired 10/31/2021 and tuberculin needles, all of which were not prescribed for any residents in the home were found in black storage cabinets in the second floor exam room.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The discontinued polyethylene glycol and the expired/non resident medical supplies identified during the inspection were immediately removed from the home's medication and storage areas in accordance with the home's medication disposal and supply procedures.
The medication room and second floor exam room were audited to identify and remove any additional discontinued, expired, or non resident medications and medical supplies.
The Regional Director of Health Services re educated all Med Tech's regarding the requirement that only current medications and supplies applicable to residents living in the home may be maintained in the facility.
To prevent recurrence, The GHS/Designee will audit medication storage areas weekly for discontinued, expired, or non resident medications and supplies. Any identified item will be removed promptly and appropriately disposed of or returned in accordance with applicable procedures 9 14 26 through 12 14 26
The General Manager/Designee will conduct random monthly audits to ensure compliance. 9 14 26 to 12 14 26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

183e - Storing Medications

18. Requirements

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

Description of Violation

On 8/19/2026 a blister card of resident 5's lubiprostone 24 mcg capsules, was torn at pill slot 8 and the pill remained in the packaging.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The identified medication packaging was immediately addressed, and the pill was removed and discarded in the drug buster by Med Tech.

The Regional Director of Health Services re-educated the Med Tech's to inspect medication packaging and blister cards for damage prior to medication administration and to report damaged packaging promptly. The medication storage and administration process will include continued observation for damaged packaging or other conditions that could compromise medication security or integrity.
GHS/Designee will conduct weekly med cart audits 9-14-26 to 12-14-26
GM/Designee will review the audits to ensure compliance.9-14-26 to 12-14-26
Regional Director of Health Services will conduct random monthly med cart audits to verify compliance. 9-14-26 to 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

185a - Implement Storage Procedures

19. 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 8/19/2026 at 12:36 PM, resident 5's glucometer was not calibrated to the correct date or time. Date and time shown were 3/2 at 3:18 PM.

On 8/19/2026 resident 5's 8/2026 medication administration record (MAR) was reviewed and the following discrepancies observed:

8/17 the MAR had a reading documented as 127, however the meter had a reading of 126.
8/11 the MAR had a reading documented as 128, however the meter had a reading of 137.

Resident 6 is prescribed lidocaine patches 4% apply 1 patch topically to lower back as needed. On 8/19/2026 this medication was not available in the home.

Resident 7's controlled substance accountability log for alprazolam 0.25 mg tablets did not contain the signature of the staff person who removed the medication on 8/16/2026 at 12:26 PM.

185a Implement Storage Procedures (continued)

The home's controlled substance policy states:

1. Each time a schedule II or III medication is removed from the locked area, it must be signed out on the correct page in the controlled substances record book.
2. Documentation is to include the following:
... b. The signature of team member who withdrew the medication. "

Plan of Correction ***Accept (- 09/15/2026)***

The identified medication management concerns were immediately reviewed and addressed. Resident 5's glucometer was corrected to the appropriate date and time, and the discrepancies identified between glucometer readings and MAR documentation were reviewed with the Med Tech's, by Regional Director of Health Services.
Resident #6's prescribed lidocaine patches were obtained and made available in the home.
The controlled substance accountability record for Resident #7 was reviewed and corrected in accordance with the home's controlled substance procedures.
The Regional Director of Health Services re educated the Med Tech's regarding accurate documentation, verification of blood glucose readings, availability of prescribed medications, and completion of controlled substance accountability records at the time medications are removed.
The GHS/Designee will conduct weekly med cart audits to verify that glucometers are correctly dated and timed, MAR documentation corresponds with actual readings, prescribed medications are available and controlled substance records are complete and accurately signed. 9 14 26 to 12 14 26
The GM will review the weekly med cart audits for any patterns identified. 9 14 26 to 12 14 26
The Regional Director of Health Services will conduct monthly random audits of glucometers, med carts and narcotic logs. 9 14 26 to 12 14 26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented (- 11/06/2026)

187a - Medication Record

20. Requirements

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

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

187a - Medication Record *(continued)*

10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 6 is prescribed blood glucose monitoring twice daily. Resident 6 utilizes a continuous glucose monitoring (CGM) sensor with a handheld reader. However, resident's 6's 8/2026 MAR does not indicate the use of this device, instead documentation indicates that an external Easy touch glucometer is being used.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

Resident #6's medication record was immediately reviewed to ensure that the blood glucose monitoring method being utilized is accurately reflected in the resident's record.
The Regional Director of Health Services re-educated the Med Tech's regarding accurate documentation of the method/device used to obtain blood glucose readings and the requirement that medication records accurately reflect the services provided to the resident.
Resident #6 has an Easy Touch glucometer as needed in the event the Libre becomes faulty. The order in the EMAR accurately reflects to obtain Blood Glucose Readings via Libre Reader
Ghs/Designee will review applicable MARs to verify that blood glucose monitoring and other medication-related services are documented accurately and correspond with the resident's current orders and method of administration/monitoring via weekly med cart audits. 9-14-26 to 12-14-26
The GM will review the weekly med cart audits for any patterns identified. 9-14-26 to 12-14-26

The Regional Director of Health Services will conduct monthly random audits of glucometers, med carts and narcotic logs. 9-14-26 to 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident 1 is prescribed Tubi grip stockings apply at 9:00 AM and remove at 9:00 PM. However, resident 1 was not administered these on 8/19/2026 because they were not available in the home.

Resident 5 is prescribed blood glucose monitoring once daily at 9:00 AM, however on 8/10 at 9:00 AM no verification of a reading being taken was found in the resident's glucometer.

187d Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The identified concerns were immediately reviewed. Resident #1's prescribed Tubi grip stockings were obtained and made available in the home and then resident requested the Tubi grips be discontinued order was obtained from PCP to discontinue Tubi grips. DHS State Reportable completed

Resident #5's blood glucose monitoring process was reviewed to ensure that the prescribed monitoring schedule is followed and appropriately documented.

The Regional Director of Health Services re educated the Med Tech's regarding the requirement to follow current prescriber's orders and to promptly report and address any unavailable medication/treatment to Supervisor.

GHS/Designee will conduct weekly med cart audits/glucometer audits to ensure all medications/treatments are available and results in the glucometer match the EMAR. 9 14 26 to 12 14 26

The GM will review the weekly med cart audits for any patterns identified. 9 14 26 to 12 14 26

The Regional Director of Health Services will conduct monthly random audits of glucometers, med carts and narcotic logs. 9 14 26 to 12 14 26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 10/27/2026)

190b - Insulin Injections

23. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 8/14/2026 at 7:00 AM, staff person B administered Trulicity to resident 6. The home does not have a waiver for non licensed staff to administer this medication.

On 8/07/2026 at 7:00 AM, staff person C administered Trulicity to resident 6. The home does not have a waiver for non licensed staff to administer this medication.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The administration of Trulicity by non licensed staff without the required waiver was immediately discontinued.

The Regional Director of Health Services reviewed the medication administration requirements with the

190b - Insulin Injections (continued)

appropriate staff and reinforced that non-licensed staff may administer medications covered by this regulation only when all required regulatory qualifications and approvals are in place.
.Resident #6 is the only resident on a GLP1, there is a licensed nurse in the community to administer. the weekly Trulicity injection.
The GM will look into obtaining a waiver in October/November.

Licensee's Proposed Overall Completion Date: *09/14/2026*

Implemented ([redacted] - 10/27/2026)

251b - Record Entries Legible

24. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The controlled substance record for resident 7's alprazolam .25 mg tablets is not legible on lines 55, 56, 57 due to multiple numbers being written over one another.

The controlled substance record for resident 8's alprazolam .25 mg tablets does not show a legible time on line 10 and date and time on line 18 because multiple number have been written over each other. On lines 39 and 40 numbers in blue and black in have been written over each other also making the date illegible.

Plan of Correction ***Accept ([redacted] - 09/15/2026)***

The identified controlled-substance records were reviewed with the responsible medication staff.
The Regional Director of Health Services re-educated Med Tech's regarding the requirement that all resident record entries be permanent, legible, dated, and signed by the staff person making the entry. Med Tech's
Staff were specifically reminded not to write over, alter, or obscure an existing entry. Any correction to a record must be made in accordance with the home's established documentation and correction procedures.
The GHS/Designee will conduct weekly med cart audits that includes a review of controlled-substance records to verify that entries remain legible and are completed appropriately. Any identified documentation concern will be addressed promptly with the responsible Med Tech and additional education will be provided as necessary. Audits 9-14-26 to 12-14-26
GM to review weekly audits identify any patterns/trends. 9-14-26 to 12-14-26
Regional Director of Health Services will conduct random monthly audits to verify compliance. 9-14-26 to 12-14-26

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 11/06/2026)