

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

September 28, 2026

[REDACTED]
HAYES MANOR INC
[REDACTED]
[REDACTED]

RE: HAYES MANOR
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131
LICENSE/COC#: 14223

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/20/2026 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: HAYES MANOR

License #: 14223

License Expiration: 08/22/2027

Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA 19131

County: PHILADELPHIA

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: HAYES MANOR INC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other

Date: 04/12/1985

Issued By: Philadelphia Labor and Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 41

Waking Staff: 31

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Monitoring

Exit Conference Date: 08/20/2026

Inspection Dates and Department Representative

08/20/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 65

Residents Served: 39

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: NA

Number of Residents Who:

Receive Supplemental Security Income: 3

Are 60 Years of Age or Older: 39

Diagnosed with Mental Illness: 3

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 2

Have Physical Disability: NA

Inspections / Reviews

08/20/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/21/2026

Inspections / Reviews (*continued*)

09/28/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/28/2026

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

09/28/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/28/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

85e - Trash Outside Home**1. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [REDACTED] one of the four dumpsters located outside was uncovered and was filled with trash. Additionally, there was a broken washing machine and approximately 25 wooden pallets stacked behind the opened dumpster.

Plan of Correction**Accept [REDACTED] - 09/28/2026)**

-The violation was reviewed by the administrative and maintenance staff on 9/14/26.

-A new washing machine was ordered and installed on 8/14/26, and the company did not remove the old one from the premises.

-A scrap company was called on 8/17/26 and did not arrive until 8/21/2026 to remove the old washing machine from the premises.

-New procedure regarding replaced items moving forward will be if they are or cannot be removed immediately, then the old items will be maintained in the basement until they are picked up and disposed of the prevent clutter in the outside trash area.

-We were in the process of changing trash and recyclable vendors, that is why there were four dumpsters. We now have two. This was explained to the inspector at the time of the visit.

-The dumpster and trash area will continue to be monitored by the maintenance manager and admin or designee daily.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] - 09/28/2026)**141a - Medical Evaluation****2. 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

Resident [REDACTED] date of admission is [REDACTED]. The resident's initial medical evaluation was completed on [REDACTED]

Repeat Violation: [REDACTED]

Plan of Correction**Accept [REDACTED] - 09/28/2026)**

-The violation was reviewed by the administrative staff on 9/14/26.

-The resident was admitted on 10/31/2025. The DME received from the PCP date of completion was signed 10/2/2025. (see attached)

-When the nurse manager pointed out this to the inspector, [REDACTED] stated that the resident was evaluated on 2/10/25. But we were always informed to go by the date of completion which clearly states 10/2/2025 which is within the 60 days before and 30 days after admission.

-The nurse manager received an updated and completed Medical Evaluation on August 31, 2026. (copy attached)

-The nurse manager will review and verify on admission that the medical evaluation is within 60 days prior to admission or within 30 days after.

141a Medical Evaluation (continued)

The potential new resident's documents will be reviewed 24 hours prior to admission by the admission staff member and nurse manager.

A medical evaluation check list has been developed that includes each resident's name, prior and current evaluation dates, admission date, annual eval date due, appt. date, medication list, and date received. (list included)

All medical personel have been in serviced on 9/14/2026 by the nurse manager.

The nurse manager will review monthly while completing the medication review.

The administrator will review all new admission documents upon completion of admission, and observe for dates and that documents are completed.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] - 09/28/2026)

141a 1-10 Medical Evaluation Information**3. Requirements**

2600.

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [REDACTED]'s medical evaluation dated [REDACTED] did not include medication regimen, contraindicated medications, medication side effects and the ability to self administer medications.

Plan of Correction

Accept ([REDACTED] - 09/28/2026)

The violation was reviewed by the administrative staff on 9/14/26.

The PCP has signed the attached updated medication list on 8/31/26.

A Medical Evaluation Content Checklist will accompany or be done monthly for each new and annual medical evaluation.

Within one business day of receipt, the Nurse Manager or designee will compare the evaluation with the checklist.

Moving forward an evaluation is complete only when all applicable requirements are met and an authorized healthcare provider has properly signed and dated the form.

All medical personnel have been in serviced on 9/14/2026 by the nurse manager.

This will be monitored monthly by the nurse manager.

The administrator will observe the documents after completion of the audit.

141a 1 10 Medical Evaluation Information (continued)

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented () - 09/28/2026)

141b1 - Annual Medical Evaluation

4. Requirements

2600.

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

Description of Violation

Resident () most recent medical evaluation was completed on ().

Repeat Violation: ()

Plan of Correction

Accept () - 09/28/2026)

*The violation was reviewed by the administrative staff on 9/14/26.**The updated, completed Medical Evaluation for Resident () was received on August 31, 2026. (see attached)**The Nurse Manager confirmed that an authorized healthcare provider had properly signed and dated the evaluation and addressed all information required.**To identify any other affected residents, the Nurse Manager completed an audit for each resident's current Medical Evaluation.**(audit included)**All medical personnel have been in serviced on 9/14/2026 by the nurse manager. (see attached)**This will be monitored monthly by the nurse manager upon completing monthly medication review.**The admin will monitor quarterly for completion.*

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented () - 09/28/2026)

185a - Implement Storage Procedures

5. Requirements

2600.

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

Description of Violation

Resident ()'s glucometer was not calibrated with the correct time. On () at 10:59am, the glucometer displayed the time as 12:00pm.

Plan of Correction

Accept () - 09/28/2026)

*The violation was reviewed by the administrative staff on 9/14/26**On 8/20/26 the Nurse Manager immediately corrected Resident () glucometer time and verified its date, settings, control testing, cleanliness, and proper operation.*

185a - Implement Storage Procedures (continued)

- All other glucometers in the home were also inspected by the nurse manager on 8/21/26, and any discrepancies were corrected and documented.
- Staff responsible for blood-glucose testing was retrained on 8/24/26 to verify the glucometer's date, time, operation, control-testing status, supplies, and secure storage before use. (pls. see attached)
- Staff competency will be documented during medication observation every 6 months by nurse manager.
- All new glucometers were received for each resident by 8/25/26.
- A Glucometer Calibration and Accuracy Log will be maintained for each device. (See included)
- The Nurse Manager will audit all glucometers and logs weekly starting 9/1/26 for four weeks and monthly thereafter.
- The Administrator will review and initial the monthly audits. Any discrepancy will be corrected immediately, and malfunctioning equipment will be removed from service and replaced as needed.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] - 09/28/2026)

186a - Authorized Prescriber**6. Requirements**

2600.

186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

Resident [REDACTED] is prescribed blood sugar readings three times a day as ordered by the resident physician originally ion [REDACTED]. The tests are scheduled daily for 9:00am, 1:00am and 5:00pm. These orders remained on the August 2026 Physician orders document that was signed by staff person C, who is not a licensed nurse, on [REDACTED] however, there is no physician signature on this orders document. Resident [REDACTED]'s August 2026 medication administration record (MAR) has a handwritten note indicating that these orders were discontinued on [REDACTED]. The home did not have a signed physician order to discontinue the check 3x a day. The home provided a signed order dated [REDACTED] indicating to test blood sugar twice daily. The home checked residents' glucose on [REDACTED] and [REDACTED] at 9am, 1pm and 5pm, and then only twice daily from [REDACTED] to [REDACTED] according to the residents August 2026 MAR.

Plan of Correction

Accept [REDACTED] - 09/28/2026)

- The violation was reviewed by the administrative and nursing staff a on 9/14/26
- A signed and dated order clarifying Resident [REDACTED] blood-glucose testing schedule was obtained from the authorized prescriber on 8/20/26.
- The resident's MAR and physician orders were reviewed and corrected to match the current order. (pls. see included)
- The Nurse Manager reviewed all residents' physician orders and MARs to ensure that each medication and treatment was supported by a current, signed, and dated prescriber's order on 9/1/26.
- Staff was retrained on 9/14/26 by nurse manager so that medications and treatments may not be started, changed, held, or discontinued without a properly documented order from an authorized prescriber.
- The nurse manager will monitor monthly during medication and treatment review.
- Will be observed quarterly by the admin.

Licensee's Proposed Overall Completion Date: 09/19/2026

186a - Authorized Prescriber (continued)

Implemented () - 09/28/2026

186c - Change in Medications

7. Requirements

2600.

186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

Description of Violation

On (), the home transcribed verbal orders to " Stop () four times a day" and "Start () three times a day as needed" for Resident (). The home had not received a written order from an authorized prescriber for the change and does not have licensed nurses authorized to receive verbal orders.

On (), the home transcribed verbal orders to " Start () twice daily" and " Start () twice a day if glucose level is () or above. Hold if under ()" for Resident (). The home had not received a written order from an authorized prescriber for the change and does not have licensed nurses authorized to receive verbal orders.

Plan of Correction

Accept () - 09/28/2026

-The violation was reviewed by the administrative and nursing staff on 9/14/26

-The Nurse Manager contacted the authorized prescribers on 9/14/26 for Residents () and () and obtained written, signed, and dated orders clarifying their current medication and blood-glucose testing instructions; their physician-order records and MARs were immediately updated to match the written orders, the residents were assessed, and the prescribers were notified of the discrepancies.

-The Nurse Manager audited all residents' physician orders and MARs to ensure that every medication or treatment change was supported by a written order from an authorized prescriber, and any discrepancies were immediately clarified and corrected.

-All medication-administration staff was retrained on 9/14/26 by the nurse manager that they may not accept or transcribe verbal medication orders and that no medication, insulin, treatment, or blood-glucose testing schedule may be started, changed, held, or discontinued until a written, signed, and dated prescriber's order is received. Verbal orders cannot be taken unless you are licensed to do so.

-The Nurse Manager will review all new and changed orders before implementation and audit physician orders against the MAR weekly for four weeks and monthly thereafter.

-The Nurse Manager will reconcile physician orders with the MAR whenever an order is received and monthly thereafter. Any discrepancy will be reported to the prescriber and corrected immediately.

-The Administrator will review and initial the monthly audits.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented () 09/28/2026

187b - Date/Time of Medication Admin.

8. Requirements

2600.

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

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] "Inject [REDACTED] daily and True Metrix Test Glucose " Test blood sugar daily". However, Resident [REDACTED]s August 2026 medication administration record does not indicate name and initials of the staff person administering medication on [REDACTED]

Plan of Correction**Accept** [REDACTED] 09/28/2026)

- The violation was reviewed by the nursing staff on 9/14/26
- The Nurse Manager reviewed Resident [REDACTED]s August 2026 MAR, medication records, and staff schedule to determine who administered the Lantus and completed the blood-glucose test on 8/6/2026.
- Any permitted correction was documented as a dated late entry without altering or backdating the original record.
- Resident [REDACTED] was assessed, and all residents' MARs were reviewed for missing dates, times, signatures, or staff initials, with identified discrepancies addressed immediately.
- Medication-administration staff was retrained on 9/14/26 by the nurse manager to document the date, time, and their initials directly after administering each medication or completing each blood-glucose test and never before administration. (Included)
- The Charge Nurse will review MARs at the end of each shift, and the Nurse Manager will audit them weekly for four weeks and monthly thereafter.
- Missing documentation will be investigated and corrected according to facility policy, followed by additional education or corrective action when necessary.
- The Administrator will review and initial the monthly audits.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] 09/28/2026)

187d - Follow Prescriber's Orders

9. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed blood sugar readings daily at 9:00am. The resident's glucometer has recorded blood sugar readings completed at the following times:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Additionally, there are no recorded glucose levels for Resident [REDACTED] on [REDACTED] and [REDACTED] in the residents glucometer.

Resident [REDACTED] is prescribed blood sugar readings twice daily at 6:30am and 4:30pm. The resident's glucometer has recorded blood sugar readings completed at the following times:

187d Follow Prescriber's Orders (continued)

- [REDACTED]
- [REDACTED]
- [REDACTED]

Resident [REDACTED] is prescribed blood sugar readings three times a day at 9:00am, 1:00am and 5:00pm. The resident's glucometer has recorded blood sugar readings completed at the following times:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Resident [REDACTED] is prescribed blood sugar readings twice daily at 9:00am and 9:00pm. The resident's glucometer has recorded blood sugar readings completed at the following times:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Resident [REDACTED] is prescribed blood sugar readings twice daily at 9:00am and 5:00pm. The resident's glucometer has recorded blood sugar readings completed at the following times:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Resident [REDACTED] is prescribed [REDACTED] "Take one tablet by mouth daily", the home was not administering the correct dosage as the medication in the home had a label reading [REDACTED] "Take two tablets by mouth daily".

Plan of Correction**Accept [REDACTED] - 09/28/2026)**

The violation was reviewed by the nursing staff on 9/14/26.

The Nurse Manager reviewed the physician orders, MARs, and glucometer histories for Residents 1 5 and notified

187d - Follow Prescriber's Orders (continued)

each authorized prescriber of the blood-glucose tests completed outside the prescribed times, missed tests, and any abnormal results.

-Each resident was assessed, and all prescriber instructions were given in a physician order.

-They have been updated and received in the form of a script. A current written order was obtained for each resident's required testing schedule, and the MARs were updated accordingly.

-Resident 5's Vitamin D3 discrepancy was reported to the prescriber and pharmacy, the correct written order and pharmacy-labeled medication were obtained, and the MAR was reconciled before further administration. (pls. see included)

-The Nurse Manager also audited all residents' medication, treatment, and blood-glucose orders against their MARs, medication labels, and glucometer histories, with discrepancies corrected immediately.

-Medication-administration staff was retrained on 9/14/26 by the nurse manager to follow the exact medication dosage and blood-glucose testing times ordered by the prescriber, document results at the time completed, and immediately report missed, late, early, abnormal, or unavailable medications or tests to the Nurse Manager and administrator.

-Staff may not change any administration or testing times without a written prescriber's order.

-The Charge Nurse will review the MAR and glucometer history at the end of each shift.

-The Nurse Manager will review and initial the monthly audits.

-Any future discrepancy will be investigated and corrected immediately, with prescriber notification, resident assessment, retraining, or corrective action completed as necessary.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] - 09/28/2026)

190a - Completion Medication Course**10. Requirements**

2600.

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

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration annual practicum after being initially certified on [REDACTED]. They did not complete the required medication observations and medication record reviews- required once every 6 months, between [REDACTED] and [REDACTED].

Staff person B administered medications to residents to include the following:

On [REDACTED] and [REDACTED] at 6:30am, administered [REDACTED], to Resident [REDACTED]

On [REDACTED] at 9pm, administered [REDACTED], and [REDACTED] to Resident [REDACTED]

On [REDACTED] through [REDACTED] at 9am, administered [REDACTED], and [REDACTED] to Resident [REDACTED]

Plan of Correction

Accept [REDACTED] - 09/28/2026)

-The violation was reviewed by the nursing staff on 9/14/26.

190a Completion Medication Course (continued)

On 8/24/26 the nurse manager and HR personnel reviewed each med tech credentials including required practicums.

Staff person B's last day of work was 8/24/26. [REDACTED] was removed from the schedule until [REDACTED] receives a medication training certificate from an authorized medication trainer.

Staff person B was given 15 days to complete the training. We have not heard from staff person B since the removal.

Staff person B has been permanently removed from the direct care staff schedule in any capacity.

Moving forward all med techs practicums and observations will be tracked as required every 6 months by the nurse manager and HR quarterly to verify compliance.

The admin will ask to review every 6 months all practicums and observations to ensure compliance.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] 09/28/2026)

190c - Record of Training**11. Requirements**

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff Person A's record of medication administration training is incomplete. The staff person has an annual practicum summary page with an original qualification date listed as [REDACTED] with only one of the two required medication administration record review activities completed in [REDACTED] and one of the two required medication administration observations done in [REDACTED]. This annual practicum form has no indication of requalification status for staff person A and it is not dated by the trainer. Staff person A also has a printed certificate from the medication administration training program indicating that the course was completed by staff person A on [REDACTED] however, there was no user report provided to the Department showing the required information for the MAR reviews and Observations or the trainer attestation signature and date completed.

Plan of Correction

Accept [REDACTED] - 09/28/2026)

The violation was reviewed by the nursing staff on 9/14/26.

Yes, staff person A completed and passed the medication administration course on 8/11/26.

Staff person A has not worked since 8/25/26 due to a work related injury with Hayes and have been advised by legal counsel not to communicate with us. Therefore, [REDACTED] is not responding to my request for information. (pls. see attached)

I have also reached out to the medication administration trainer several times to request the necessary documents to forward and [REDACTED] has not responded.

Upon receipt I will forward all required documents to the department.

Moving forward we will also request the MAR reviews and Observations or the trainer attestation signature and date completed.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] - 09/28/2026)

225a - Assessment 15 Days

12. 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] assessment, dated [REDACTED], does not include an assessment related to residents psychological/mental health needs.

Resident [REDACTED] requires the assistance of one person for transferring. The resident's assessment, dated [REDACTED], does not include an assessment or address this need.

Plan of Correction**Accept [REDACTED] - 09/28/2026)**

-The violation was reviewed by the nursing staff on 9/14/26

-The nurse manager reviewed and corrected Resident 6's initial assessment to include the resident's psychological and mental-health needs on 9/15/26. (Pls. see attached)

-Resident 7's pre-admission medical evaluation indicated that [REDACTED] required the assistance of one person for transfers. During the resident's first 15 days at Hayes Manor, staff directly observed [REDACTED] ambulating and transferring into and out of [REDACTED] bed and chair independently, safely, and without physical assistance.

-Based on these documented observations, the initial assessment now reflects that the resident was independent with ambulation and transfers at the time of assessment. (Pls. see attached)

-Staff will continue to monitor [REDACTED] mobility and help if [REDACTED] condition or functional ability changes and document if necessary.

-The resident's assessment was updated to acknowledge that the pre-admission medical evaluation identified a need for one-person assistance with transfers.

-[REDACTED] current transfer status and demonstrated level of functioning were accurately documented in both [REDACTED] assessment and support plan.

-Any incomplete or inaccurate assessment will be corrected immediately, the support plan was updated, and additional staff training or corrective action will be completed as necessary

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] - 09/28/2026)**251b - Record Entries Legible****13. 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 blood sugar reading documented [REDACTED] on the glucose log sheet for Resident [REDACTED] was written over and illegible.

Plan of Correction**Accept [REDACTED] - 09/28/2026)**

-The violation was reviewed by the nursing staff on 9/14/26

-The Nurse Manager reviewed Resident [REDACTED]'s glucose log and verified the 8/18/2026 blood-glucose result using the resident's glucometer history.

-The illegible entry was corrected according to facility policy without erasing, covering, or backdating the original documentation on 9/18/26. --The correction was identified as a dated late entry and signed by the staff member making

251b - Record Entries Legible (continued)

the correction.

-The Nurse Manager reviewed all residents' glucose logs, MARs, and medication records for entries that were illegible, undated, unsigned, written over, erased, or otherwise altered, and any discrepancy was investigated and corrected appropriately.

-Medication-administration staff was retrained on 9/14/26 by the nurse manager that all record entries must be permanent, legible, dated, and signed or initialed at the time the entry is made.

-Errors must be corrected with one line through the incorrect entry so the original information remains readable, followed by the correct information, date, and staff initials; staff may not erase, use correction fluid, scribble over, or write over an entry.

-The Charge Nurse will review medication and glucose documentation at the end of each shift.

-The Nurse Manager will audit records weekly for four weeks and monthly thereafter. Any future discrepancy will be corrected immediately and followed by additional staff education or corrective action as necessary.

-The Administrator will review and initial the monthly audits.

Licensee's Proposed Overall Completion Date: 09/19/2026

Implemented [REDACTED] - 09/28/2026)

251c - Standardized Forms**14. Requirements**

2600.

251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident [REDACTED]'s documentation of medical evaluation, dated [REDACTED], was not completed on the Department's current standardized form.

Plan of Correction

Accept [REDACTED] - 09/28/2026)

-The violation was reviewed by the nursing staff on 9/14/26.

-The PCP included the old form along with the new and updated DHS form on 10/2/25.

-The nurse manager checked all resident charts to verify that the DME is correct and current on 9/3/26.

-The admission staff and nurse manager will review all documents for admission and when annually received from PCP.

-The nurse manager will observe monthly during recaps.

-The admin will observe quarterly for compliance.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] 09/28/2026)