

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

October 8, 2026

[REDACTED], CORPORATE RN
PARAMOUNT SENIOR LIVING AT FAYETTEVILLE LLC
[REDACTED]
[REDACTED]

RE: PARAMOUNT SENIOR LIVING AT
STONEBROOK
6361 CHAMBERSBURG ROAD
FAYETTEVILLE, PA, 17222
LICENSE/COC#: 33384

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/24/2026, 08/25/2026 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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: PARAMOUNT SENIOR LIVING AT STONEBROOK **License #:** 33384 **License Expiration:** 04/09/2027
Address: 6361 CHAMBERSBURG ROAD, FAYETTEVILLE, PA 17222
County: ADAMS **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: PARAMOUNT SENIOR LIVING AT FAYETTEVILLE LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 01/12/2017 **Issued By:** Franklin Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 23 **Waking Staff:** 17

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Incident **Exit Conference Date:** 08/25/2026

Inspection Dates and Department Representative

08/24/2026 - On-Site: [REDACTED]
08/25/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 44 **Residents Served:** 21

Secured Dementia Care Unit

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

Hospice

Current Residents: 3

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 21
Diagnosed with Mental Illness: 4 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 2 **Have Physical Disability:** 0

Inspections / Reviews

08/24/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/21/2026

09/21/2026 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 10/07/2026
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/28/2026

Inspections / Reviews (*continued*)

09/21/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/07/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/07/2026

10/08/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/07/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License**1. Requirements**

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 8/24/26, the home's previous renewal inspection, dated 4/20/25, was not posted in a conspicuous and public place in the home.

Plan of Correction**Accept () - 09/21/2026)**

- 1. Upon notification from the surveyers that the current licensing inspection summary were not posted, it was printed out and placed in the binder.*
- 2. On 8/26/26 the Executive director, resident care manager and assistant resident care manager were educated on this regulation.*
- 3. Starting the week of 9/21/26, the binder will be audited weekly x4 weeks to ensure the current licensing inspection summary remains present.*
- 4. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.*
- 5. All documentation will be kept.*

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

Implemented () - 10/08/2026)**65e - 12 Hours Annual Training****2. 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 person A received only 7.5 hours of annual training in calendar training year 2025.

Direct care staff person B received only 5.5 hours of annual training in calendar training year 2025.

Plan of Correction**Accept () - 09/21/2026)**

- 1. Due to the binder for the annual trainings missing and staff did not have their 12hrs of trainings, all staff have been caught up on their annual trainings in 2026.*
- 2. On 8/26/26 the Executive director, resident care manager and assistant resident care manager were educated on this regulation.*
- 3. On 9/17/26, all staff will be educated on the requirements to complete 12hours of annual training that is provided at our monthly staff meetings on the third Thursday of every month.*
- 4. Ancillary staff (maintenance and activities that transport residents) completed 6 hours of their annual trainings by 6/30/26 and the additional 6hrs will be completed by 9/30/26.*
- 5. On 9/15/26, the ED completed an audit to ensure all staff are up to date with trainings for January- August 2026. Any missing educations will be completed by 9/30/26.*
- 6. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.*
- 7. All documentation will be kept.*

65e - 12 Hours Annual Training (continued)

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

Implemented () - 10/08/2026

65f - Training Topics

3. Requirements

2600.

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

1. Medication self-administration training.
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.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training; infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration; safe management techniques; safe management techniques; care for residents with mental illness or mental retardation, or both, if the population is served in the home during calendar training year 2025.

Direct care staff person B did not receive training in medication self-administration training; infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration; instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan; safe management techniques; care for residents with mental illness or mental retardation, or both, if the population is served in the home during calendar training year 2025.

Plan of Correction

Accept () - 09/21/2026

1. Due to the binder for the annual trainings missing and staff did not have their annual trainings; all staff have been caught up on their annual trainings with the identified topics in 2026.
2. On 8/26/26 the Executive director, resident care manager and assistant resident care manager were educated on this regulation.
3. On 9/17/26, all staff will be educated on the requirements to complete 12hours of annual trainings that include specific areas of trainings will be provided at our monthly staff meetings on the third Thursday of every month.
4. Both staff member A and B will be educated in these identified areas for 2026 by 10/5/2026.
5. On 9/15/26, the ED completed an audit to ensure the yearly education forms we are using include all of the training areas identified annually. Our training forms go from January-December. As of 9/15/26, all staff are up to date with trainings for January- August 2026. Any missing educations up to this date will be completed by 9/30/26.
6. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented () - 10/08/2026

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.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Direct care 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; resident rights; the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) during calendar training year 2025.

Direct care staff person B did not receive training in falls and accident prevention during the calendar training year 2025.

Plan of Correction**Accepted () - 09/21/2026)**

1. Due to the binder for the annual trainings missing and staff did not have their annual trainings; all staff have been caught up on their annual trainings with the identified topics in 2026.
2. On 8/26/26 the Executive director, resident care manager and assistant resident care manager were educated on this regulation.
3. On 9/17/26, all staff will be educated on the requirements to complete 12hours of annual trainings that include specific areas of trainings will be provided at our monthly staff meetings on the third Thursday of every month.
4. Both staff member A and B will be educated in these identified areas for 2026 by 10/5/2026.
5. On 9/15/26, the ED completed an audit to ensure the yearly education forms we are using include all of the training areas identified annually. Our training forms go from January-December. As of 9/15/26, all staff are up to date with trainings for January- August 2026. Any missing educations up to this date will be completed by 9/30/26.
6. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 10/05/2026**Implemented () - 10/08/2026)****82a - Poisonous Materials****5. Requirements**

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

82a - Poisonous Materials (continued)

Description of Violation

On 8/24/26 at 9:24 AM, there was a unlabeled spray bottle full of a clear liquid located in the staff break room. The sprayer nozzle has the word "floor" written on it.

Plan of Correction

Accept () - 09/21/2026)

1. Upon notification from the surveyor on 8/24/26, the director of housekeeping ordered labels for the floor cleaner that was found in the employee breakroom. The unlabeled bottle was removed from the floor.
2. On 9/1/26, the new label arrived and was placed on the cleaner bottle.
3. On 9/14/26, the director of housekeeping and staff were educated on the regulations of all poisonous materials being labeled properly.
4. Starting the week of 9/21/26, the director of housekeeping will audit all areas of the facility by completing a walk-through daily Monday-Friday x4 weeks to ensure compliance of this regulation.
5. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

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

Implemented () - 10/08/2026)

91 - Telephone Numbers

7. 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 telephone in Resident #1's bedroom.

Plan of Correction

Accept () - 09/21/2026)

1. Upon notification that the emergency numbers were not hung in 2 resident rooms, housekeeping was made aware and numbers were hung in those rooms.
2. On 8/26/26, all rooms were audited and any room missing emergency numbers were identified. All rooms got new emergency numbers hung for view.
3. On 9/14/26 all housekeeping staff were educated on compliance of this regulation.
4. On 9/17/26 all staff were educated that resident rooms must have emergency numbers hung at all times.
5. Starting the week of 9/21/26, the assistant resident care manager will check all rooms weekly x4 weeks to ensure numbers are present and replace if missing.
6. On 9/22/26 at the resident council meeting, residents will be reminded that these phone numbers are a regulation and need to remain in their rooms.
7. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
8. All documents will be kept.

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

91 - Telephone Numbers *(continued)**Implemented () - 10/08/2026)*

96a - First Aid Kit

8. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the staff office does not include bandages or antiseptic. The first aid kit in the kitchenette does not include a thermometer or eye coverings.

Plan of Correction**Accept () - 09/21/2026)**

1. Upon notification from the surveyor on 8/24/26, the missing adhesive bandages and antiseptic were placed into the first aid kit in the nurse's station. The dietary first aid kit that was in the kitchen had eye protection and a thermometer added.
2. On 8/26/26 the Executive director, resident care manager and assistant resident care manager were educated on this regulation.
3. Starting the week of 9/21/26, The executive director or designee will audit the first aid kits weekly x4 weeks
4. In November 2026 the ARCM will continue to audit first aid kits Bimonthly to ensure compliance.
5. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
6. All documents will be kept.

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

Implemented () - 10/08/2026)

103d - Storing Food Off Floor

10. Requirements

2600.

103.d. Food shall be stored off the floor.

Description of Violation

On 8/25/26 at 1:46 PM, a box of Blue Bunny vanilla ice cream cups and a box of dinner rolls were stored on the floor of the external walk-in freezer.

Plan of Correction**Accept () - 09/21/2026)**

1. On 8/25/26, the dietary manager was informed of food being stored on the floor in the external freezer. immediately took the boxes off of the floor and placed the items on the shelf.
2. On 8/26/26 the dietary manager was re-educated on compliance of this regulation.
3. On 9/14/26, dietary manager will educate the staff of this regulation
4. Starting 8/26/26 the food order will be put away immediately upon delivery, and dietary manager will implement a sheet with order delivery time and order put away time.
5. Starting the week of 9/21/26 the Dietary Manager or designee will audit the walk-in freezer every Monday, Wed and Friday afternoon after delivery to make sure no boxes are on the floors x4 weeks
6. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
7. All documents will be kept.

103d - Storing Food Off Floor (continued)

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

Implemented () - 10/08/2026)

132b - Safety Inspection/Fire Drill

12. 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

The last fire drill observed by a fire safety expert was conducted on 4/2/26. The previous fire drill observed by a fire safety expert was on 11/20/24.

Plan of Correction

Accept () - 09/21/2026)

1. The annual fire drill was completed on 4/2/26, it was missed in 2025. The ED added a calendar reminder for November every year to reach out the to fire chief to schedule the annual fire inspections for the next year.
2. On 9/14/26, the maintenance director was educated on compliance of this regulation.
3. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
4. All documentation will be kept.

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

Implemented () - 10/08/2026)

141a - Medical Evaluation

14. 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 #2's medical evaluation was not completed within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction

Accept () - 09/21/2026)

1. On 8/26/26 the ED, RCM and ARCM were educated on compliance of this regulation.
2. By 9/18/26, the Executive Director or designee will audit all current resident DMEs to confirm compliance. All current DMEs are within compliance.
3. Starting the week of 9/21/26, the Executive Director or designee will audit all new admissions x4 weeks to ensure compliance of this regulation.
4. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

141a Medical Evaluation (continued)

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

Implemented () - 10/08/2026)

141b1 - Annual Medical Evaluation

15. Requirements

2600.

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

Description of Violation

Resident #3's most recent medical evaluation was completed on [REDACTED] The resident's previous medical evaluation was completed [REDACTED]

Plan of Correction

Accept () - 09/21/2026)

1. Surveyor notified the ED of one late DME noted during review.
2. On 8/26/26 the ED, RCM and ARCM were educated on compliance of this regulation.
3. Starting the week of 9/21/26, the Executive Director will review and initial all completed DMEs to ensure compliance x4 weeks.
4. Starting 8/26/26, all DMEs completed will be recorded on the DME/RASP tracker indicating compliance with the annual medical evaluation. The Resident Care Manager will audit the binder monthly to ensure compliance.
5. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

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

Implemented () - 10/08/2026)

162c - Menus Posted

16. 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

There were five weeks of menus posted in the home, however, it is not possible to determine which if any are current as the latest date on any of the menus is July 19th.

Plan of Correction

Accept () - 09/21/2026)

1. On 8/24/26 dietary manager was made aware that the menus were not up to date that were posted. The dietary manager changed the menus out immediately. Our menus are posted monthly for the entire next month.
2. On 8/26/26 the dietary manager was educated on compliance of this regulation.
3. Starting the week of 9/21/26, the dietary manager will audit weekly that the most current menu is posted x4 weeks.
4. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

162c Menus Posted (*continued*)

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

Implemented () - 10/08/2026

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 8/24/26 at 10:43 AM, there was a 0.5 MG tube of Neosporin Ointment stored in the home's medication cart. The tube states the medication expires 03/2024.

Plan of Correction

Accept () - 09/21/2026

1. Upon notification from the surveyor of the expired Neosporin in the med cart, the med tech removed the medication and disposed of it properly.
2. On 9/17/26 all staff were educated on compliance of this regulation.
3. By 9/18/26 the medication cart will be audited by the RCM or designee to ensure compliance.
4. Starting the week of 9/21/26, the RCM or designee will audit the medication cart weekly using the medication cart/room audit form to ensure compliance.
5. On 9/25/26, Diamond pharmacy will be here to complete their quarterly audit this month. A pharmacy representative will audit all medication and treatment carts for compliance.
6. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 09/25/2026

Implemented () - 10/08/2026

184b - Labeling OTC/CAM

19. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 8/24/26 at 10:43 AM, a 0.5 MG tube of Neosporin Ointment was stored in the home's medication cart. There was no label indicating to whom this medication belongs.

Plan of Correction

Accept () - 09/21/2026

1. Upon notification from the surveyor of the unlabeled Neosporin in the med cart, the med tech removed the medication and disposed of it properly.
2. On 9/17/26 all staff were educated on compliance of this regulation.
3. By 9/18/26 the medication cart will be audited by the RCM or designee to ensure compliance.
4. Starting the week of 9/21/26, the RCM or designee will audit the medication cart weekly using the medication cart/room audit form to ensure compliance.

184b Labeling OTC/CAM (continued)

5. On 9/25/26, Diamond pharmacy will be here to complete their quarterly audit this month. A pharmacy representative will audit all medication and treatment carts for compliance.
6. On 10/22/26 the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 09/25/2026

Implemented () - 10/08/2026

185a - Implement Storage Procedures**20. 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 #2 is prescribed insulin to be administered based on a sliding scale three times daily at 0800, 1200, and 1700. The resident uses a FreeStyle Libre 3 continuous glucose monitor, however, when attempting to verify blood sugar readings documented on the medication administration record versus those stored in the resident's glucometer, it was discovered that the meter only stored some of the readings including:

8/23 at 11:37 AM 251
 8/21 at 8:09 AM 251
 8/20 at 10:27 AM 251
 8/20 at 8:18 AM 251
 8/20 at 12:33 PM 251
 8/20 at 11:38 AM 251
 8/18 at 8:54 AM 256
 8/18 at 8:14 AM 256
 8/17 at 8:59 PM 252

Repeated Violation 4/30/25

Plan of Correction

Accept () - 09/21/2026

1. Upon notification from the surveyor of resident #2's freestyle libre not holding continuous date specific readings on the reader, the staff notified family about purchasing a phone/tablet so that we could download the app to upload all of the resident's readings. Family brought in a tablet and the app was installed. The app shows a daily graph with readings but does not show time specific readings.
2. Staff document resident #2 BS to PCC from () reader once they check it to () libre.
3. On 9/18/26, the RCM checked all residents with this type of monitoring device to ensure they have the app downloaded to check past readings.
4. All new admissions with a libre device or similar devices will be notified that they will be required to have a phone/tablet to have the app for their meter downloaded for staff to access the history of their blood sugar readings.
5. This compliance will be discussed at the quarterly QA meeting 10/22/26.
6. All documentation will be kept.

185a Implement Storage Procedures (continued)

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

Implemented () - 10/08/2026

190a - Completion Medication Course

22. Requirements

2600.

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

Description of Violation

Staff person A, who has not successfully completed the Department approved medications administration course, administered medications to residents to include the following:

On 8/11/26 and 8/7/26 at 8:00 PM, gave Florastor capsules to Resident #2

On 8/7/26 at 8:00 PM, gave Eliquis 2.5 MG to Resident #1

Plan of Correction

Accept () - 09/21/2026

1. On 8/12/26 the Resident care manager completed the medication course with staff person A. On 12/10/25 Staff person A completed () annual insulin training.
2. On 7/28/26 an audit was completed and all med tech certs were renewed and updated to be compliant with regulations.
3. On 8/26/26 the Executive director and resident care manager were educated on this regulation.
4. Med tech observations have been entered on monthly calendars when due to ensure compliance.
5. On 10/22/26 compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

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

Implemented () - 10/08/2026

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

Staff person A, who has not successfully completed the Department approved medications administration course, administered insulin to Resident #2 on 8/11/26 at 5:00 PM and on 8/7/26 at 5:00 PM.

190b - Insulin Injections (continued)

Plan of Correction

Accept () - 09/21/2026

1. On 8/12/26 the Resident care manager completed the medication course with staff person A. On 12/10/25 Staff person A completed annual insulin training.
2. On 7/28/26 an audit was completed and all med tech certs were renewed and updated to be compliant with regulations.
3. On 8/26/26 the Executive director and resident care manager were educated on this regulation.
4. Med tech observations have been entered on monthly calendars when due to ensure compliance.
5. On 10/22/26 compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

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

Implemented () - 10/08/2026

225c - Additional Assessment

24. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

Description of Violation

Resident #3's current assessment was completed on However, the resident's previous assessment was completed on

Plan of Correction

Accept () - 09/21/2026

1. The surveyor notified the ED that resident #3 current assessment was completed late.
2. On 8/26/26 the executive director, resident care manager and assistant resident care manager were educated on compliance of this regulation
3. By 9/18/26, the Executive Director or designee will audit all current resident RASPs to confirm compliance. All current RASPs are within compliance.
4. Starting the week of 9/21/26, the Executive Director will review and initial all completed annual RASPs to ensure compliance
5. The Resident care manager will audit the DME/RASP tracker monthly to ensure compliance.
6. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

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

Implemented () - 10/08/2026

227d - Support Plan Medical/Dental

25. Requirements

2600.

227d - Support Plan Medical/Dental (continued)

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.

Description of Violation

Resident #2 is prescribed continuous oxygen at 2L/min via nasal cannula. The resident also has a foley catheter that requires emptying every shift. The resident's current support plan, dated [REDACTED] does not include the use of the oxygen or the catheter including the assistance needed to safely use and maintain these supports.

Plan of Correction**Accept ([REDACTED] - 09/21/2026)**

1. Upon notification of the surveyor about resident #2's RASP missing [REDACTED] O2 orders and catheter orders, the ARCM updated the RASP to reflect these orders.
2. On 8/26/26 the executive director, resident care manager and assistant resident care manager were educated on compliance of this regulation
3. Starting the week of 9/21/26, the Executive Director will review and initial all completed RASPs to ensure compliance x4 weeks.
4. Starting the week of 9/21/26 the assistant resident care manager will audit the 24hour report and any new orders every morning Monday-Friday x4 weeks to ensure any updates are added to the RASPs.
4. The Resident care manager will audit the DME/RASP tracker monthly to ensure compliance.
5. On 10/22/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 09/21/2026**Implemented ([REDACTED] - 10/08/2026)**