

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

October 2, 2026

[REDACTED], PRESIDENT
BERWYN REAL ESTATE LP
1450 E LANCASTER AVENUE
SPRINGFIELD, PA, 19064

RE: DAYLESFORD CROSSING
1450 EAST LANCASTER AVENUE
PAOLI, PA, 19301
LICENSE/COC#: 14154

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/26/2026, 08/27/2026 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: DAYLESFORD CROSSING

License #: 14154

License Expiration: 09/05/2026

Address: 1450 EAST LANCASTER AVENUE, PAOLI, PA 19301

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: BERWYN REAL ESTATE LP

Address: 1450 E LANCASTER AVENUE, SPRINGFIELD, PA, 19064

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1

Date: 08/05/2015

Issued By: Tredyffrin Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 89

Waking Staff: 67

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 08/27/2026

Inspection Dates and Department Representative

08/26/2026 - On-Site: [REDACTED]

08/27/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 100

Residents Served: 70

Secured Dementia Care Unit

In Home: Yes

Area: Wellspring

Capacity: 24

Residents Served: 14

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 70

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 19

Have Physical Disability: 0

Inspections / Reviews

08/26/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/24/2026

09/28/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/21/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/09/2026

Inspections / Reviews (*continued*)

10/02/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/30/2026

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 8/26/2026 the home's current violation report, dated 11/19/2025, was not posted in a conspicuous and public place in the home.

Plan of Correction

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

Regulation: 2600.3(c) Posting Requirements

Citation: 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.

Deficiency:

On 8/26/2026, the home's current violation report/inspection summary dated 11/19/2025 was not posted in a conspicuous and public location within the community.

Plan of Correction:

1. Corrective Action for Identified Deficiency

o Upon discovery of the deficiency, the Administrator obtained and posted the current license inspection summary/violation report dated 11/19/2025 in the designated public posting area located at the main entrance/lobby of the community where residents, families, visitors, and staff can readily access and review required regulatory information.

2. Systemic Changes to Prevent Recurrence

o The Administrator reviewed required posting documents to ensure compliance with 55 Pa. Code §2600.3(c), including:

o A Regulatory Posting Checklist has been implemented to verify required postings remain current, complete, and visibly displayed in the designated public location.

3. Monitoring Procedure

o The Administrator or designee will conduct a monthly audit of required postings using the Regulatory Posting Checklist.

o Any missing, damaged, or outdated documents identified during the audit will be replaced.

4. Date of Compliance

The deficiency was corrected on August 27, 2026.

Responsible Person - Administrator and/or Designee

Proposed Overall Completion Date: 12/01/2026

Licensee's Proposed Overall Completion Date: 12/01/2026

Implemented ([REDACTED] - 10/02/2026)

15b - Supervisor Plan**2. Requirements**

2600.

- 15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

15b Supervisor Plan (continued)

Description of Violation

On 7/31/2026 at 3:00 PM, the home received an allegation of abuse involving staff person A . The home did not develop and implement a plan of supervision that was approved by the Department.

Plan of Correction

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

Deficiency:

The facility was cited for noncompliance with 55 Pa. Code § 2600.15(b) regarding the requirements for reporting suspected abuse and taking protective action when an allegation of abuse involves a staff person.

Corrective Action

The Administrator or designee will review the identified concerns that required actions related to the allegation are completed.

The community will report suspected abuse in accordance with applicable Pennsylvania protective services requirements. When an allegation involves a staff person, the facility will develop and implement a plan of supervision or suspend the staff person involved, as appropriate.

When a plan of supervision or suspension is required, the Administrator or designee will support that the appropriate documentation is submitted to the Department's personal care home regional office.

The resident and the resident's designated person will also be notified as required.

Systemic Correction Prevention

The Administrator will review the facility's abuse reporting policy and procedures with management and supervisory staff to support that the requirements of 55 Pa. Code § 2600.15 are understood and followed.

Education will include:

- 1. The requirement to report suspected abuse.*
 - 2. The requirement to protect the resident when an allegation involves a staff person.*
 - 3. The requirement to develop and implement a plan of supervision or suspend the involved staff person.*
 - 4. The requirement to submit the plan of supervision or notice of suspension to the Department's personal care home regional office.*
 - 5. The requirement to notify the resident and designated person as applicable.*
 - 6. The importance of documenting actions taken in response to an allegation.*
- Staff will be instructed that suspected abuse must not be delayed or handled solely as an internal personnel matter. Staff are required to follow the facility's abuse reporting procedures and notify the Administrator or designee of any allegation or suspicion of abuse.*

Monitoring

The Administrator or designee will review 100% of abuse allegations involving residents for four consecutive weeks, if any occur during the monitoring period.

The review will verify:

- The allegation was identified and reported.*
- Required protective services reporting was completed.*
- Appropriate action was taken when a staff person was involved.*
- A plan of supervision or suspension was implemented when required.*
- Required documentation was submitted to the Department.*
- The resident and designated person were notified as required.*
- Documentation of actions taken was maintained.*

If no abuse allegations occur during a monitoring week, the Administrator or designee will document "No abuse allegations during this monitoring period" and initial the monitoring record.

If any concern or missed step is identified, corrective action will be taken and additional staff education will be

15b - Supervisor Plan (continued)

provided as necessary.

Ongoing Compliance

Following the four-week monitoring period, the Administrator or designee will continue to monitor compliance with the abuse reporting policy through the facility's quality assurance process.

New management and supervisory staff will receive education on the facility's abuse reporting procedures as part of orientation.

The Administrator or designee will review abuse reporting procedures with staff on an ongoing basis and whenever there is a change in applicable regulations, policy, or reporting requirements.

Any allegation of abuse will be reviewed by the Administrator or designee to support that

Proposed Overall Completion Date: 11/01/2026

Licensee's Proposed Overall Completion Date: 11/01/2026

Implemented () - 10/02/2026)

17 - Record Confidentiality**3. 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 8/26/2026, at approximately 9:20 AM, resident files were unlocked, unattended, and accessible in the 3rd floor nursing station.

Repeated Violation 9/24/2025 et al.

Plan of Correction

Accept () - 09/28/2026)

The community will identify that resident records and resident information are maintained in a confidential manner and are accessible only to individuals authorized in accordance with 55 Pa. Code § 2600.17.

Upon identification of the deficiency, the Executive Director/Wellness Director reviewed the circumstances surrounding the cited incident and took corrective action the affected resident's information was secured and protected from unauthorized access or disclosure. As an additional security measure, the locks on the Nursing Office door were changed to further restrict access to resident records and confidential information to authorized personnel only.

The Executive Director/Wellness Director reviewed current practices related to the storage, access, handling, and disclosure of resident records to determine whether other residents could potentially be affected. Any concerns identified during this review were corrected.

Applicable staff will be re-educated regarding resident confidentiality, protection of resident information, appropriate access to resident records, and the requirement that resident information only be accessed or disclosed to authorized individuals. Staff will also be reminded that resident information should only be accessed when necessary to perform their assigned responsibilities.

The Executive Director/Wellness Director or designee will conduct weekly audits for four weeks and monthly audits for three months thereafter to verify continued compliance with confidentiality requirements. Audit reviews will also include verification that secure areas containing resident information remain secured and accessible only to

17 - Record Confidentiality (continued)

authorized personnel. Any concerns identified will be addressed through additional education and/or corrective action as appropriate.

Results of the audits will be reviewed by the Executive Director/Wellness Director to identify trends and sustained compliance.

Responsible Person: [REDACTED] LPN/DOHS.

Proposed Overall Completion Date: 12/01/2026

Licensee's Proposed Overall Completion Date: 12/01/2026

Implemented ([REDACTED]) - 10/02/2026)

23a - Activities of Daily Living Assistance**4. Requirements**

2600.

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

Description of Violation

The assessment and support plan, dated [REDACTED], for resident 1 indicates the resident requires assistance with assistance in pushing [REDACTED] wheelchair throughout the community. On 8/27/2026 the resident reported [REDACTED] did not receive this assistance as required, and waited over an hour for assistance to and from meals.

The resident's call bell log lists the following:

8/26/26 at 3:58 PM 47 minutes

8/25/26 at 8:49 AM 1 hour and 37 minutes

8/25/26 at 7:47 AM 41 minutes

8/24/26 at 7:13 AM 1 hour and 22 minutes

Plan of Correction

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

Statement of Deficiency

The home was cited for failing to consistently provide and/or document assistance with activities of daily living (ADLs) as identified in residents' assessments and support plans.

Corrective Action

The home will ensure that every resident receives the level of assistance with ADLs identified in their current assessment and support plan. The Administrator/Director will review the cited resident's assessment and support plan and compare the identified ADL needs with the services currently being provided.

Any discrepancies identified will be corrected, and staff will be informed of the resident's specific ADL needs and required level of assistance.

The home will also review the assessments and support plans of current residents to ensure that ADL needs are accurately identified, communicated to staff, and being provided as required.

Staff Education

Appropriate direct-care staff will receive education regarding:

1. The requirements of 55 Pa. Code § 2600.23(a).

2. The importance of reviewing and following each resident's assessment and support plan.

23a Activities of Daily Living Assistance (continued)

3. Providing assistance with ADLs according to each resident's identified needs.

4. Proper documentation of ADL assistance provided.

5. Reporting changes in a resident's ability to perform ADLs to the Administrator/designee so that the assessment and support plan can be reviewed and updated as required.

Training will be completed for current direct care staff, and new staff will receive this training during orientation before providing unsupervised resident care.

Monitoring and Quality Assurance

The Administrator/designee will conduct a monthly review of resident ADL services using the Monthly ADL Assistance Monitoring Checklist for the next 3 months.

The audit will include a review of resident assessments/support plans and documentation to verify that:

- ADL assistance needs are identified.
- Staff are providing the required level of assistance.
- Documentation reflects the assistance provided.
- Any changes in the resident's functional status are reported.
- Identified discrepancies are corrected promptly.

The Administrator/designee will audit 100% of residents monthly for three consecutive months. If compliance is maintained, monitoring will continue monthly as part of the home's quality assurance process.

Any deficiency identified during monitoring will result in corrective action, including staff re education and/or additional supervision as appropriate.

Proposed Overall Completion Date: 11/30/2026

Licensee's Proposed Overall Completion Date: 11/30/2026

Implemented (██████) - 10/02/2026)

25b - Contract Signatures**5. Requirements**

2600.

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

Description of Violation

The resident home contract, dated ████████ for resident 2 was not signed by the resident. There was no indication the resident was given the opportunity to sign.

Plan of Correction

Accept (██████) - 09/28/2026)

Deficiency:

The facility was cited for noncompliance with 55 Pa. Code § 2600.25(b) because the contract was not signed by the resident as required.

Corrective Action

The Marketing Director will review the identified resident's file the required contract is signed by the resident. Any missing resident signature will be obtained promptly, and the completed contract will be maintained in the resident's record.

Systemic Correction/Prevention

To prevent recurrence, the Marketing Director will audit current resident files over a four week period to verify that the contract in resident's file has been signed by the resident.

25b - Contract Signatures (continued)

The Marketing Director will maintain an audit tracking sheet identifying current resident and whether the required resident signature is present.

The goal of the four-week audit is to achieve 100% compliance for current resident files.

Any file identified as missing the required resident signature will be corrected promptly. The Marketing Director will document the corrective action taken and the date the file was brought into compliance.

Monitoring

The Marketing Director will review resident files weekly for four consecutive weeks until 100% of current resident files have been reviewed.

The audit will verify:

- 1. A contract is present in the resident's file.*
- 2. The contract is signed by the resident.*
- 3. The required signature is complete and legible.*
- 4. The contract is maintained in the resident's record.*
- 5. Any missing signature is corrected promptly.*

The Marketing Director will document file reviewed and the results of the review.

The Administrator or designee will review the completed audit documentation at the end of the four-week monitoring period to verify that 100% compliance has been achieved.

Maintaining Compliance Going Forward

After the four-week audit has been completed and 100% compliance has been achieved, the Marketing Director will incorporate contract-signature verification into Daylesford's standard admission process.

For every new admission, the Marketing Director will verify that the resident has signed the required contract before the admission file is considered complete.

A contract/admission checklist will be used to document that the resident's signature has been obtained.

The Marketing Director will also verify the resident's signature whenever a new contract or required contract update is completed.

The Administrator or designee will conduct periodic audits of newly completed admission files to the process remains effective and that required resident signatures are consistently obtained.

Any identified deficiency will be corrected documented.

Responsible Person

Marketing Director: Responsible for auditing current resident files, correcting missing signatures, and verifying resident signatures for new admissions.

Administrator or Designee: Responsible for reviewing audit results and ensuring continued compliance.

Frequency

Current resident files: Weekly review for four consecutive weeks until 100% have been audited.

New admissions: Contract signature verified as part of the admission process.

Ongoing: Periodic audit by the Administrator or designee.

Verification of Compliance

Compliance will be verified through the four-week resident file audit and the facility's admission contract checklist.

At the conclusion of the four-week monitoring period, the Marketing Director will provide documentation demonstrating that 100% of current resident files reviewed have the required resident signature.

The completed audit documentation will be maintained for review as evidence of compliance with 55 Pa. Code § 2600.25(b).

Completion Date:

Four-Week Monitoring Period: 09/02/2026 through 10/02/2026

25b Contract Signatures (continued)

Proposed Overall Completion Date: 10/01/2026

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 10/02/2026)

28e - Death of a Resident

6. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident 3 passed away on [REDACTED] Resident 3's personal belongings were removed on from the [REDACTED] room on [REDACTED] however, a refund of \$2524.63 owed to the resident's estate was not issued until [REDACTED]

Plan of Correction

Accept () - 09/28/2026)

Corrective Action

The Business Office Manager will review the identified resident account and determine the amount of the refund due. The refund will be calculated and issued in accordance with the requirements of 55 Pa. Code § 2600.28(e) 30 days from time of move out.

Documentation of the refund, including the amount, date issued, and method of payment, will be maintained in the resident's financial record.

Systemic Correction Prevention

The Business Office Manager will review the facility's resident discharge and financial procedures to ensure that all required refunds are identified, calculated, and issued within the required timeframe.

A Resident Refund/Discharge Checklist will be completed whenever a resident is discharged or otherwise becomes eligible for a refund. The checklist will include verification of the resident's account balance, calculation of any refund due, date the refund is due, date the refund is issued, and documentation of the payment.

The Business Office Manager will verify the refund calculation and required documentation prior to the refund being issued.

Monitoring

The Business Office Manager will conduct a review of 100% of resident refunds for four consecutive weeks to verify compliance with 55 Pa. Code § 2600.28(e).

The review will verify:

1. The resident account was reviewed.
2. The refund amount was accurately calculated.
3. The refund was issued within the required timeframe.
4. Documentation of the refund was maintained.
5. The resident's financial record accurately reflects the refund.

Any discrepancy identified during the monitoring process will be corrected immediately and documented.

At the conclusion of the four week monitoring period, the Administrator or designee will review the results and determine whether additional monitoring is necessary.

Responsible Person Business Office Manager

28e - Death of a Resident (continued)*Frequency**100% of resident refunds reviewed weekly for four consecutive weeks.**Verification of Compliance**Compliance will be verified through review of resident financial records, refund documentation, discharge checklists, and payment records. The Administrator or designee will maintain the monitoring documentation for review and verification of continued compliance with 55 Pa. Code § 2600.28(e).**Completion Date**Corrective action will be completed by: The Business Office**Four-week monitoring period: 09/01/2026 through 09/30/2026**Proposed Overall Completion Date: 09/30/2026***Licensee's Proposed Overall Completion Date: 09/30/2026****Implemented (████ - 10/02/2026)****42s - Privacy****7. Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation*On 8/26/2026 the home was utilizing an Inspiren surveillance system in resident rooms who chose to opt-in to the program. The system involves a camera device mounted near the ceiling in the resident room, and sends ongoing alerts, video recording and live views of the resident's room to community cell phone devices. Staff who are utilizing the device will receive alerts such as "leaving bed", staff can then open the live feed camera and watch the resident in the room with rainbow colored stick figure partially superimposed over the resident, if the person is standing/moving. The system also records videos tied to the alerts that can be viewed later.***Plan of Correction****Accept (████ - 09/28/2026)***Corrective Action**The Administrator has disabled all fall monitoring cameras in the community and filed for a waiver on 08/28/2026 to █████, Regulatory Manager |Bureau of Human Services Licensing. Administrators will continue to train and educate the residents' right to privacy and the expectation that privacy will be maintained through appropriate use of doors, curtains, and other privacy measures as applicable.**Compliance**The fall monitoring system was disabled until a waiver was issued on 09/15/2026**Monitoring**The Administrator and/or designee will conduct weekly audits for four (4) consecutive weeks to support the resident privacy rights are being maintained during bathing, dressing, changing, and medical procedures. Findings will be documented and reviewed with department managers.**In addition, resident care observations will be completed monthly for two (2) months to verify staff compliance with privacy practices, including the appropriate use of doors, privacy curtains, and other privacy measures. Any identified concerns will be addressed immediately through coaching, re-education, and corrective action as appropriate.**Results of all audits and observations will be maintained on file and reviewed by the Administrator during quality assurance meetings to ensure ongoing compliance with 55 Pa. Code § 2600.42(s). An approved waiver has been*

42s - Privacy (continued)

received from the Bureau of Human Services Licensing and attached.

Proposed Overall Completion Date: 11/06/2026

Licensee's Proposed Overall Completion Date: 11/06/2026

Implemented (████) - 10/02/2026)

63a - First Aid/CPR Training**8. 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 7/30/2026, from 3:00 PM to 11:00 PM, 70 residents were present in the home. During this time only one staff person was present in the home who was certified in first aid.

Plan of Correction

Accept (████) - 09/28/2026)

Corrective Action:

The Administrator has recently become certified as an American Red Crossing First Aid and CPR trainer and will provide First Aid / CPR training to the appropriate number of staff members. Daylesford is licensed for 100 residents and will ensure that sufficient trained and certified staff are available to meet the regulatory requirement of at least one qualified staff person for every 50 residents.

The Administrator or designee will ensure that qualified staff are scheduled to provide appropriate First Aid, CPR, and obstructed airway coverage on each shift and that required coverage is maintained while residents are present in the facility.

Completion Date:

Required staff training will be completed by September 30, 2026.

Monitoring:

The Administrator or designee will review staff schedules and First Aid/CPR certifications to verify that the required number of qualified staff members are scheduled and present on each shift. Certification records will be maintained and monitored for expiration and timely renewal to ensure continued compliance with Code 2600.63

Plan of corrective action – Review The schedule weekly for 4 weeks and then monthly for 2 months to ensure appropriate staff have been trained.

Responsible Person:

Administrator or CPR / First Aid instructor.

Proposed Overall Completion Date: 11/06/2026

Licensee's Proposed Overall Completion Date: 11/06/2026

Implemented (████) - 10/02/2026)

65g - Annual Training Content

9. 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.

Repeated Violation 9/24/2025 et al.

Plan of Correction

Accept (████) - 09/28/2026)

Correction/Prevention:

The Administrator or designee will review the home's staff orientation and training process to ensure newly hired direct care staff persons, ancillary staff persons, receive the required fire safety and emergency preparedness orientation in accordance with 55 Pa. Code § 2600.65.

The Administrator or designee will verify completion of required fire safety training before or during the staff person's first work day, as applicable, and will ensure that required training documentation is maintained in each staff person's personnel/training record.

A staff training checklist will be utilized to identify required training, the date completed, the training source, and any required supporting documentation. No staff member will be considered compliant with the fire safety training requirement until the required training and documentation have been verified.

Monitoring:

The Administrator or designee will conduct a review of current staff training records to verify that required fire safety training has been completed and appropriately documented.

Going forward, the Administrator or designee will review the training records of newly hired staff at the time of orientation and again during the monthly staff record audit to verify that required fire safety training has been completed and documented.

The Administrator or designee will also conduct a monthly audit of 100% of staff training records for a period of three consecutive months. The audit will verify the following:

- 1. Fire safety training has been completed as required.*
- 2. Training was completed within the required timeframe.*
- 3. The training documentation identifies the staff person, date, source, content, and length of training.*
- 4. Certificates or other supporting documentation are maintained when applicable.*
- 5. Staff training records are current and complete.*

Audit results will be documented and maintained by the Administrator or designee. If any missing or incomplete training documentation is identified, the Administrator or designee will address the deficiency, obtain the required documentation or training, and document the corrective action taken.

After three consecutive months of 100% compliance, the Administrator or designee will continue to monitor staff training records through the home's ongoing monthly training/quality assurance process to ensure continued compliance.

65g Annual Training Content (continued)

Responsible Person:

Administrator or Designee

Completion Date:

The identified staff person's required fire safety training and documentation will be completed immediately and no later than 11/30/2026.

Proposed Overall Completion Date: 11/30/2026

Licensee's Proposed Overall Completion Date: 11/30/2026

Implemented () - 10/02/2026)

88a - Surfaces**10. 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 8/27/2026 pieces of the carpet in the middle of the memory care hallway were torn and lifting up, creating a possible tripping hazard.

Plan of Correction

Accept () - 09/28/2026)

The Maintenance Director will identified the rugs in Wellsprings are in compliance and correct as needed. Rugs that are curled, raised, loose, or otherwise creating a potential tripping hazard will be removed, secured, or replaced as appropriate.

The Maintenance Director will inspect the affected areas to ensure that the rugs are properly secured and that walking surfaces are safe and free of hazards.

Systemic Correction Prevention

To prevent recurrence, the Maintenance Director will conduct a weekly inspection of the floors and walking surfaces in Wellsprings for four consecutive weeks.

The inspection will specifically include area rugs and mats to ensure that they:

- *Remain flat and securely in place.*
- *Do not have curled, raised, loose, or frayed edges.*
- *Do not create a tripping hazard.*
- *Are appropriate for the area and residents using the space.*
- *Are properly secured or have appropriate non slip backing when applicable.*

Staff will be instructed to report any loose, curled, or raised rugs immediately to the Maintenance Director or Administrator/designee so that corrective action can be taken without waiting for the next scheduled inspection.

Monitoring

The Maintenance Director will inspect 100% of the rugs and mats in Wellsprings weekly for four consecutive weeks. The Maintenance Director will document each inspection, including the date, area/room inspected, condition of the rug or mat, and signature.

The Administrator or designee will review the completed inspection documentation weekly to verify that inspections were completed and that any identified hazards were corrected promptly.

If any rug or mat is identified as unsafe during the monitoring period, immediate corrective action will be taken and documented.

88a - Surfaces (continued)

At the conclusion of the four-week monitoring period, the Administrator or designee will review the results and determine whether additional monitoring is necessary to maintain continued compliance.

Frequency

100% of rugs and mats in Wellsprings – weekly for four consecutive weeks.

Completion Date

Corrective action for the identified deficiency will be completed by: Maintenance Director

Four-week monitoring period: 09/01/2026 through 09/30/2026

Verification of Compliance

Compliance will be verified through the Weekly Rug and Floor Safety Inspection Log. The Administrator or designee will review the inspection records weekly and verify that they have been identified rug-related hazards are corrected and documented.

The completed monitoring records will be maintained for review as evidence of continued compliance with 55 Pa. Code § 2600.88(a).

Proposed Overall Completion Date: 09/30/2026

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

Implemented () - 10/02/2026)

101j7 - Lighting/Operable Lamp**11. 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 4 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept () - 09/28/2026)

Corrective Action

The Maintenance Director will inspect the identified resident room for operable lamp or other source of lighting that can be turned on at bedside is available and functioning properly.

Any necessary repair or replacement will be completed. The Administrator or designee will verify that the corrective action has been completed and that the bedside lighting is operational.

Systemic Correction/Prevention

To prevent recurrence, the Maintenance Director will inspect approximately 25% sample of resident rooms weekly for four consecutive weeks.

During each weekly inspection, the Maintenance Director will verify resident room being inspected has an operable lamp or other source of lighting that can be turned on at bedside.

The rooms inspected will be rotated each week to ensure that all resident rooms are monitored during the four-week period.

Rooms identified as not having an operable bedside light or other source of lighting will be documented and corrected. The Maintenance Director will document the corrective action taken and the date the issue was resolved.

Monitoring

101j7 Lighting/Operable Lamp (continued)

The Maintenance Director will complete a Weekly Bedside Lighting Inspection Log for four consecutive weeks. The Administrator or designee will review the completed inspection log weekly for four consecutive weeks to verify that 25% of all resident rooms were inspected and that identified concerns were corrected.

If a room is found to be out of compliance, the Maintenance Director will take immediate corrective action. The Administrator or designee will verify that the corrective action has been completed.

At the conclusion of the four week monitoring period, the Administrator or designee will review the monitoring records to determine continued compliance and whether additional monitoring is necessary.

Responsible Person

Maintenance Director: Conducts weekly inspections of 25% of resident rooms and corrects any identified bedside lighting concerns.

Administrator or Designee: Reviews the weekly inspection documentation and verifies completion of corrective actions.

Frequency

25% of all resident rooms weekly for four consecutive weeks.

Completion Date

Corrective action for the identified deficiency will be completed by: 09/30/2026

Four week monitoring period: 09/01/2026 through 09/30/2026

Verification of Compliance

Compliance will be verified through the Weekly Bedside Lighting Inspection Log and documentation of any corrective actions taken. The Administrator or designee will review and maintain the completed monitoring records as evidence of continued compliance with 55 Pa. Code § 2600.101(7).

Proposed Overall Completion Date: 09/30/2026

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

Implemented () - 10/02/2026)

171b5 - First Aid Kit**12. Requirements**

2600.

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

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the van used to transport residents does not include a thermometer or breathing shield.

Plan of Correction

Accept () - 09/28/2026)

Corrective Action

The Community has reviewed and restocked the first aid kit to ensure that required items are available/accessible. The required items include nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, and tweezers.

The Administrator or designee will review the first aid kit with designated staff to support staff know the location and accessibility of the kit.

Staff Education

By 9/16/2026, the Administrator or designee will educate applicable staff regarding the requirements of 55 Pa.

171b5 - First Aid Kit (continued)

Code § 2600.171, including the required contents of the first-aid kit, its location, accessibility, and the process for reporting and replacing missing or depleted supplies.

Monitoring

Beginning 08/31/2026, the Administrator or designee will inspect the first-aid kit monthly for 3 consecutive months using a First-Aid Kit Checklist. The checklist will identify required item and document whether the item is present and available in the appropriate quantity.

missing, expired, damaged, or depleted item identified during the monthly inspection will be replaced.

The Administrator or designee will review and sign the completed checklist monthly to support compliance. If a deficiency is identified, corrective action will be taken and documented.

Proposed Overall Completion Date: 11/06/2026

Licensee's Proposed Overall Completion Date: 11/06/2026

Implemented (████ - 10/02/2026)

181f - Record of Medication**13. Requirements**

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 8/27/26, resident 1's record did not include a current list of medications. The list in the resident's record did not include the following: Dayquil, Nyquil, █████ one-a-day vitamin, stool softener, and refresh eye drops. The list did include multiple medications the resident is no longer taking including a █████ chewable vitamin, vitamin b-12 and a lidocaine patch.

On 8/27/2026, resident 5's record did not include a current list of medications. The list in the resident's record included pravastatin 10 mg and did not include bumetanide 2 mg.

Repeated Violation 9/24/2025 et al.

Plan of Correction

Accept (████ - 09/28/2026)

Corrective Action

The Health and Wellness Director will review the records of identify residents who self-administer medications to support the resident's record contains a list of prescription, complementary and alternative medicine (CAM), and over-the-counter (OTC) medications.

discrepancies or missing medication information identified during the review will be corrected. The resident's medication list will be updated as necessary based on current medication orders and available medical documentation.

Systemic Correction/Prevention

181f - Record of Medication (continued)

The Health and Wellness Director will implement a process to monitor the medication records of residents who self-administer medications.

The Health and Wellness Director will review of residents who self-administer medications weekly for four consecutive weeks to verify that resident's record contains a current list of prescription, CAM, and OTC medications. The review will include comparison of the residents' medication list with current medication orders and other applicable medical documentation available to the facility.

medication change received by the facility will be reviewed and the residents' medication list will be updated.

Monitoring

The Health and Wellness Director will complete the Self-Administration Medication Record Review Checklist weekly for four consecutive weeks.

The checklist will verify:

- 1.The resident is identified as self-administering medications.*
- 2.The resident's record contains a current medication list.*
- 3.Prescription medications are included.*
- 4.CAM medications are included, if applicable.*
- 5.OTC medications are included, if applicable.*
- 6.Medication changes have been reflected on the current medication list.*
- 7. identified discrepancy has been corrected and documented.*
- 8.The Health and Wellness Director will review residents who self-administer medications weekly.*

If a discrepancy is identified, the Health and Wellness Director will provide corrective action, update the resident's medication record as appropriate, and document the action taken.

At the conclusion of the four-week monitoring period, the Administrator or designee will review the completed monitoring records to determine continued compliance and whether additional monitoring is necessary.

Responsible Person

Health and Wellness Director: Conducts weekly reviews of residents who self-administer medications and ensures medication lists are current and complete.

Administrator or Designee: Reviews the completed monitoring documentation and verifies corrective actions when applicable.

Frequency

residents who self-administer medications – weekly for four consecutive weeks.

Verification of Compliance

Compliance will be verified through review of the resident records and completion of the weekly Self-Administration Medication Record Review Checklist.

The completed checklists will be maintained by the Health and Wellness Director and made available for review as evidence of continued compliance with 55 Pa. Code § 2600.181(f).

Proposed Overall Completion Date: 10/01/2026

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 10/02/2026)

183d - Prescription Current

14. 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 8/27/2026, Senexon- S tab 8.5-50 mg prescribed for individual resident 6, was in the home's medication cart; however, the medication was discontinued on 8/18/2026.

Plan of Correction**Accept (████ - 09/28/2026)**

The community will ensure that only current prescription medications, over-the-counter medications, sample medications, and complementary and alternative medications for individuals currently residing in the home are maintained within the community.

Upon identification of the deficiency, the Wellness Director/Designee immediately reviewed the medication(s) identified during the inspection. Any discontinued, outdated, or otherwise non-current medications were removed from active medication storage and handled in accordance with the community's medication disposal procedures. To identify whether other residents could be affected by the same practice, the Wellness Director/Designee completed an audit of medication carts and medication storage areas for all residents receiving medication management services. Medications were compared with current physician/prescriber orders and the Medication Administration Record (MAR) to verify that only current medications for residents presently residing in the community were maintained. Any discrepancies identified were corrected immediately.

Licensed nursing staff and medication administration staff will be re-educated regarding § 2600.183(d), with emphasis on promptly identifying and removing discontinued medications and ensuring that medications belonging to discharged or former residents are not maintained in the community.

The Wellness Director/Designee will conduct weekly medication storage audits for four weeks and monthly audits for three months thereafter to verify continued compliance. Audits will include comparison of medications maintained in the medication carts/storage areas with current prescriber orders and MARs.

Any discrepancies identified during these audits will be corrected immediately, and additional staff education and/or corrective action will be implemented as appropriate.

The Wellness Director/Designee will review audit results to identify trends and ensure sustained compliance.

Responsible Person: ██████████ LPN/DOW

Completion Date: 12/15/2026

Proposed Overall Completion Date: 12/15/2026

Licensee's Proposed Overall Completion Date: 12/15/2026

Implemented (████ - 10/02/2026)**183e Storing Medications****15. 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 8/27/2026 fluticasone nasal spray for resident 7, was stored in a box in the 1st floor medication cart, however the cap was missing. According to the manufacturer's instructions "keep the cap tightly closed when not in use to prevent moisture contamination and degradation of the active ingredients".

183e - Storing Medications (continued)

On 8/27/2026 the following were observed in a staff person B's office:

- Resident 2's morphine 20 mg/ml syringes that expired on 4/1/2026 and lorazepam .5 mg tablets that expired on 1/13/2026.
- Resident 8's tramadol 50 mg tablets that expired on 6/13/2026 and was torn at slots 9 and 10 with the pill still remaining inside the packaging.

Repeated Violation 9/24/2025 et al.

Plan of Correction

Accept () - 09/28/2026)

The community will ensure that only current prescription medications, over-the-counter medications, sample medications, and complementary and alternative medications for individuals currently residing in the home are maintained within the community.

Upon identification of the deficiency, the Wellness Director/Designee immediately reviewed the medication(s) identified during the inspection. Any discontinued, outdated, or otherwise non-current medications were removed from active medication storage and handled in accordance with the community's medication disposal procedures. To identify whether other residents could be affected by the same practice, the Wellness Director/Designee completed an audit of medication carts and medication storage areas for all residents receiving medication management services. Medications were compared with current physician/prescriber orders and the Medication Administration Record (MAR) to verify that only current medications for residents presently residing in the community were maintained. Any discrepancies identified were corrected immediately.

Licensed nursing staff and medication administration staff will be re-educated regarding § 2600.183(d), with emphasis on promptly identifying and removing discontinued medications and ensuring that medications belonging to discharged or former residents are not maintained in the community.

The Wellness Director/Designee will conduct weekly medication storage audits for four weeks and monthly audits for three months thereafter to verify continued compliance. Audits will include comparison of medications maintained in the medication carts/storage areas with current prescriber orders and MARs.

Any discrepancies identified during these audits will be corrected immediately, and additional staff education and/or corrective action will be implemented as appropriate.

The Wellness Director/Designee will review audit results to identify trends and ensure sustained compliance.

Responsible Person: () LPN/DOW

Completion Date: 12/15/2026

Proposed Overall Completion Date: 12/15/2026

Licensee's Proposed Overall Completion Date: 12/15/2026

Implemented () - 10/02/2026)

185a - Implement Storage Procedures

16. 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.

185a - Implement Storage Procedures (continued)**Description of Violation**

Resident 6 is prescribed acetaminophen suppository every 6 hours as needed. On 8/27/2026 this medication was not available in the home.

Resident 9 is prescribed glucagon kit as needed. On 8/27/2026 this medication was not available in the home.

On 8/27/2026, resident 2's morphine 20 mg/ml syringes and lorazepam .5 mg tablets, and resident 8's tramadol 50 mg tablets were stored inside staff person B's office in an unlocked filing cabinet after being removed from the medication carts.

The home's controlled substance policy states:

- 1. Controlled medications will be stored under double lock, separate from other medications"*

Plan of Correction**Directed (████ - 09/28/2026)**

The community will ensure that established medication management procedures are implemented consistently to provide for the safe storage, access, security, distribution, and use of medications and medical equipment by trained staff persons.

DOW conducted an audit of medication storage areas and medication management practices for all residents receiving medication administration services to identify any additional areas of potential noncompliance. Any concerns identified during the audit were corrected.

Medication administration staff will be re-educated on the community's medication management policies and procedures, including medication storage, security, access, distribution, documentation, and the requirement that medications and medical equipment be handled only in accordance with established procedures and by appropriately trained staff.

To ensure continued compliance, the Wellness Director/Designee will conduct weekly medication management audits for four weeks, followed by monthly audits for three months.

DOW will maintain documentation of the audits and corrective actions for review. Results will also be incorporated into the community's quality management process to identify trends and ensure sustained compliance.

Responsible Person: ██████████ LPN/DOW

Proposed completion Date: 12/15/2026

Directed Plan of Correction (████ 9/28/26):

In addition to the steps noted in the submitted plan of correction, the Wellness Director will ensure all missing medications are available for administration within the next five (5) days of receipt of this directed plan.

Proposed Overall Completion Date: 12/15/2026

Directed Completion Date: 12/15/2026

Implemented (████ - 10/02/2026)**187a - Medication Record****17. Requirements**

2600.

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

187a - Medication Record (continued)**Description of Violation**

Resident 10 is prescribed Metoprolol 50 mg with vitals parameters, hold if SBP less than 120 and pulse less than 60. However, resident's 8/2026 medication administration record indicated this medication was not administered due to being outside the parameter on 8/08, 8/09, and 8/23 but does not indicate what the SBP and pulse were on those days.

Repeated Violation 9/24/2025 et al.

Plan of Correction

Accepted (████ - 09/28/2026)

The community will ensure that a complete and accurate medication record is maintained for each resident for whom medications are administered in accordance with 55 Pa. Code § 2600.187(a).

Upon identification of the deficiency, the Wellness Director/Designee reviewed the medication record(s) of the resident(s) identified during the inspection. Missing or incomplete information was reviewed against the current physician/prescriber orders and pharmacy records and corrected as appropriate.

To determine whether additional residents were affected, the Wellness Director/Designee completed an audit of medication administration records for all residents receiving medication administration services. The audit included verification of the resident's name, drug allergies, medication name, strength, dosage form, dose, route, frequency, administration times, duration of therapy when applicable, special precautions when applicable, diagnosis or purpose of the medication including PRN medications, and required medication administration information. Any discrepancies identified were addressed immediately.

All staff responsible for medication administration will be re-educated regarding the requirements of § 2600.187(a), including the importance of maintaining complete, accurate, and current medication administration records and verifying medication records against current prescriber orders.

DOW will conduct weekly MAR audits for four weeks and monthly audits for three months thereafter to ensure continued compliance. Any discrepancies identified during these audits will be corrected promptly, and additional staff education or corrective action will be provided as necessary.

Audit findings will be reviewed by the Wellness Director/Executive Director to identify trends and ensure sustained compliance.

Responsible Person: ██████████ LPN/DOW

Completion Date: 12/15/2026

Proposed Overall Completion Date: 12/15/2026

Licensee's Proposed Overall Completion Date: 12/15/2026

Implemented (████ - 10/02/2026)

187b - Date/Time of Medication Admin.**18. Requirements**

2600.

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

Description of Violation

On 8/27/2026 at 7:00 AM, resident 5 was not administered TEDS XL elastic bandages & supports and triamcinolone cream .05%

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

. However, staff person C initialed the 8/2026 MAR these were administered. Additionally, TED XL elastic bandages & supports were documented as administered from 8/16/2026 through 8/26/2026, but resident 5 stated during an interview that the home did not have them in stock and [REDACTED] had not been using them due to a change in medication.

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

The community will ensure that a complete and accurate medication record is maintained for each resident for whom medications are administered in accordance with 55 Pa. Code § 2600.187(b).

Upon identification of the deficiency, the Wellness Director/Designee reviewed the medication record(s) of the resident(s) identified during the inspection. Missing or incomplete information was reviewed against the current physician/prescriber orders and pharmacy records and corrected as appropriate.

To determine whether additional residents were affected, the Wellness Director/Designee completed an audit of medication administration records for all residents receiving medication administration services. The audit included verification of the resident's name, drug allergies, medication name, strength, dosage form, dose, route, frequency, administration times, duration of therapy when applicable, special precautions when applicable, diagnosis or purpose of the medication including PRN medications, and required medication administration information. Any discrepancies identified were addressed immediately.

All staff responsible for medication administration will be re-educated regarding the requirements of § 2600.187(b), including the importance of maintaining complete, accurate, and current medication administration records and verifying medication records against current prescriber orders.

DOW will conduct weekly MAR audits for four weeks and monthly audits for three months thereafter to ensure continued compliance. Any discrepancies identified during these audits will be corrected promptly, and additional staff education or corrective action will be provided as necessary.

Audit findings will be reviewed by the Wellness Director/Executive Director to identify trends and ensure sustained compliance.

Responsible Person: [REDACTED] LPN/DOW

Completion Date: 12/15/2026

Proposed Overall Completion Date: 12/15/2026

Licensee's Proposed Overall Completion Date: 12/15/2026

Implemented ([REDACTED] - 10/02/2026)**187d - Follow Prescriber's Orders****19. Requirements**

2600.

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

Description of Violation

Resident 5 is prescribed TEDS elastic bandages and supports. However, this medication was not administered to resident 5 on 8/27/2026 because the medication was not available in the home.

Repeated Violation 9/24/2025 et al.

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

The community will ensure that a complete and accurate medication record is maintained for each resident for

187d - Follow Prescriber's Orders (continued)

whom medications are administered in accordance with 55 Pa. Code § 2600.187(d).

Upon identification of the deficiency, the Wellness Director/Designee reviewed the medication record(s) of the resident(s) identified during the inspection. Missing or incomplete information was reviewed against the current physician/prescriber orders and pharmacy records and corrected as appropriate.

To determine whether additional residents were affected, the Wellness Director/Designee completed an audit of medication administration records for all residents receiving medication administration services. The audit included verification of the resident's name, drug allergies, medication name, strength, dosage form, dose, route, frequency, administration times, duration of therapy when applicable, special precautions when applicable, diagnosis or purpose of the medication including PRN medications, and required medication administration information. Any discrepancies identified were addressed immediately.

All staff responsible for medication administration will be re-educated regarding the requirements of § 2600.187(d), including the importance of maintaining complete, accurate, and current medication administration records and verifying medication records against current prescriber orders.

DOW will conduct weekly MAR audits for four weeks and monthly audits for three months thereafter to ensure continued compliance. Any discrepancies identified during these audits will be corrected promptly, and additional staff education or corrective action will be provided as necessary.

Audit findings will be reviewed by the Wellness Director/Executive Director to identify trends and ensure sustained compliance.

Responsible Person: [REDACTED] LPN/DOW

Completion Date: 12/15/2026

Directed Plan of Correction ([REDACTED] 9/28/26):

In addition to the steps noted in the submitted plan of correction, the Wellness Director will ensure resident ted stockings are ordered and available, within the next five days..

Proposed Overall Completion Date: 12/15/2026

Directed Completion Date: 12/15/2026

Implemented ([REDACTED] - 10/02/2026)

225c - Additional Assessment**20. Requirements**

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 11 utilizes a bedrail. Resident 11's assessment, dated [REDACTED], does not include the need for a bedrail.

Plan of Correction

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

The community will ensure that each resident receives an updated assessment annually, when there is a significant change in the resident's condition prior to the annual assessment, and when requested by the Department in

225c - Additional Assessment (continued)

accordance with 55 Pa. Code § 2600.225(c).

Upon identification of the deficiency, the Wellness Director/Designee reviewed the assessment for the resident identified during the inspection. The required assessment was completed/updated to reflect the resident's current condition and care needs.

To determine whether other residents were affected, the Wellness Director/Designee completed an audit of all resident records to verify that required annual assessments were current and that residents who experienced a significant change in condition had been appropriately reassessed. Any overdue or incomplete assessments identified during the audit were addressed.

The Wellness Director/Designee will maintain an assessment tracking system identifying each resident's required annual assessment date. The Wellness Director/Designee will review the tracking system monthly to identify assessments approaching their due dates and complete.

For residents experiencing a significant change in condition, the Wellness Director/Designee will review the resident's assessment and ensure that an updated assessment is completed as required and that the resident's support plan is reviewed and updated as appropriate.

The Wellness Director/Designee will conduct monthly audits for three months to verify compliance. Any deficiencies identified will be corrected immediately, and additional education or corrective action will be provided as necessary.

Responsible Person: [REDACTED] LPN/DOW

Completion Date: 12/01/2026

Directed Plan of Correction ([REDACTED] 9/28/26):

In addition to the steps noted in the submitted plan of correction, the Wellness Director will ensure the assessment and support plan for resident #11's is updated to include the need for bedside supportive device, within the next 30 days. All residents that require a bedside supportive device will have their assessment and support plan updated as well, within the next 30 days.

A copy of the resident updated assessments will be made available for the Departments review.

Proposed Overall Completion Date: 12/01/2026

Directed Completion Date: 10/28/2026

Implemented ([REDACTED] - 10/02/2026)

251c - Standardized Forms**21. Requirements**

2600.

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

Description of Violation

Resident 12's documentation of medical evaluation, dated [REDACTED] was not completed on the Department's current standardized form. The final page of the form is for 2800 regulations.

Plan of Correction

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

The community will ensure that a separate, complete, and accurate record is maintained for each resident in accordance with 55 Pa. Code § 2600.251. All entries in resident records will be permanent, legible, dated, and signed by the staff person making the entry. Standardized forms will be utilized as required, and resident records will be

251c Standardized Forms (continued)

maintained on the premises where the resident resides.

Upon identification of the deficiency, the Wellness Director/Designee immediately reviewed the record(s) of the resident(s) identified during the inspection and corrected the identified deficiency to the extent possible.

To determine whether other residents were potentially affected, the Wellness Director/Designee completed an audit of resident records to verify that each resident had a separate record and that required documentation was complete, legible, dated, signed, and maintained appropriately. Any deficiencies identified during the audit were corrected. The Wellness Director/Designee will conduct weekly resident record audits for three weeks to verify continued compliance.

Any deficiencies identified during the audits will be corrected promptly.

Results of the audits will be reviewed by the Wellness Director/Executive Director to identify trends and determine whether additional corrective measures are necessary to maintain ongoing compliance.

Responsible Person: [REDACTED] LPN/DOW

Monitoring: All charts audited 100%

Completion Date:

Directed Plan of Correction ([REDACTED] 9/28/26):

In addition to the steps submitted in the plan of correction, the Wellness Director will correct resident #12's medical evaluation and identify any other resident medical evaluations completed on the wrong form, within the next 30 days. In the future the Wellness Director will ensure all medical evaluations are on the correct Department mandated form, starting immediately.

A copy of the corrected medical evaluation will be maintained for the Departments review.

Proposed Overall Completion Date: 10/01/2026

Directed Completion Date: 10/28/2026

Implemented ([REDACTED] - 10/02/2026)