pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ORION CARE LLC**
LEGAL ENTITY

To operate **ORION PERSONAL CARE**
NAME OF FACILITY OR AGENCY

Located at **2191 FERGUSON ROAD, ALLISON PARK, PA 15101**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **25**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 25**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 26, 2026** until **February 26, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **455761**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 26, 2026

[redacted]
Orion Care LLC
[redacted]

RE: Orion Personal Care
2191 Ferguson Road
Allison Park, Pennsylvania 15101
License/COC #: 455761

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on February 23, 2026, February 24, 2026, June 11, 2026, and June 12, 2026, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 455760) dated July 9, 2026 – July 9, 2027, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from AUGUST 26, 2026 to FEBRUARY 26, 2027.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
141(b)(1)	III	15	$3	$45	15 calendar days from mailing date of this letter
225(c)(1)	III	15	$3	$45	15 calendar days from mailing date of this letter
231(c)	III	15	$3	$45	15 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *ORION PERSONAL CARE* **License #**: *45576* **License Expiration**: *07/09/2026*

Address: *2191 FERGUSON ROAD, ALLISON PARK, PA 15101*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *ORION CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *06/14/2024* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/24/2026*

Inspection Dates and Department Representative

02/23/2026 On Site: [redacted]

02/24/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *14*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *25* **Residents Served**: *14*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *14*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *14*

Have Physical Disability: *0*

Inspections / Reviews

02/23/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *04/03/2026*

04/15/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/10/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *04/21/2026*

04/22/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/08/2026*

08/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/08/2026*

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

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 [redacted], the following license inspection summaries were not posted in a conspicuous and public place in the home:

- *License inspection summary, dated [redacted]*
- *License inspection summary, dated [redacted]*

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Immediate action was taken and the license inspection summary dated 9/16/25 and 8/26/25 were posted in the entry way of the home in a conspicuous place. This was completed on 2/23/2026 By [redacted]
Long-Term Monitoring Steps for Compliance with 2600.3c:
Designated Responsible Party: [redacted] will oversee and be responsible for ensuring continuous compliance.
Weekly Compliance Checks: [redacted], or an appointed delegate, will perform weekly checks to verify that all necessary documents, including license inspection summaries, are maintained in a visible and public location. (DIRECTED: The weekly audits shall begin on 4/27/26 to ensure compliance with 2600.3c. [redacted] 4/22/26).
Monthly Audit: A monthly audit will be carried out by the management team to ensure ongoing adherence to display requirements. Any discrepancies will be addressed immediately.
Staff Training: Regular training sessions will be conducted to educate staff on the importance of maintaining compliance with the display requirements. (DIRECTED: The staff education shall be completed by 5/4/26. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26)
Quality Management Review:
Our next quality management review will occur on May 5 2026. This review will be comprehensive, covering all aspects specified in 2600.26b.
Documentation of Review: The quality management review will be thoroughly documented, and records will be kept at the central office for reference and future inspections.

Completion Date: All corrective actions addressed during this review will be completed by May 4 2026

Proposed Overall Completion Date: 05/04/2026

Directed Completion Date: *05/05/2026*

Implemented [redacted] - 08/17/2026)

18 - Compliance With Laws

2. Requirements

2600.

18 - Compliance With Laws *(continued)*

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on [redacted], requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors and must be changed at least annually. However, on [redacted] the date of battery installation indicated on the carbon monoxide detector located in the basement was dated as [redacted].

On [redacted], no influenza poster was posted in a conspicuous and public place in the home in accordance with the Influenza Awareness Act of July 2016.

On [redacted], there were no signs posted at the home's entrances indicating if the home permits smoking in accordance with the Clean Indoor Air Act, enacted on [redacted]

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Immediate action was taken on 2/23/26 by [redacted]. Please see attached photos of the date of new battery installation indicated on the carbon monoxide detector located in the basement dated 2/23/26,
Influenza poster was posted immediately on 2/23/26 in a conspicuous and public place in the home in accordance with the Influenza Awareness Act of July 2016,
No Smoking sign was also immediately posted at the home s entrances on 2/23/26 and a new sign was ordered and posted on the front entrance door on 2/24/26
Completion Date: 2/24/26
Monitoring Plan:
monthly checks.will be conducted by designated staff P. Moran and/or M. Rengers, verifying battery are up to date, No Smoking signs and Influenza poster remains visible and in good condition. (DIRECTED: The monthly checks shall begin on 5/1/26. [redacted] 4/22/26).
Verification records will be maintained in a logbook within the administrative office. In addition, Seasonal photographic documentation will be maintained to verify compliance.

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/01/2026*

18 - Compliance With Laws *(continued)*

Implemented [redacted] - 08/17/2026)

25b - Contract Signatures

3. Requirements

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

Description of Violation

Resident [redacted] resident-home contract, dated [redacted], is not signed by the resident.

Resident [redacted] resident-home contract, dated [redacted] is not signed by the resident.

Resident [redacted] resident-home contract, dated [redacted], is not signed by the resident.

Plan of Correction ***Directed [redacted] 04/22/2026)***

Immediate action was taken by the Office Manager and Administrator to review all files and contracts. The comprehensive review of all current resident contracts was completed by March 20, 2026.
For residents [redacted] and [redacted] it was noted that they were unable to sign their names. In compliance with guidelines, the responsible staff member marked "unable to sign" and included [redacted] initials and date on the contracts.
The current Admin. (that was hired in Sep. 2025) has introduced new training protocols as of February 25, 2026, and March 20, 2026, to adequately prepare staff for handling contracts when residents are unable to sign their names. This includes proper notation and staff initials as a part of the signing process.
Moving forward, all contracts will be revised or redone as necessary with the aim to complete this process ~~within 90 days from March 20, 2026.~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 4/22/26)
(DIRECTED: By 5/5/26: The administrator shall review all current resident-home contracts to ensure compliance with 2600.25b. [redacted] 4/22/26).
Training was conducted on February 25, 2026, to ensure all staff are aware of and follow these protocols.
Admin. will follow up with Continued training sessions for office staff to ensure they understand the procedures for handling contracts when residents are unable to sign.
Admin. has initiated bi-annual audits from June 2026 to verify correct procedures are being adhered to in all resident contracts.
Completion of review and re-signing adherence to protocols for all contracts is planned within 90 days from March 20, 2026.

DIRECTED: By 4/30/26: The administrator shall develop and implement a new admission checklist to ensure timely resident-home contracts are completed at the time of admission and to ensure all resident-home contracts are signed at admission in accordance with 2600.25b. Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/30/2026*

25b - Contract Signatures *(continued)*

Not Implemented (08/17/2026)

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident record does not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident record does not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident record does not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed 04/22/2026)***

Immediate action was taken to have all residents or their designee review and sign the residents rights. After being thoroughly read their rights and complaint procedures on April 7 2026, The residents signed the documents on same date (April 7 2026). Those not able to sign were written UNABLE TO SIGN.
Docs have been systematically placed in their individual records to ensure full compliance with the stated regulation.
Long-Term Monitoring Steps for Compliance:
Office manager willl be responsible for quarterley reviewing compliance.
Staff Training:
Annual training sessions will be provided by Admin. to our office staff to emphasize the critical importance of maintaining complete and accurate resident records. These sessions include proper procedures for obtaining, verifying, and documenting acknowledgement signatures.

DIRECTED: By 5/5/26: The administrator shall review all current resident-home contracts to ensure signed acknowledgments are present in each resident's record in accordance with 2600.41e. 4/22/26.

DIRECTED: By 4/30/26: The administrator shall develop and implement a new admission checklist to ensure signed acknowledgements of receipt of the resident rights and complaint procedures are obtained at the time of admission in accordance with 2600.41e. Copies of the completed new admission checklists shall be kept in each resident's record. 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/05/2026*

Not Implemented 08/17/2026)

60a - Staff/Support Plan

6. Requirements

60a - Staff/Support Plan *(continued)*

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The entire home is licensed as a secured dementia care unit (SDCU). On [redacted] and [redacted] there were 14 residents present in the home, including 14 residents with mobility needs. Of the 14 residents with mobility needs, 3 of the residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair. According to the most recent documentation from a fire safety expert, dated [redacted] the maximum evacuation time to the home's numerous internal fire-safe areas is 3 minutes, 45 seconds. The home routinely schedules 2 staff persons in the home during the 11:00pm through 7:00am shift, which is not adequate to evacuate all residents in an emergency. Also, the home exceeded the maximum evacuation time during the following fire drills:

- *The evacuation time for the fire drill conducted on [redacted] at 3:00pm was conducted in 8 minutes, 15 seconds. During this fire drill, 13 residents were present in the home and 5 staff persons assisted with evacuation*
- *The evacuation time for the fire drill conducted on [redacted] at 2:30pm was conducted in 10 minutes, 3 seconds. During this fire drill, 10 residents were present in the home and 4 staff persons assisted with evacuation*

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Staffing and mobility care plans were addressed immediately. Staff was increased to reflect the care and currrent evacuation needs. Fire Safety inspector was contacted and the time is being adjusted and a new letter is being issued. Fire Safety inspector arrived on 4/21/2026. Evacuation time with 2 staff and 9 residents was 8 mins 39 sec. See attached letter.

DIRECTED: By 5/1/26: The home shall conduct an unannounced fire drill during the 11:00pm-7:00am shift utilizing the minimum number of staff persons to ensure all residents can evacuate to a public thoroughfare or to a fire-safe area designated in writing within the past year by a fire safety expert within the time specified in writing within the past year by a fire safety expert. If all residents are unable to evacuate within the time specified by the fire safety expert, immediate remedial action shall occur, which may include increasing the home's staffing levels to ensure compliance. If the fire drill is unsuccessful, the home shall conduct another unannounced fire drill within 5 calendar days. Documentation of all fire drills shall be kept in accordance with 2600.132c. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall review the direct care staffing schedule daily to ensure compliance with 2600.60a. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator shall re-educate all current staff persons on the home's fire drill procedures, which includes the location of all fire-safe areas. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/06/2026*

Not Implemented ([redacted] - 08/17/2026)

65e - 12 Hours Annual Training

7. 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 C, hired on [redacted], only received 6.5 hours of annual training during the 2025 training year.

Direct care staff person D, hired on [redacted], only received 6.5 hours of annual training during the 2025 training year.

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Current Admin. has implemented a new training schedule for year 2026 (see attached). The schedule will monitor all training completed and the date when it was completed. The new schedule template will make sure that staff recieve all trainings on time and are in compliance.
Admin. has implemented this new training guide in order to avoid past errors from 2025 occuring again in 2026. Trainings are spread out throughout the year (see schedule attatched) and a strict monitoring system is followed by the office manager and Admin. to ensure all hours are met. Training files will be audited quarterly by office manager and Admin. to ensure all trainings were given. (DIRECTED: The quarterly audits shall begin on 5/1/26 to ensure all direct care staff persons receive at least 12 hours of annual training during each training year in accordance with 2600.65e. [redacted] 4/22/26).
Admin. will keep all records in appropriate folder in main office.

DIRECTED: By 5/5/26: The administrator shall provide an additional 5.5 hours of training to direct care staff persons C and D that is related to their job duties. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/05/2026*

Implemented [redacted] - 08/17/2026)

65f - Training Topics

8. Requirements

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

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

Description of Violation

Direct care staff person C, hired on [redacted], did not receive training on the following topics during the 2025 training year:

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*

65f Training Topics (continued)

- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration*
- *Personal care service needs of the resident*
- *Safe management techniques*

Direct care staff person D, hired on [redacted] did not receive training on the following topics during the 2025 training year:

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration*
- *Personal care service needs of the resident*
- *Safe management techniques*

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Previous Admin. was the one designated to do the trainings in 2025. Seems like [redacted] has not logged the trainings properly. Current Admin. has implemented a training schedule which will prevent any confusion as in the past admin. Staff received VDT and Dementia experience training on 2/26/2026. (see Attached) Additional trainings to meet required annual training is scheduled monthly. Currently Hope Hospice will be holding additional training June 2026 and July 2026.

Training files will be audited quarterly by Admin. to ensure all trainings were given and were done properley with full attendance.

Admin. will keep all records in designated folder in main office. (DIRECTED: The quarterly audits shall begin on 5/1/26 to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. [redacted] 4/22/26).

DIRECTED: By 5/5/26: The administrator shall provide training to direct care staff persons C and D on all topics specified in 2600.65f. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] *4/22/26*

Proposed Overall Completion Date: 05/01/2026

Directed Completion Date: *05/05/2026*

Implemented [redacted] - 08/17/2026)

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:

65g - Annual Training Content *(continued)*

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
5. Falls and accident prevention.

Description of Violation

Direct care staff person C, hired on [redacted], did not receive training on the following topics during the 2025 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Falls and accident prevention*

Direct care staff person D, hired on [redacted], did not receive training on the following topics during the 2025 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Falls and accident prevention*

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Previous Admin. was the one designated to do the trainings in 2025. Seems like [redacted] has not logged the trainings properly. Current Admin. has implemented a training schedule which will prevent any confusion as in the past admin.
Staff C and D received training from fire expert. (see attached documents) (DIRECTED: Documentation of the fire safety training provided to direct care staff persons C and D by a fire safety expert shall be kept in accordance with 2600.65i. [redacted] 4/22/26). Scheduled training for falls prevention is scheduled for May 2026. (DIRECTED: By 5/5/26: The administrator shall provide training to direct care staff persons C and D on falls and accident prevention. Documentation of the training shall be kept in accordance with 2600.65i. [redacted] 4/22/26).
By Administrator/ office manager will continue to add monthly training to calendar to meet annual training requirement. Full calendar will be completed 4/30/2026 once dates are confirmed by various trainers.
Training files will be audited quarterly by Admin. to ensure all trainings were given and were done properley with full attendance.
Admin. will keep all records in designated folder in main office. (DIRECTED: The quarterly audits shall begin on 5/1/26 to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. [redacted] 4/22/26).

Proposed Overall Completion Date: 04/30/2026

Directed Completion Date: *05/05/2026*

Not Implemented [redacted] - 08/17/2026)

65i - Training Record

10. Requirements

2600.

65i - Training Record *(continued)*

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

Description of Violation

The home's record of training, titled, "Dementia-what is Dementia?" does not include the date or content of the course.

The home's record of training, titled "Diabetic training", dated [redacted], does not include the length of course.

The home's record of training, titled "Reportable incidents training 2025", does not include the training source, the date or the length of the course.

The home's record of training, titled, "Medication self admin", does not include the content of the course or the date.

The home's record of training, titled, "fire extinguishers, alarm, exit, evac plan", dated [redacted], does not include the training source.

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Administrator / Office Manager will ensure a record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, are kept. Office Manager is in the process of updating training records.
Sign in log was not kept by the previous administrator. Administrator/ office manager will continue to add monthly training to the current calendar to meet annual training requirement. Full calendar will be completed 4/30/2026 once dates are confirmed by various trainers.
Training files will be audited quarterly by Admin. to ensure all trainings were given and were done properley with full attendance.
Admin. will keep all records in appropriate folder in main office. (DIRECTED: The quarterly audits shall begin on 5/1/26 to ensure accurate and complete training records are present in accordance with 2600.65i. [redacted] 4/22/26).

DIRECTED: By 5/1/26: The administrator shall update all training records specified in this violation to ensure accurate and complete training records are present in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 05/01/2026

Directed Completion Date: *05/01/2026*

Implemented [redacted] 08/17/2026)

82c - Locking Poisonous Materials

11. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

On [redacted] at 10:20am, there were 11 one-gallon cans of various paints and 1 five-gallon bucket of white paint with manufacture labels indicating "If swallowed get medical attention immediately ", unlocked, unattended and accessible to residents in the sun porch/medication cart room. The entire home is licensed as a SDCU and numerous residents, including resident[redacted] have not been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Directed [redacted] 04/22/2026)***

Immediate action was taken and all paint was removed from the locked med room and place in the basement and locked closet. All staff will keep poisonous materials locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.
On 03/05/2025, Admin ([redacted] trained all day staff on the regulation concerning the storage and handling of poisonous materials.
P. Moran conducted training for the night shift on the same date to ensure comprehensive coverage.
Quarterly Audits will be conducted by the Admin. and office manager to ensure materials are secured. In addition Admin. will hold random checks to verify procedure adherence. All training sessions are documented in compliance with regulation 2600.65i. and will be placed in main office.

DIRECTED: By 5/5/26: The administrator shall ensure all current staff persons have been re-educated on ensuring all poisonous materials are kept in an area that is locked. Documentation of all staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: Beginning on 4/27/26: The administrator/designee shall inspect the entire home daily for 1 week then weekly thereafter to ensure all poisonous materials are kept in an area that is locked. [redacted] 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/05/2026*

Implemented [redacted] - 08/17/2026)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On [redacted] at 10:55am, there were no paper towels, hand dryer or sanitary means to dry hands present in the 2nd floor common bathroom near bedroom [redacted]

Plan of Correction ***Directed [redacted] - 04/22/2026)***

Immediate action was taken and paper towels were placed in the upstairs bathroom 4/24/2026. Admin. ([redacted] has then conducted on 4/24/26 a review of the regulation (85.a) with all staff members. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26).
Caregivers on duty have been scheduled to inspect prior to starting their shift all bathrooms confirmiong sanitory is

85a - Sanitary Conditions (continued)

in compliance including having adequate paper towels in bathrooms.
Admin. ([redacted] will do a daily walkthrough to insure that regulation has been met. Admin. will keep a log in the main office of inspection results. (DIRECTED: The daily walkthroughs shall begin on 4/27/26. [redacted] 4/22/26).

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/27/2026*

Not Implemented [redacted] ***- 8/17/2026)***

101j2 - Bedroom Chairs

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

On [redacted] *at 10:38am, only 1 chair was present in bedroom* [redacted] *which is occupied by 2 residents.*

Plan of Correction ***Directed*** [redacted] ***- 04/22/2026)***

All rooms have been inspected by the Administrator on February 23, 2026. During this inspection A chair was added to Bedroom [redacted] *on this date. (02/23/26). It was verified that the appropriate number of chairs were present in all bedrooms.*
Moving forward, the Office Manager, [redacted] *will conduct bi-weekly inspections to ensure that all rooms comply with the following:*
Sanitary and cleanliness standards. (DIRECTED: The bi-weekly inspections of all resident bedrooms shall begin on 4/27/26. [redacted] *4/22/26).*
The presence of the appropriate number of chairs and lamps.

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/27/2026*

Implemented [redacted] ***- 08/17/2026)***

103f - Refrigerator/Freezer Temps

14. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On [redacted] *at 11:05am, there was no thermometer present in the basement chest freezer.*

Plan of Correction ***Directed*** [redacted] ***- 04/22/2026)***

A Thermometer was placed in the basement freezer on 2/24/26 by Admin. [redacted]
All other refrigeraters and freezers were inspected by Admin. on 2/24/26 ensuring food requiring refrigeration is stored at or below 40°F, and frozen food is kept at or below 0°F, and thermometers are currently present in refrigerators and freezers. Admin. has also ordered additional thermometers which were placed in the office in case of any thermostat that defaults, so kitchen personnel can replace it immediately.

103f - Refrigerator/Freezer Temps (continued)

Basement freezer chest was unplugged on 02/23/26 as its not in use all year round.
Kitchen manager ([redacted] will conduct daily inspections when arriving at the facility and before leaving, in order to make sure thermostat are in good condition. Kitchen manager will document this in safety/compliance log for Admin. to review.
Admin. will keep logs in office and inspect daily. (DIRECTED: The daily audits of all refrigerators/freezers shall begin on 4/27/26 to ensure compliance with 2600.103f. [redacted] 4/22/26).

DIRECTED: By 5/5/26: The administrator shall re-educate all current staff persons on proper food handling temperatures in refrigerators/freezers in accordance with 2600.103f. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26.

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/05/2026*

Implemented ([redacted] - 08/17/2026)

103g - Storing Food

15. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On [redacted] at 9:50am, there was an opened and unsealed box of Thin Mint girl scout cookies present on the kitchen shelving unit.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

The cookies were immediately thrown away on 2/23/26. Admin. ([redacted] has conducted a review food safety handling regulations, including 103.g together with kitchen staff and all personell on 2/25/26
Admin. has kept documentation in the appropriate binder.
All staff will ensure food is stored in closed or sealed containers on a daily basis. Cook [redacted] will be responsible to chack daily that kitchen stays in compliance and report in daily log which will be kept in the main office. (DIRECTED: The daily audits shall begin on 4/27/26 to ensure compliance with 2600.103g. [redacted] 4/22/26).

Admin. will review the log bi weekly to ensure compliance

DIRECTED: By 5/5/26: The administrator shall re-educate all current staff persons on proper food storage procedures in accordance with 2600.103g. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26.

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/05/2026*

Not Implemented ([redacted] - 08/17/2026)

121a - Unobstructed Egress

16. Requirements

121a Unobstructed Egress *(continued)*

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 10:50am, a large 4 tier shelving unit was present at the bottom of the staircase leading from the 2nd floor to the 1st floor, blocking this egress route.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

On 2/23/2026 the 4 tier shelving unit was removed immediately. The staircase is now completely clear .
Admin. ([redacted] has conducted training and regulation review with all staff members on 2/24/26 and has kept the documentation in main office.
Admin. will conduct once a month compliance review training with all staff. Next review is scheduled on 5/24/26.
Admin. will keep a log of all training. In addition Admin. will conduct daily walkthroughs to ensure all spaces are in compliant with 2600.65i

DIRECTED: Beginning on 4/27/26: The administrator/designee shall inspect the entire home daily for 1 week then weekly thereafter to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed in accordance with 2600.121a. [redacted] 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/27/2026*

Not Implemented ([redacted] - 08/17/2026)

127a Portable Space Heaters

17. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On [redacted] at 11:40am, there was a portable space heater present in the medication room.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Immediate action was taken and space heater was removed by administrator.
Responsible Person: Admin. ([redacted] has held a compliance re-education on 2/25/26 with all staff members which included 2600 65i regarding the prohibition of portable space heaters.
Records of the education sessions are maintained in the main office adherence to regulation 2600.65i.
Office manager ([redacted] will conduct Monthly room inspections focusing on validating compliance with safety regulations. (DIRECTED: The monthly audit of resident bedrooms shall begin on 4/27/26 and include an inspection of all resident bedrooms during each audit to ensure compliance with 2600.127a. [redacted] 4/22/26).
Inspection results will be documented and reviewed by the office manager to ensure ongoing adherence.
Admin. will Incorporate reminders in monthly staff meetings to reinforce the absence of space heaters and compliance with all safety protocols.
Next meeting should be held on 5/25/26

127a - Portable Space Heaters (continued)

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/27/2026*

Implemented (- 08/17/2026)

129a - Fireplace Screens

18. Requirements

2600.
129.a. A fireplace must be securely screened or equipped with protective guards while in use.

Description of Violation

On at 10:09am, no protective screen was present on the 1st floor dining room fireplace, which was in use at the time of inspection and measured 190 degrees Fahrenheit in the front of the fireplace.

Plan of Correction ***Directed (- 04/22/2026)***

The heating element was disabled and now the fire place is used only for decoration.
Worker Paul has disabled the fire place on 02/23/26.
Admin. will review and audit the space once a month to make sure facility is in compliant with 129.a. (DIRECTED: The monthly audits shall begin on 4/27/26. 4/22/26).
If there will be a need of using the fireplace, Admin. will order protective guards pursuant to 2600 129a. to ensure residents safety

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/20/2026*

Implemented (- 08/17/2026)

132a - Monthly Fire Drill

19. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the following months:

- *December, 2025*
- *October, 2025*
- *August, 2025*
- *July, 2025*
- *June, 2025*

Plan of Correction ***Directed (- 04/22/2026)***

Monthly fire drills will be completed monthly starting immediately.

132a - Monthly Fire Drill (continued)

Last Admin. was in charge but did not complete the task. Pls. see attached fire drill records showing that we have been in compliance for 2026. staff supervisor Paul and [redacted] will be in charge of compliance going forward including 1 overnight drill. Please see attached.

DIRECTED: Beginning on 5/1/26: The administrator shall review all fire drill records monthly to ensure an unannounced fire drill is conducted at least monthly. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *04/27/2026*

Implemented ([redacted] - 08/17/2026)

132d - Evacuation

20. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The most recent documentation from a fire safety expert, dated [redacted], indicates a maximum evacuation time to the home's fire-safe areas of 3 minutes, 45 seconds; however, the evacuation time during the following fire drills exceeded this time:

- *The evacuation time for the fire drill conducted on [redacted] at 3:00pm was conducted in 8 minutes, 15 seconds*
- *The evacuation time for the fire drill conducted on [redacted] at 2:30pm was conducted in 10 minutes, 3 seconds*

The documentation from a fire safety expert, dated [redacted], indicates a maximum evacuation time to the home's fire-safe areas of 4 minutes, 50 seconds; however, the evacuation time for the fire drill conducted on [redacted] at 1:30pm was conducted in 7 minutes, 21 seconds.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Administrator has reached out to the fire expert to adjust the time. A new document is attatched herein where the fire safety expert has updated the info. This was completed as well as new inspection and fire drill was conducted at 3pm on 4/21/2026. See attached letter and drill sheet. New letter is 8 mins 39 seconds with 2 staff. Supervisor Med Tech Paul/ Administrator will be insuring all compliance,

DIRECTED: By 5/1/26: The home shall conduct an unannounced fire drill during the 11:00pm-7:00am shift utilizing the minimum number of staff persons to ensure all residents can evacuate to a public thoroughfare or to a fire-safe area designated in writing within the past year by a fire safety expert within the time specified in writing within the past year by a fire safety expert. If all residents are unable to evacuate within the time specified by the fire safety expert, immediate remedial action shall occur, which may include increasing the home's staffing levels to ensure compliance. If the fire drill is unsuccessful, the home shall conduct another unannounced fire drill within 5

132d Evacuation (continued)

calendar days. Documentation of all fire drills shall be kept in accordance with 2600.132c. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator shall re educate all current staff persons on the home's fire drill procedures, which includes the location of all fire safe areas. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator shall review all fire drill documentation monthly to ensure compliance with 2600.132d. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/06/2026*

Not Implemented ([redacted] - 08/17/2026)

132e - Fire Drill Sleeping Hours

21. Requirements

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

Description of Violation

The most recent fire drill conducted during sleeping hours was held on [redacted] at 3:00am.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

An overnight drill was completed in March 2026. See attached document. Drill was held 3/20/2026 at 630am. 14 residents and 2 staff. I staff member arrived in the middle of the drill to assist. Time was 6 mins 9 sec. Monthly fire drills will be completed monthly starting immediately.
Pls. see attached fire drill records showing that we have been in compliance for 2026. staff supervisor Paul and [redacted] will be in charge of compliance going forward. following up with monthly audits to ensure fire drills were inndeed done and documented properley. Please see attached.

DIRECTED: By 5/1/26: The home shall conduct an unannounced fire drill during the 11:00pm 7:00am shift utilizing the minimum number of staff persons to ensure all residents can evacuate to a public thoroughfare or to a fire safe area designated in writing within the past year by a fire safety expert within the time specified in writing within the past year by a fire safety expert. If all residents are unable to evacuate within the time specified by the fire safety expert, immediate remedial action shall occur, which may include increasing the home's staffing levels to ensure compliance. If the fire drill is unsuccessful, the home shall conduct another unannounced fire drill within 5 calendar days. Documentation of all fire drills shall be kept in accordance with 2600.132c. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator shall re educate all current staff persons on the home's fire drill procedures, which includes the location of all fire safe areas. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator shall review all fire drill documentation monthly to ensure compliance with 2600.132e. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

132e Fire Drill Sleeping Hours *(continued)*

Directed Completion Date: *05/06/2026*

Not Implemented (- 08/17/2026)

141b1 - Annual Medical Evaluation

22. Requirements

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

Description of Violation

Resident s most recent medical evaluation was completed on however, resident s previous medical evaluation was completed on Also, resident s most recent medical evaluation, dated , does not indicate a need for resident to be served in a SDCU. The entire home is licensed as a SDCU.

Resident s most recent medical evaluation, dated , is blank in numerous areas, to include the following:

- *Allergies*
- *Pulse rate*
- *The medical license number for the medical professional who completed the medical evaluation*
- *The signature of the medical professional who completed the medical evaluation*
- *The date the medical professional completed the medical evaluation*

Resident s most recent medical evaluation, dated , does not indicate a need for resident to be served in a SDCU. The entire home is licensed as a SDCU.

Resident s most recent medical evaluation, dated , is blank in numerous areas, to include the following:

- *Pulse rate*
- *Body positioning/movement*
- *The medical license number for the medical professional who completed the medical evaluation*
- *The signature of the medical professional who completed the medical evaluation*

REPEAT VIOLATION:

Plan of Correction ***Directed (- 04/22/2026)***

The Administrator will be ensuring each resident has a medical evaluation annually and as needed.
Resident s and 4's most recent medical evaluation, is blank in numerous areas. Requested new evaluation will be completed by the IN HOUSE DOCTOR on next visit. Visit is scheduled 4/24/2026. Areas to be addressed will include the following:
Allergies
Pulse rate
The medical license number for the medical professional who completed the medical evaluation

141b1 - Annual Medical Evaluation (continued)

The signature of the medical professional who completed the medical evaluation
The date the medical professional completed the medical evaluation

Audit will be done annually by administrator to ensure compliance with regulation. 2600. 141.b.1. A resident shall have a medical evaluation: At least annually.

DIRECTED: By 5/5/26: The administrator shall review all current medical evaluations for all residents, including residents [redacted] and [redacted] to ensure each resident has an accurate and complete medical evaluation present and to ensure the need to be served in a SDCU is present on each medical evaluation for the residents who require the need to be served in a SDCU. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator shall develop and implement a tracking system to ensure all residents have a medical evaluation completed in its entirety at least annually. Documentation of the tracking system shall be kept. The tracking system shall be reviewed/updated by the administrator monthly. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator shall review all medical evaluations within 48 hours of completion to ensure accuracy and completeness. [redacted] 4/22/26

Proposed Overall Completion Date: 04/27/2026

Directed Completion Date: *05/05/2026*

Not Implemented ([redacted] - 08/17/2026)

162c - Menus Posted

23. Requirements

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

Description of Violation

On [redacted] at approximately 11:00am, the only menu posted in a conspicuous and public place in the home was a daily menu, dated 2/23/26.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

The Office Manager will prepare menus, stating the specific food being served at each meal for 1 week in advance and to follow the menu, and to post weekly menus 1 week in advance in a conspicuous and public place in the home. This was completed 2/24/2023 and has continued.
Admin. will follow up to ensure that office manager is up to date and in compliant with posting the menu in advance. Office manager will send a proposed copy for Admin. to review and approve prior to posting. Office manager will have to check off when menu is posted. Admin. will review each week. Log will be kept in main office.

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for generating and posting menus on the requirements specified in 2600.162c. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall inspect the home at least weekly to ensure

162c - Menus Posted (continued)

compliance with 2600.162c. [redacted] 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/01/2026*

Not Implemented ([redacted] - 08/17/2026)

184a - Resident's Meds Labeled

24. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On [redacted], there was no pharmacy label present on resident [redacted]s [redacted].

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Any prescription that are in cart pharmacy health direct pharmacy or hospice pharmacy will be contacted by head med tech. Head med tech will keep in med cart audit binder
Med Tech immediately labeled the medication on 2/23/2026. The Med Techs will be ensuring the original container for prescription medications will be labeled with a pharmacy label that includes correction was made on 2/24/26

, including
the resident's name
, and
the name of the medication
, and
the date the prescription was issued
, and
the prescribed dosage and instructions for administration
, and
the name and title of the prescriber

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator/designee shall review all of resident [redacted]s medications, including resident [redacted]s Albuterol, to ensure accurate and complete pharmacy labels are present in accordance with 2600.184a. [redacted] 4/22/26

DIRECTED: By 5/5/26: The administrator shall re-educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes ensuring accurate and complete pharmacy labels are present on all prescribed medications. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

184a Resident's Meds Labeled (continued)

DIRECTED: By 5/1/26: The administrator/designee shall review all current medications for all residents to ensure accurate and complete pharmacy labels are present on all prescribed medications in accordance with 2600.184a. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall audit the medications for at least 3 different residents weekly for 1 month then monthly thereafter to ensure compliance with 2600.184a. Documentation of the audits shall be kept for 1 month. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/08/2026*

Implemented ([redacted] - 08/17/2026)

184b - Labeling OTC/CAM

25. 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 [redacted] resident [redacted]s bottle of [redacted], which were stored in the home's medication cart, did not include resident [redacted]s name.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Med Techs will be ensuring if the OTC medications and CAM belong to the resident, they will be identified with the resident's name. All medication were completed on 2/24/2026 was corrected by Paul Moran before the inspector. Supervisor Med Tech will be checking this during weekly cart audit.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator/designee shall review all of resident [redacted]s medications, including resident [redacted]s Tylenol, to ensure accurate and complete pharmacy labels are present and to ensure all OTC medications for resident [redacted] are labeled with the resident's name. [redacted] 4/22/26

DIRECTED: By 5/5/26: The administrator shall re educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes ensuring resident names are present on all OTC medications. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator/designee shall review all current medications for all residents to ensure accurate and complete pharmacy labels are present on all prescribed medications, and to ensure all OTC medications are labeled with the resident's name. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall audit the medications for at least 3 different residents weekly for 1 month then monthly thereafter to ensure compliance with 2600.184b. Documentation of the audits shall be kept for 1 month. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/08/2026*

Implemented ([redacted] - 08/17/2026)

184b Labeling OTC/CAM *(continued)*

185a - Implement Storage Procedures

26. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [redacted], the following medications prescribed to resident [redacted] were not present in the home and available for administration:

- *[redacted] tablet Take 1 tablet by mouth every 12 hours as needed for [redacted]*
- *[redacted] tablet Take 1 tablet by mouth every 8 hours as needed for [redacted]*

On [redacted], resident [redacted]s [redacted] tablet Dissolve 1 tablet under tongue every 4 hours as needed for nausea was not present in the home and available for administration.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Med Techs / Administrator will be ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons
2/25/26 they were delivered to the home.
2/25/26 all meds were again reviewed on 2/26/2026. We no more use multiple pharmacies for regular medications to avoid conflict when medication is entered on MAR and delivered to the home. The only prescriptions not from pharmacy are compound and care meds those come from the Hospice Pharmacy Admin. responsible. Education for all med techs has been schedule using Health Direct and Commonwealth Hospice for May 2026.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator/designee shall review all of resident [redacted] and [redacted]s medications to ensure all prescribed medications are present in the home and available for administration. [redacted] 4/22/26

DIRECTED: By 5/5/26: The administrator shall re educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes the home's procedures for ensuring medications are reordered prior to depleting the current supply. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator/designee shall review all current medications for all residents to ensure all medications are present in the home and available for administration. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall audit the medications for at least 3 different residents weekly for 1 month then monthly thereafter to ensure medications are present in the home and available for administration. Documentation of the audits shall be kept for 1 month. [redacted] 4/22/26

Proposed Overall Completion Date: 05/31/2026

185a - Implement Storage Procedures *(continued)*

Directed Completion Date: *05/08/2026*

Not Implemented (- 08/17/2026)

186a - Authorized Prescriber

27. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On , there was no current prescription order present in the home for resident s cream, which was present in the home's medication cart at the time of inspection.

Plan of Correction ***Directed (- 04/22/2026)***

Med Techs / Administrator will be ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons

2/25/26 they were added to the MAR.
2/25/26 all meds were again reviewed on 2/26/2026. We no more use multiple pharmacies for regular medications to avoid conflict when medication is entered on MAR and delivered to the home. The only prescriptions not from pharmacy are compound and care meds those come from the Hospice Pharmacy Admin. responsible. Education for all med techs has been schedule using Health Direct and Commonwealth Hospice for May 2026.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall ensure a current copy of resident s BHR cream is present in resident s record. 4/22/26

DIRECTED: By 5/5/26: The administrator shall re-educate all staff persons qualified to administer medications on the home's procedures for ensuring copies of all current prescription orders are present in each resident's record. Documentation of the staff education shall be kept in accordance with 2600.65i. 4/22/26

DIRECTED: By 5/1/26, then quarterly thereafter: The administrator/designee shall review all resident records to ensure copies of all current prescription orders are present in each resident's record. 4/22/26

Proposed Overall Completion Date: 05/31/2026

Directed Completion Date: *05/05/2026*

Implemented (- 08/17/2026)

187a - Medication Record

28. Requirements

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

187a Medication Record *(continued)*

6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

According to resident [redacted]s controlled drug record, resident [redacted] is prescribed [redacted] cream Apply 1ml topically to inner wrist or back of neck every 4 hours as needed for [redacted] however, this medication is not indicated on resident [redacted]s February 2026 medication administration record (MAR). According to the controlled drug record, this medication was administered to resident [redacted] on [redacted] at 10:00pm and on [redacted] at 5:00pm.

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Med Techs / Administrator will be ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons
2/26/26 everything was added to the MAR and audit was performed to ensure everything match by supervisor med tech.
2/25/26 all meds were again review. We no longer use multiple pharmacies for regular medications to avoid conflict when medication is entered on MAR and delivered to the home. The only prescriptions not from pharmacy are compound and care meds those come from the Hospice Pharmacy Admin. responsible. Education for all med techs has been schedule using Health Direct and Commonwealth Hospice for May 2026. Supervisor Med Tech will ensure compliance by weekly audit and 2x review of all care meds.

DIRECTED: By 5/5/26: The administrator shall re educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes the home's procedures for updating resident MAR's immediately upon receipt of a new order. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] *4/22/26*

DIRECTED: Beginning on 5/1/26: The administrator/designee shall audit the medications and MAR's for at least 3 different residents weekly for 1 month then monthly thereafter to ensure compliance with 2600.187a. Documentation of the audits shall be kept for 1 month. [redacted] *4/22/26*

Proposed Overall Completion Date: 05/31/2026

187a - Medication Record *(continued)*

Directed Completion Date: *05/08/2026*

Not Implemented (- 08/17/2026)

187b - Date/Time of Medication Admin.

29. 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

Resident is currently prescribed -Take 1 tablet by mouth daily at bedtime. This medication has not been administered to resident since ; however, staff persons documented the medication as being administered on resident s February 2026 MAR on 6 and

On numerous occasions, direct care staff persons E and F used direct care staff person C's log-in credentials in the home's electronic MAR system to document medication administrations to numerous residents, to include the following. At the time of these medication administrations, direct care staff person C was not present in the home and did not administer the medications to residents or

- *At approximately 8:00pm on and direct care staff person F administered a , an and a to resident however, documented the medication administrations on resident s February 2026 MAR using direct care staff person C's log-in credentials*
- *At approximately 8:00pm on , direct care staff person E administered a tablet, an tablet and a to resident however, documented the medication administrations on resident s February 2026 MAR using direct care staff person C's log-in credentials*
- *At approximately 8:00pm on and direct care staff person F administered a and a to resident however, documented the medication administrations on resident s February 2026 MAR using direct care staff person C's log-in credentials*
- *At approximately 8:00pm on , direct care staff person E administered a and a tablet to resident however, documented the medication administrations on resident s February 2026 MAR using direct care staff person C's log-in credentials*
- *At approximately 8:00pm on and , direct care staff person F administered a tablet and a tablet to resident however, documented the medication administrations on resident s February 2026 MAR using direct care staff person C's log-in credentials*
- *At approximately 8:00pm on direct care staff person E administered a tablet and a tablet to resident however, documented the medication administrations on resident s February 2026 MAR using direct care staff person C's log-in credentials*

REPEAT VIOLATION:

Plan of Correction ***Directed (- 04/22/2026)***

Administrator had a retraining with all med techs to insure compliance. Med Techs/ Administrator will be ensuring the information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. The Med Techs did have credentials but were not using them, Administrator observed that log ins were working. Both Tech

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

were place on 30 day probation. Correct log in were used going forward. Going forward all Techs will have their own log in before starting their 1st training shift. Passwords for all med checks have been changed on 4/26/2026.

DIRECTED: By 5/1/26: The administrator shall develop and implement procedures for enrolling new staff persons who are qualified to administer medications into the home's electronic MAR system using their own username and password. The procedures shall include ensuring other employee log in credentials are never shared with any other person. Documentation of the procedures shall be kept, and the administrator shall re educate all staff persons qualified to administer medications on the new procedures by 5/5/26. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

DIRECTED: By 5/5/26: The administrator shall re educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes proper, complete and accurate medication administration documentation in accordance with 2600.187b. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall audit the MAR's for at least 3 different residents weekly for 1 month then monthly thereafter to ensure compliance with 2600.187b. Documentation of the audits shall be kept for 1 month. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/08/2026*

Not Implemented ([redacted] - 08/17/2026)

187d - Follow Prescriber's Orders

30. Requirements

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

Description of Violation

Resident [redacted] is currently prescribed [redacted] Take 1 tablet by mouth daily at bedtime; however, this medication has not been administered to resident [redacted] since [redacted], because the medication is not present in the home and available for administration.

Resident [redacted] is currently prescribed [redacted] tablet Take 1 tablet by mouth once daily in the evening; however, this medication has not been administered to resident [redacted] since [redacted] because the medication is not present in the home and available for administration.

Resident [redacted] is currently prescribed [redacted] Inject subcutaneously 3 times daily before meals (15 minutes before eating) per sliding scale: [redacted] and notify physician. According to resident [redacted]s February 2026 MAR, the current physician order was not followed on numerus occasions, to include the following:

- *On [redacted] and [redacted] at 5:00pm, resident [redacted]s blood glucose was not taken, so it is unable to be determined if resident [redacted] should have received insulin*
- *On [redacted] at 5:00pm, resident [redacted]s blood glucose was [redacted] and received [redacted] of insulin; however, resident [redacted]s physician was not notified of this blood glucose reading*
- *On [redacted] at 5:00pm, resident [redacted]s blood glucose was [redacted] and should have received [redacted] of insulin;*

187d - Follow Prescriber's Orders (continued)

however, resident [redacted] only received 6 units of insulin

REPEAT VIOLATION:[redacted]

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Administrator had a retraining with all med techs to insure compliance. Med Techs will be ensuring the home must follow the directions of the prescriber.Med Techs / Administrator will be ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons
2/25/26 all medications were in the home and matched the MAR.
All meds were again reviewed on 2/26/2026. We no more use multiple pharmacies for regular medications to avoid conflict when medication is entered on MAR and delivered to the home. The only prescriptions not from pharmacy are compound and care meds those come from the Hospice Pharmacy Admin. responsible. On 2/26/2026 Hospice nurse reviewed with all med techs to ensure accurate and complete blood sugar readings are obtained and proper amount of insulin is administered. Our annual training is currently scheduled for Aug 2026.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall review all medications for residents [redacted] and [redacted] to ensure all prescribed medications are present in the home and available for administration. [redacted] 4/22/26

DIRECTED: By 5/1/26: The administrator/designee shall review all current medications for all residents to ensure all prescribed medications are present in the home and available for administration. [redacted] 4/22/26

DIRECTED: Beginning on 5/1/26: The administrator/designee shall audit the medications and MAR's for at least 3 different residents weekly for 1 month then monthly thereafter to ensure compliance with 2600.187d. Documentation of the audits shall be kept for 1 month. [redacted] 4/22/26

DIRECTED: By 5/5/26: The administrator shall re-educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes the home's procedures for ensuring medications are reordered prior to depleting the current supply and ensuring accurate and complete blood glucose documentation is obtained. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 08/31/2026

Directed Completion Date: *05/08/2026*

Not Implemented ([redacted] - 08/17/2026)

221c - Post Activity Calendar

31. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

On 2/23/26, no current weekly activity calendar was posted in a conspicuous and public place in the home.

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Activity calendar was updated and posted 4/23/2024 by office manager . Office manager will be insuring that

221c Post Activity Calendar (continued)

calendar is posted and updated as needed.
Admin. will follow up weekly on the activities schedule. Will conduct weekly inspection and monitor compliance (DIRECTED: The administrator weekly audits shall begin on 4/27/26 to ensure compliance with 2600.221c. [redacted] 4/22/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/27/2026*

Implemented ([redacted] - 08/17/2026)

225a - Assessment 15 Days

32. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [redacted]s assessment, dated [redacted], does not include an assessment of resident [redacted]s supervision or medication needs. These sections of resident [redacted]s assessment are blank. Also, resident [redacted]s assessment does not include any of the medical diagnoses indicated on resident [redacted]s medical evaluation, dated [redacted], to include the following:

- [redacted]
- [redacted]
- [redacted]

Resident [redacted]s assessment, dated [redacted], does not include numerous diagnoses indicated on resident [redacted]s medical evaluation, dated [redacted], to include [redacted] and [redacted].

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Office Manager / Administrator will be ensuring each resident has a written initial assessment that is documented on the Department's assessment form within 15 days of admission. Audit of all resident files was performed and completed 3/4/2026 by office manager. Assessments were updated and completed on 3/6/2026 by office manager and in house Doctor. The administrator will be performing annual audit and office Manager will be performing quarterly audit to insure compliance. (DIRECTED: The quarterly reviews of all resident assessments shall begin on 5/1/26 to ensure each resident has an accurate and complete assessment present. [redacted] 4/22/26)

DIRECTED: By 5/1/26: The administrator shall re educate all staff persons responsible for completing resident assessments to ensure accuracy and completeness in accordance with 2600.225a. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/01/2026*

Not Implemented ([redacted] - 08/17/2026)

225c - Additional Assessment

33. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident [redacted]s most recent assessment is dated as [redacted]; however, is also dated by the assessor as being completed on 9/25/25. Also, resident [redacted]s assessment does not include numerous diagnoses as indicated on resident [redacted]s most recent medical evaluation, dated [redacted], to include [redacted] and [redacted].

Resident [redacted]s most resent assessment, dated [redacted], does not include numerous diagnoses as indicated on resident [redacted]s most recent medical evaluation, dated [redacted] to include [redacted] and [redacted].

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Audit of all resident files was performed and completed 3/4/2026 by office manager. Assessments were updated and completed on 3/6/2026 by office manager and in house Doctor. The administrator will be performing annual audit and office Manager will be performing quarterly audit to insure compliance. (DIRECTED: The quarterly reviews of all resident assessments shall begin on 5/1/26 to ensure each resident has an accurate and complete assessment present. [redacted] 4/22/26)

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing resident assessments to ensure accuracy and completeness in accordance with 2600.225c. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/01/2026*

Not Implemented ([redacted] - 08/17/2026)

226a - Mobility Assessment

34. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident [redacted]s assessment, dated [redacted], indicates resident [redacted] is minimally mobile; however, the entire home is licensed as a SDCU and resident [redacted] requires assistance from staff persons to evacuate.

Resident [redacted]s most recent assessment, which is dated by the assessor as being completed on [redacted] indicates resident [redacted] is independently mobile; however, the entire home is licensed as a SDCU and resident [redacted] requires assistance from staff persons to evacuate.

226a - Mobility Assessment (continued)

Plan of Correction ***Directed (- 04/22/2026)***

Administrator / Office Manager ensuring each resident is assessed for mobility needs as part of the resident's assessment. Correction were made by the administrator on 3/6/2026. Audit of all resident files was performed and completed 3/4/2026 by office manager. Assessments were updated and completed on 3/6/2026 by office manager and in house Doctor. The administrator will be performing annual audit and office Manager will be performing quarterly audit to insure compliance. (DIRECTED: The quarterly reviews of all resident assessments shall begin on 5/1/26 to ensure each resident has an accurate and complete assessment present, which includes an accurate mobility needs assessment. 4/22/26)

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing resident assessments to ensure an accurate assessment of resident mobility needs is present on resident assessments. Documentation of the staff education shall be kept in accordance with 2600.65i. 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/01/2026*

Not Implemented (- 08/17/2026)

227h - Support Plan Refuse Sign

35. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident s support plan, dated , is not signed by resident and does not indicate if resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident s most recent support plan, which is dated by the assessor as being completed on is not signed by resident and does not indicate if resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident s most recent support plan, dated , is not signed by resident and does not indicate if resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Directed (- 04/22/2026)***

Administrator / Office Manager will be ensuring that if a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign is documented.
All current support plans have been reviewed and corrected as needed on 3/6/2026 and were also updated on same day as resident rights support plans were reviewed and signed by residents. Office Manager will be insuring compliance through audit of all files every quarter. (DIRECTED: The quarterly reviews of all resident support plans

227h - Support Plan Refuse Sign (continued)

shall begin on 5/1/26 to ensure compliance with 2600.227g and 2600.227h. [redacted] 4/22/26)

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing resident support plans to ensure all applicable signatures are obtained at the time of completion in accordance with 2600.227g and to ensure if a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented on the support plan in accordance with 2600.227h. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/01/2026*

Implemented ([redacted] 08/17/2026)

231b - Medical Evaluation

36. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the SDCU on [redacted]; however, resident [redacted] medical evaluation was completed on [redacted] Resident [redacted] medical evaluation also does not include a diagnosis of [redacted] or [redacted] and indicates resident [redacted] does not require secured dementia care. Additionally, resident [redacted] medical evaluation does not include the following:

- *The medication addendum section indicates "see copy of [redacted] med list from office"; however, no medication list is attached*
- *A determination by the medical professional who completed resident [redacted] medical evaluation indicating the resident's needs can be met safety at the home. This section of resident [redacted] medical evaluation is blank.*

Resident [redacted] was admitted to the SDCU on [redacted] Resident [redacted] medical evaluation, dated [redacted] does not include a diagnosis of [redacted] or [redacted] and does not indicate a need for resident [redacted] to be served in a SDCU.

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed ([redacted] 04/22/2026)***

Administrator / Office Manger will be ensuring residents have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission, and that documentation includes the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit. The medication addendum was added to the file on 3/6/2026 by the administrator and the in house Doctor. An audit of all files was completed by

231b - Medical Evaluation (continued)

office manager on 3/4/2026. Admin. and office manager will review files monthly to make sure compliance.

DIRECTED: By 5/5/26: The administrator shall review all current resident records, including residents #1 and #2's records, to ensure each resident has an accurate and complete medical evaluation present in accordance with 2600.231b, which includes the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a SDCU. Copies of the completed medical evaluations shall be kept in each resident's record. [redacted]/22/26

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for overseeing the completion of resident medical evaluations to ensure accuracy and completeness in accordance with 2600.231b. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]/22/26

DIRECTED: By 5/1/26: The administrator shall develop and implement a new admission checklist to ensure timely, complete and accurate medical evaluations are obtained at admission for all newly admitted residents in accordance with 2600.231b. Copies of the completed checklists shall be kept in each resident's record. [redacted]/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/05/2026*

Not Implemented ([redacted] 08/17/2026)

231c - Preadmission Screening

37. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] cognitive preadmission screening, dated [redacted] does not include the title of the person who completed the screening or resident [redacted] diagnoses. These sections of resident [redacted] cognitive preadmission screening are blank. Resident [redacted] was admitted to the SDCU on [redacted]

Resident [redacted] was admitted to the SDCU on [redacted] however, resident [redacted] cognitive preadmission screening was completed on [redacted] Also, resident [redacted] cognitive preadmission screening is blank under the diagnosis section.

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed [redacted] 04/22/2026)***

Administrator / Office Manager will be ensuring a written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form is completed for each resident within 72 hours prior to admission to a secured dementia care unit. All Files were audited by office manager and completed on 3/4/2026. Corrections were made 3/6/2026 by

231c - Preadmission Screening (continued)

administrator. Administrator will be performing annual audit to insure compliance. (DIRECTED: The annual audit of all resident records shall begin on 5/1/26. [redacted]4/22/26).

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing cognitive preadmission screenings to ensure accuracy and completeness in accordance with 2600.231c. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]4/22/26

DIRECTED: By 5/1/26: The administrator shall develop and implement a new admission checklist to ensure timely, complete and accurate cognitive preadmission screenings are obtained at admission for all newly admitted residents in accordance with 2600.231c. Copies of the completed checklists shall be kept in each resident's record. [redacted] 4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *04/21/2026*

Not Implemented [redacted]08/17/2026)

233c - Key-Locking Devices

38. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On [redacted]t approximately 10:30am, the directions for operating the locking mechanism on the gate in the home's exterior courtyard were not conspicuously posted near the courtyard gate.

Plan of Correction ***Directed ([redacted]04/22/2026)***

This was corrected and posted by the gate 2/24/2026 by the administrator.
Admin. has also inspected all doors at the facility on 2/24/26 to ensure they are in compiance. All doors in the home were found to be in compliance on 2/24/26
Office manager will inspect twice a week all doors of facility to ensure all are in compliant with 233.c. (DIRECTED: The weekly audits of all doors shall begin on 4/27/26. [redacted]4/22/26). Office manager will keep documentation in building compliant folder which will be reviewed weekly by Admin.

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *04/27/2026*

Not Implemented (LM - 08/17/2026)

234a - Admission Support Plan

39. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the SDCU on 3/25/25; however, resident #2's initial support plan was not completed

234a - Admission Support Plan (continued)

until 3/31/25.

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed ([redacted] 04/22/2026)***

Office Manager / Administrator will be ensuring that within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan is developed, implemented and documented in the resident record. Office manager completed audit of all files on 3/4/2026. Corrections were made by administrator3/6/2026. All support plans will be reviewed by administrator annually or as needed due to change. (DIRECTED: The annual audit of all resident records shall begin on 5/1/26. [redacted]/22/26).

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing resident support plans to ensure timeliness, accuracy and completeness in accordance with 2600.234a. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]4/22/26

DIRECTED: By 5/1/26: The administrator shall develop and implement a new admission checklist to ensure timely, complete and accurate resident support plans are obtained for all newly admitted residents in accordance with 2600.234a. Copies of the completed checklists shall be kept in each resident's record. [redacted]4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/01/2026*

Not Implemented ([redacted] - 08/17/2026)

234b - Support Plan Needs Elements

40. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident [redacted] support plan, dated [redacted] indicates "N/A" for numerous sections, to include the following:

- *Resident [redacted] assessment, dated [redacted], indicates resident [redacted] requires some physical assistance with bladder management; however, resident [redacted] support plan indicates "N/A" for the plan to meet this service need*
- *Resident [redacted] assessment, dated [redacted] indicates resident [redacted] is moderately immobile; however, resident [redacted] support plan indicates "N/A" for the description and plan to meet this service need*

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed ([redacted] - 04/22/2026)***

Administrator/ Office Manager ensuring the support plan identifies the resident's physical, medical, social, cognitive and safety needs. Assessments were corrected by the administrator. Review of all filles was completed by office manager 3/4/2026. Corrections were made by administrator and completed on 3/6/2026. All care plans will be reviewed annually to ensure compliance or as needed due to change and will be done by

234b - Support Plan Needs Elements (continued)

administrator. (DIRECTED: The annual audit of all resident records shall begin on 5/1/26. [redacted]4/22/26).

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing resident support plans to ensure accuracy and completeness in accordance with 2600.234b. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]/22/26

DIRECTED: Beginning on 5/5/26: The administrator shall review at least 5 different resident records each month to ensure each resident has an accurate and complete support plan present in accordance with 2600.234b. [redacted]4/22/26

Proposed Overall Completion Date: 04/21/2026

Directed Completion Date: *05/05/2026*

Not Implemented ([redacted] - 08/17/2026)

236 - Staff Training

41. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person C, hired on [redacted], only received approximately 1.5 hours of training related to dementia care and services during the 2025 training year. The entire home is licensed as a SDCU.

Direct care staff person D, hired on [redacted], only received approximately 1.5 hours of training related to dementia care and services during the 2025 training year. The entire home is licensed as a SDCU.

REPEAT VIOLATION: [redacted]

Plan of Correction ***Directed ([redacted] 04/22/2026)***

Office Manager / Administrator will be ensuring that each direct care staff person working in a secured dementia care unit has 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation). Training plan is in the process of being finalized for the year once trainers confirm all dates. VDT (2 hours of dementia training) was given on 2/26/2026. see attached . Office manager and administrator will be insuring scheduling of all required training and trainers. and review quarterley to make sure all is up to date. (DIRECTED: The quarterly audits shall begin on 5/1/26 to ensure all direct care staff persons receive at least 6 additional hours of annual training related to dementia care and services during each training year in accordance with 2600.236. LM 4/22/26).

DIRECTED: By 5/5/26: The administrator shall provide an additional 4.5 hours of training to direct care staff

236 - Staff Training (continued)

persons C and D related to dementia care and services. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]4/22/26

Proposed Overall Completion Date: 05/31/2026

Directed Completion Date: *05/05/2026*

Implemented ([redacted]08/17/2026)

251c - Standardized Forms

42. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #[redacted] most recent medical evaluation, dated [redacted]s not completed on the Department's current medical evaluation form.

Resident #[redacted] most recent medical evaluation, dated [redacted] is not completed on the Department's current medical evaluation form.

Plan of Correction ***Directed [redacted] 04/22/2026)***

Administrator will ensure that standardized forms to record information in the resident's record. Administrator is current working with the in house Doctor[redacted]) to insure all forms are correct and all corrections will be made on the Doctors next visit which is scheduled for 4/24/2026. Administrator will be performing annual audits to ensure compliance.

DIRECTED: By 5/1/26: The administrator shall ensure new medical evaluations are completed on the Department's current medical evaluation form for residents[redacted]and [redacted] Copies of the completed medical evaluations shall be kept in each resident's record. [redacted]/22/26

DIRECTED: By 5/1/26: The administrator shall re-educate all staff persons responsible for completing resident paperwork to ensure the Department's current forms are in use. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]4/22/26

DIRECTED: Beginning on 5/5/26: The administrator shall review at least 5 different resident records each quarter to ensure the Department's current forms are present.[redacted]/22/26

DIRECTED: By 5/5/26: The administrator/designee shall review all current resident records to ensure the Department's current forms, including the Department's current medical evaluation form, are present in each resident's record. [redacted]/22/26

Proposed Overall Completion Date: 04/27/2026

Directed Completion Date: *05/05/2026*

251c Standardized Forms *(continued)*

Not Implemented [redacted] 08/17/2026)

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

Facility Information

Name: *ORION PERSONAL CARE* **License #**: *45576* **License Expiration**: *07/09/2026*

Address: *2191 FERGUSON ROAD, ALLISON PARK, PA 15101*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *ORION CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *06/14/2024* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date**: *06/12/2026*

Inspection Dates and Department Representative

06/11/2026 On Site: [redacted]

06/12/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *15*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire home* **Capacity**: *25* **Residents Served**: *15*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *15* **Have Physical Disability**: *1*

Inspections / Reviews

06/11/2026 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *07/18/2026*

07/29/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/23/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/04/2026*

08/06/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/04/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/15/2026*

08/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

According to staff person A, the home's administrator, the fire department has responded to the home on numerous occasions, to include on [redacted] at approximately 7:45pm; however, none of these incidents were reported to the Department.

On [redacted], numerous controlled substances were discovered missing for residents [redacted] and [redacted] however, these incidents were not reported to the Department until[redacted]

According to the control record for resident [redacted]s [redacted] tablets, 1 tablet of Lorazepam was discovered missing on [redacted] and was reported to staff person A, the home's administrator, on the same day; however, this incident was not reported to the Department.

Repeated Violation-[redacted]

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

All staff was educated on 7/16-17, 2026 in regards to the regulation listed above pertaining to proper timeline on required reportable. this training was given by the administrator and will be kept in the staff training book located in the administrators office

A new policy was written on proper ways to handle Narcotics and when and who to notify if there is a concern. A audit was put in place to audit the narcotic count to ensure it is being done properly and all medication is accounted for at all times. This audit will be completed by the Administrator daily to ensure all reports are being completed and submitted timely.

Med-techs and administrative staff was educated on the policy on 7/15-16, 2026 by the administrator and this will be kept in the staff training book located in the administrator office for review at all times.
Administrator will complete the audit and audit will stay in the POC audit book for review.

A new policy was wrote to address proper reporting requirements for all reportable (2600.16) and all staff will educated on this policy by the administrator on 7/31/2026. This training will be kept in the staff training binder located in the administrators office for review at all times.

A reportable log will be kept in the med cart for all med-techs to log any reportable issues and this log will be reviewed by the administrator Monday-Friday and staff will notify administrator on Saturday and Sunday of any incident via phone. This will be implemented on 7/31/2026 This log will be pulled monthly from the med cart and

16c - Written Incident Report (continued)

filed in the POC audit book that will be kept in the administrators office for review at all times.

All med-techs will be educated on this log on 7/31/2026 by the administrator and education will be kept in the staff education binder located in the administrator office for review at all times.

A Quality management meeting will be held on 8/3/2026 at 3pm and the facility will continue these meetings the first Monday of the month for 12-months. The meeting will be held by the administrator and all departments will be represented at the meeting. The meeting notes and form will be kept in a binder located in the administrators office for review at all times (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 8/6/26)

DIRECTED: By 8/10/26: The administrator shall report all the incidents specified in this 2600.16c violation to the Department. Documentation of submission to the Department shall be kept. [redacted] 8/6/26)

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/10/2026*

Not Implemented ([redacted] - 08/17/2026)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff person B was hired on or around [redacted] however, a Pennsylvania criminal background check was not completed for direct care staff person B until [redacted]

Repeated Violation[redacted]

Plan of Correction ***Accept ([redacted] - 08/06/2026)***

Administrator audited all background checks on 7/14/2026and complete all background checks that were not done in a timely manner. Audit will be kept in the POC audit book located in the administrator office for review at all times

All administrative staff was educated by Consultant on 7/14/2026 on the regulation and requirements for completing background checks. A new policy was put in place to outline the required timeline for completing background checks and all administrative staff was educated by consultant on 7/14/2026 in regards to the policy. This training will be kept in the staff training book in the administrator office.

A new hire and re-hire background check log was created to track all steps in completing the background process. This log will be completed by the business office manager and reviewed by the administrator for accuracy and compliance. This log will be completed on all background checks and will kept in the administrators office for review at all times. This log was started on 7/29/2026 with the new hire by the administrator and will be kept in the new

51 - Criminal Background Check (continued)

hire book located in the administrators office for review at all time.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented (- 08/17/2026)

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The entire home is licensed as a secured dementia care unit (SDCU) and numerous residents are prescribed pro re nata (PRN) medications, to include residents and however, the home routinely does not have a staff person present in the home who is qualified to administer medications during the 11:00pm through 7:00am shift, to include on and.

Plan of Correction ***Directed (- 08/06/2026)***

Administration staff was educated by the consultant on 7/15/2026 on a new schedule template and daily staffing sheets that must be used to track staffing and ensuring building is staffed to regulations. This training will be kept in the training binder for review of compliance at all times.

A daily staffing sheet will be put in place on 7/20/2026. All staff will be educated on the staffing sheet on 7/17-18, 2026 by the administrator and all trainings will be kept in the training binder for review.

Administrator will create schedule with a med-tech, certified CPR, 21 years or older and certified diabetic staff member in the building 24 hours a day. Administrator will fill in daily staffing sheets for the week and they will be posted by the schedule. (DIRECTED: By 8/13/26: The administrator shall develop and implement a tracking system which includes the dates of all initial and annual practicums for all qualified medication technicians to ensure qualified medication technicians in accordance with 2600.190a are present in the home at all times in accordance with 2600.60a. Documentation of the tracking system shall be kept and shall be reviewed and updated quarterly thereafter by the administrator. 8/6/26)

Administrator will review the schedule daily to ensure that all staffing regulations are being followed in regards to compliance. These staffing sheets will be kept in the administrators office for review at anytime for compliance.

Administrator will educated on staff on 7/17/2026 in regards to the new schedule form, new daily staffing sheet and staffing requirements. This training will be kept in the staff training book in the administrators office.
The staffing sheets were implemented on 7/20/2026 by the business office manager. These sheets will be posted by the schedule and will be kept in the schedule binder in the administrators office for review at all time.
The administrator will review the schedule Monday-Friday along with reviewing it Friday for the weekend to ensure that all positions are filled with the proper qualified staff members. This review will begin on 8/1/2026 and will be

60a - Staff/Support Plan (continued)

ongoing for 6 months and random monthly for 6 months.
The facility current has 5 trained med-techs. 1 med-tech was current on all training and 4 med-techs completed the recertification on 8/3/2026.
At the time of inspection the facility had no qualified med-tech present at the facility. Consultant was brought in after the inspection and set up a med-training class for the 4 med-techs that were out of compliance to become current with all regulations. This class was started on 7/20/2026 with Stephanie a certified train the trainer.

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/13/2026*

Not Implemented ([redacted] - 08/17/2026)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On [redacted] at 9:29am, an unlabeled, used washcloth was present on a hook in the 2nd floor shared bathroom near bedroom [redacted]

Plan of Correction ***Accept ([redacted] - 08/06/2026)***

Med-techs will round all bathrooms at the end of their shift to ensure no personal items are left in the bathroom and if they are they will be removed immediately. All med-techs were educated on this policy on 7/15-16, 2026. this training was completed by the administrator and will be kept in the administrators office for review at all times.

All staff were educated on 7/15-16, 2026 by the administrator on the regulation of sanitary conditions and that all used towels and personal items are removed from the bathroom area when the care is completed and put in the proper laundry area. This training will be kept in the staff training book and stored in the administrators office for review at all times.

Washcloth was removed at the time of inspection. Daily round audit was started on 7/14/2026 by the business office manager. These audits will be kept in the POC audit book located in the administrator office for review at all time.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Not Implemented ([redacted] - 8/17/2026)

92 - Windows

5. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On [redacted] at 9:41am, no screen was present on the exit door in the kitchen leading to the outside, which was open approximately 8" at the time of discovery.

92 - Windows *(continued)*

Plan of Correction ***Accept (- 08/06/2026)***

A house wide audit was completed on 7/14/2026 on all windows and doors for screens and proper working condition. Areas identified were fixed 7/15/2026 except for the broken screen and the 3 missing screens. These screens are ordered and will be put in when they are delivered.

A maintenance request form was created for all staff to use for reporting any physical site concerns. This maintenance request form are available by the administrator office. Administrator will review all maintenance request forms to make sure all items identified are fixed and/or any repairs. Administrator will order any supplies that are needed to make repairs and ensure they are on hand.

All staff will be educated on 7/20/2026 by the administrator in regards to completing the form and the location of the form. This training will be kept in the training book for review for compliance at all times.

The door was closed at the time of inspection. Administrator educated all staff on 8/3/2026 that all operable window and doors must be screened when open, This education will be kept in the staff training book located in the administrator office for review at all times.

The administrator will round the building weekly on Mondays starting 8/3/2026 to ensure all windows and doors have screen and are working properly. This audit will be kept in the POC audit binder that is in the administrators office for review at all time

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented (- 08/17/2026)

102i - Soap Dispenser

6. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On at 9:55am, no soap was present at the shared bathroom sink next to bedroom

Plan of Correction ***Directed (- 08/06/2026)***

House wide audit was completed on 7/14/2026 of all bathrooms to ensure residents have bath tissue, paper towels and soap within reach for personal use. This audit will be completed by administrator and documentation will be kept in the POC binder for review.

All med-techs will be educated on 7/17/2026 by the administrator on the audit and that they will be responsible to complete audit at the end of their shift starting on 7/18/2026. (DIRECTED: The daily audits shall include an audit of all bathrooms to ensure a dispenser with soap is present within reach of each bathroom sink. 8/6/26). This training will be kept in the staff training binder in the administrators office for review at all times.

102i - Soap Dispenser (continued)

Administrator will review audits daily Monday through Friday and will review the weekend audit forms on Monday also to ensure compliance this audit begin on 7/14/2026 Administrator will ensure all staff has access to the extra supplies so they can stock any items missing. Administrator will inventory stock weekly to ensure items don't run out.

Audits will be kept in the POC audit book located in the administrator office for review at all times.

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/03/2026*

Implemented ([redacted] - 08/17/2026)

103g - Storing Food

7. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On [redacted] at approximately 9:45am, the following open and unsealed food items were present on a shelf in the home's kitchen:

- *A 12 ounce bag of Snyder's pretzel rods*
- *A 4 pound bag of sugar*
- *A sleeve of thin mint cookies*

Plan of Correction ***Accept ([redacted] - 08/06/2026)***

The following food was thrown away at the time of inspection 12 oz bag of snyder pretzel rods, 4 lb bag of sugar, sleeve of thin mint cookies by the cook

Administrator audit all stored food, refrigerator food, freezer food and along with checking for dented cans and expired dates on 7/16/2026. This audit will be kept in the POC audit book for review at all times

Administrator will complete a weekly audit to ensure all open food is sealed, labeled and identified. Administrator will also check for dented cans and expired food. This audit will be preformed weekly for 3 months then monthly for 6 months. These audits will kept in the POC audit book in the administrator office.

Dietary staff will be educated by the Administrator on 7/21/2026 on proper ways of storing and labeling food in the kitchen. This education will be kept in the staff training book in the administrators office for review at all times.

The following food was thrown away at the time of inspection 12 oz bag of snyder pretzel rods, 4 lb bag of sugar, sleeve of thin mint cookies by the cook

The weekly audit of the kitchen items was started on 7/16/2026 by the administrator or designee and will be kept in the POC audit book located in the administrators office for review at all time.

103g - Storing Food (continued)

The dietary cook or designee started the food storage audit on 7/20/2026 and this audit will be kept in the POC audit book located in the administrators office for review at all time.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Not Implemented (- 08/17/2026)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On at 9:26am, a chair was present in front of the emergency exit door in bedroom blocking this emergency egress route.

Plan of Correction ***Accept (- 08/06/2026)***

Business office manager will check all egress exits Monday-Friday for 30-days and then weekly for 3 months to ensure all egress areas are clear and safe for use. This audit will be kept in the POC audit binder in the administrators office for review at all times.

All staff will be educated by the administrator on 7/21/2026 in regards to the use of egress area, the need for them to stay clear at all times and how to report any problems or concerns with an egress area. This education will be stored in the staff education book in the administrator office for review at all times.

The chair was removed at the time of inspection by business office manager.
The audit begin on 7/15/2026 for all egress areas. This audit will be kept in the POC audit book located in the administrators office for review at all times.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Not Implemented (- 08/17/2026)

132c - Fire Drill Records

9. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill records for the fire drills conducted from 9/10 through 5/25 do not include the year.

Plan of Correction ***Accept (- 08/06/2026)***

Administrative staff will be educated by the consultant on 7/20/26 in regards to the required and proper documentation needed to meet all standards for fire drills. this documentation will be kept in the staff training

132c Fire Drill Records (continued)

book in the administrator office for review at all times

Administrator will run a full fire drill on 7/21/2026 to make sure staff understands all the documentation, procedures and evacuation routes for a safe and effective fire drill. this documentation will be kept in the POC book in the administrators office for review at all times.

Administrator will conduct all fire drills and document all required information of the proper forms. Any fire drills not meeting the standards will be completed again within 48 hours and staff will be educated on any concerns or issues at the time of the drill by the administrator.

Business Office Manager will sign off on all fire drills logs monthly to ensure they are completed and accurate. This process will begin with the fire drill that is conducted in August 2026.

All fire drill documentation will be kept in the fire drill book located in the administrators office for review at all times.

Business office manager corrected the dates on the fire drill log and will now keep a log by year. This corrections were made on 8/3/2026 and the log will be kept in the fire book located in the administrators office for review at all times.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Not Implemented ([redacted] - 08/17/2026)

132d - Evacuation

10. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

According to documentation from a fire safety expert, dated [redacted], the maximum evacuation time to the home's fire safe areas was 3 minutes, 45 seconds; however, the evacuation time for the fire drill conducted on [redacted] at 6:30am was completed in 6 minutes, 9 seconds.

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Administrative will be educated by the consultant on 7/20/26 in regards to the required and proper documentation needed to meet all standards for fire drills. this documentation will be kept in the staff training book in the administrator office for review at all times
On 4/21/2026 Fire Safety Inspector completed the supervised fire drill and noted the maximum safe evacuation time for the home, from the time the fire alarms sounds until all residents have evacuated to the outside of the building or fire safe area is 8 minutes and 39 seconds.
Administrator will run a full fire drill on 7/21/2026 to make sure staff understands all the documentation,

132d - Evacuation (continued)

procedures and evacuation routes and times for a safe and effective fire drill. this documentation will be kept in the POC book in the administrators office for review at all times.

The fire safety annual inspection will be kept in the fire drill book located in the administrators office for review at all times.

Administrator will conduct all fire drills and document all required information of the proper forms. Any fire drills not meeting the standards will be completed again within 48 hours and staff will be educated on any concerns or issues at the time of the drill by the administrator.
Business Office Manager will sign off on all fire drills logs monthly to ensure they are completed and accurate. This process will begin with the fire drill that is conducted in August 2026. (DIRECTED: The business office manager shall also review fire drill records monthly to ensure all residents evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. [redacted] 8/6/26).

All fire drill documentation will be kept in the fire drill book located in the administrators office for review at all times.

The fire drill on 7/21/2026 had 12 residents present at the facility and all 12 evacuated at the time of the drill. The residents and staff evacuated in 7 min and 37 sec to the front of the building.

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/03/2026*

Not Implemented ([redacted] - 08/17/2026)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident [redacted]s most recent medical evaluation, dated [redacted] does not include a diagnosis of [redacted] disease. Also, resident [redacted]s most recent medical evaluation is blank in the following areas:

- *Medical diagnoses. This section of resident [redacted]s medical evaluation indicates "N/A" for all diagnoses; however, resident [redacted] is currently prescribed numerous medications for numerous diagnoses*
- *Resident [redacted]s pulse rate, blood pressure and temperature*
- *An assessment of the ability to use poisonous materials*
- *Advanced directives*

141b1 Annual Medical Evaluation (continued)

- *Special health or dietary needs*
- *Ability to self administer medications*
- *The date the medial evaluation was completed by the medical professional*

Resident [redacted]s most recent medical evaluation, dated 5/5/26, is blank in the following areas:

- *Medical diagnoses. This section of resident [redacted]s medical evaluation indicates "N/A" for all diagnoses; however, resident [redacted] is currently prescribed numerous medications for numerous diagnoses*
- *Resident [redacted]s pulse rate, blood pressure and temperature*
- *If resident [redacted] is a full code or do not resuscitate (DNR)*
- *Ability to self administer medications*
- *The date the medical evaluation was completed by the medical professional*

Resident [redacted]s most recent medical evaluation, dated [redacted] is blank in the following areas:

- *Pulse rate*
- *Body positioning/movement*
- *The license # of the medical professional who completed the medical evaluation*
- *The need for resident [redacted] to be served in the SDCU*

Resident [redacted]s most recent medical evaluation, dated [redacted] is blank in the following areas:

• Advanced directive
• Special health/dietary needs
• The medical professional name, the medical professional license #, medical professional signature or the date signed

Repeated Violation[redacted]

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre screen and RASP on all residents. These will be completed by 7/21/2026 and education will begin with all staff.
All staff will be educated by 7/24/2026 on the purpose, the need and the required information for medical evaluations for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.
Consultant educated administrator on 7/21/2026 on the monthly audit. Training will be kept in the staff training book located in the administrators office for review at all times.

House wide medical evaluations were all completed on the following dates 7/13/2026, 7/14/2026 and 7/15/2026. These will be audited by the consultant team to ensure they are completed according to regulations. These will be kept in the resident charts and these charts are kept in the administrators office for review at all times. This audit was completed on 8/3/2026.

Administrator is responsible for ensure all residents have medical evaluations upon admission and/or significate

141b1 Annual Medical Evaluation (continued)

change. Business office manager will review medical evaluation when completed to ensure they are accurate and completed in their entirety. This form will be kept in the Administrators office for review at all time. (DIRECTED: Beginning on 8/10/26: The Business Office Manager/designee shall review all medical evaluations within 72 hours of completion to ensure accurate, complete and timely medical evaluations are present in accordance with 2600.141b. [redacted] 8/6/26).

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/10/2026*

Not Implemented ([redacted] - 08/17/2026)

141b2 - Medical Evaluation Changes

12. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident [redacted]s status change medical evaluation, dated [redacted] is blank under numerous areas, to include the following:

- *Resident [redacted]s pulse rate*
- *Allergies*
- *The license # of the medical professional who completed the medical evaluation*
- *The date the medial evaluation was completed by the medical professional*
- *The need for resident [redacted] to be served in the SDCU*

Resident [redacted]s status change medical evaluation is dated on page 1 as being completed on [redacted] however, is dated on page 2 as being completed on [redacted] Also, the date the medial evaluation was completed by the medical professional is blank.

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre screen and RASP on all residents. These will be completed by 7/21/2026 and education will begin with all staff.

All staff will be educated by 7/24/2026 on the purpose, the need and the required information for medical evaluations for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Consultant educated administrator on 7/21/2026 on the monthly audit. Training will be kept in the staff training book located in the administrators office for review at all times.

141b2 - Medical Evaluation Changes (continued)

House wide medical evaluations were all completed on the following dates 7/13/2026, 7/14/2026 and 7/15/2026. These will be audited by the consultant team to ensure they are completed according to regulations. These will be kept in the resident charts and these charts are kept in the administrators office for review at all times. This audit was completed on 8/3/2026.

Administrator is responsible for ensure all residents have medical evaluations upon admission and/or significate change. Business office manager will review medical evaluation when completed to ensure they are accurate and completed in their entirety. This form will be kept in the Administrators office for review at all time. (DIRECTED: Beginning on 8/10/26: The Business Office Manager/designee shall review all medical evaluations within 72 hours of completion to ensure accurate, complete and timely medical evaluations are present in accordance with 2600.141b. [redacted]/6/26).

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/10/2026*

Not Implemented ([redacted] 08/17/2026)

162c - Menus Posted

13. Requirements

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

Description of Violation

On [redacted] the only menu posted in a conspicuous and public place in the home ended on [redacted]

Plan of Correction ***Accept ([redacted] 08/06/2026)***

Menus are currently posted and are available for all residents and public to see.

Dietary staff will be educated by the administrator on 7/21/2026 on the regulation requiring menus to be posted and the location of the posting. This education will be kept in the staff training book that will be kept in the administrator office for review at all times.

Menus will be signed and dated when they are posted for 3 months by the administrator to ensure they are posted when required

Administrator will review the menus that are posted every Monday to ensure there are 2 weeks of menus and that they are in plain view for all residents and visitors. This audit will begin on 8/3/2026 and the audit will be kept in the POC audit book located in the administrators office for review at all times.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Not Implemented ([redacted] - 08/17/2026)

183e - Storing Medications

14. 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

Resident [redacted] was prescribed [redacted] -Take 1 tablet by mouth every 12 hours as needed. On [redacted] resident [redacted]s hospice nurse reviewed resident [redacted]s Lorazepam and noticed 1 of the 30 doses was popped out of the blister pack, then repackaged and covered with a "direction change" sticker. Resident [redacted]s hospice nurse noticed the 1 tablet that was repackaged was different than the other 29 tablets and was stamped with "TV 53". According to resident [redacted]s hospice nurse, it was determined this tablet was [redacted], which is not currently prescribed to resident [redacted]

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

A narc per shift narc sheet was put in place and all med-techs were educated on 7/15/2026 by the administrator. Educations will be kept in the staff training book in the administrator office for review at all time. (DIRECTED: Documentation of the narcotic counts conducted between each shift shall be kept, which includes the names of the direct care staff persons conducting each count. [redacted] 8/6/26).

A narc policy was put in place on 7/21/2026 and med-tech was educated on 7/21/2026 by the administrator. education will be kept in the staff training book in the administrator office for review at all times.

A weekly narcotic count audit will be performed by the administrator weekly for 6 months then monthly thereafter. These audits will be kept in the POC book kept in the administrator office for review at all times. 2 months of audits will be kept at all times and these will begin 8/3/2026

All med-techs were educated on 7/15/2026 on the narcotic policy this policy was created on7/14/2026 by the consultant.

Consultant put medication policy, narc policy, medication error policy and medication error tracking in place and staff will all be educated 7/24/2026 on the policies by the administrator. Education will be kept in the staff training book located in the administrator office for review at all times.

The consultant created the narcotic policy on 7/14/2026 and med-tech was educated on the new policy on 7/15/2026 by the administrator. The education will be kept in the staff training book located in the administrator office for review at all times.

All med-techs are counting narcotics at the change of all shifts and administrator will continue to monitor this for accuracy. This audits will be kept on the med cart for the current month then they will be kept in a narcotic count book located in the administrators office for the current year.

183e Storing Medications (continued)

Administrator will complete a weekly audit for 6 months and then monthly thereafter for accuracy. This will start on 8/3/2026 and audit will be kept in the POC audit book located in the administrator office for review at all time. (DIRECTED: The weekly audits shall include a review of all residents prescribed narcotics and include a review of each resident's current narcotic count sheet and cross referenced to the physical count of each medication to ensure accuracy. The weekly reviews shall also include ensuring direct care staff persons are documenting the narcotic counts conducted at each change of shift. [redacted] 8/6/26). Documentation of the weekly audits shall be kept for 2 months.

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/03/2026*

Not Implemented ([redacted] - 08/17/2026)

185a - Implement Storage Procedures

15. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [redacted] resident [redacted]s Freestyle glucometer was not set to the current time of day.

On [redacted] and [redacted] the home's procedures for the safe storage, access, security, distribution and use of medications and equipment were not present in the home. According to staff person A, the home's administrator, the home's procedures are that all controlled substances are to be counted by 2 direct care staff persons at the change of each shift; however, on [redacted] during the 3:00pm shift change and in the presence of agents of the Department, no counts were completed for any of the controlled substances present in the home.

Resident [redacted] is currently prescribed [redacted] tablet Take 1 tablet by mouth every 4 hours as needed. On [redacted], resident [redacted]s narcotic count sheet indicated 1 tablet was administered to resident [redacted] on 5/20/26 and that the remaining count was 22; however, the next administration was on [redacted] and that the remaining count was 20, with no documentation present accounting for the missing dose.

Resident [redacted] is currently prescribed [redacted] by mouth under the tongue every 4 hours as needed. On [redacted] 20 prefilled syringes of resident [redacted]s Lorazepam were delivered to the home. On [redacted] 2 different narcotic count sheets were present in the home for this medication: 1 of the narcotic count sheets indicated 13 syringes were present in the home; however, the 2nd narcotic count sheet indicated 11 syringes were present in the home. Also, the 2nd count sheet indicated 1 syringe was administered to resident [redacted] on [redacted] and that the remaining count was 14; however, the next administration was on [redacted] and that the remaining count was 11, with no documentation present accounting for the missing doses. On [redacted], only 11 syringes of resident [redacted]s [redacted] were present in the home.

Resident [redacted] is currently prescribed [redacted]) by mouth under the tongue every 4 hours as needed. On [redacted], 20 prefilled syringes of resident [redacted]s Morphine was delivered to the home; however, on [redacted] only 18 syringes were present in the home. According to narcotic count sheet for this medication, no

185a - Implement Storage Procedures (continued)

Morphine has been administered to resident [redacted] since delivery, and no documentation was present accounting for the missing doses.

Resident [redacted] is currently prescribed [redacted]-Take 1 prefilled syringe 0.5ml (0.25mg) by mouth at bedtime. On [redacted] resident [redacted]s narcotic count sheet indicated 1 syringe was administered to resident [redacted] on [redacted] and that the remaining count was 26; however, the next administration was on [redacted] and that the remaining count was 24, with no documentation present accounting for the missing dose.

Resident [redacted] is currently prescribed [redacted] by mouth/under tongue every 4 hours as needed. On [redacted] 20 prefilled syringes of resident [redacted]s Lorazepam were delivered to the home; however, on [redacted] only 17 syringes were present in the home. According to the narcotic count sheet for this medication, no [redacted] has been administered to resident [redacted] sine delivery, and no documentation was present accounting for the missing doses.

Resident [redacted] was prescribed [redacted] by mouth/under tongue every 4 hours as needed. According to resident [redacted]s narcotic count sheet, 17 doses of this medication were destroyed by direct care staff person C and resident [redacted]s hospice nurse; however, the date of destruction is not indicated on the narcotic count sheet. Also, according to the narcotic count sheet, a dose was administered; however, does not include the date, time or the signature of the staff person who administered it. Additionally, the narcotic count sheet indicated another dose was administered to resident [redacted] on [redacted] and that the remaining count was 18; however, only 17 syringes were present in the home at the time of destruction, and no documentation was present accounting for the missing dose.

Resident [redacted] is currently prescribed [redacted]) topically every 6 hours as needed. On [redacted] resident [redacted]s narcotic count sheet indicated 1 syringe was administered to resident [redacted] on [redacted] and that the remaining count was 15; however, the next administration was on [redacted] and that the remaining count was 13, with no documentation present accounting for the missing dose.

Resident [redacted] was prescribed [redacted]-Take 1 tablet by mouth every 12 hours as needed. On [redacted] resident [redacted]s hospice nurse reviewed resident [redacted]s Lorazepam and noticed 1 of the 30 doses was popped out of the blister pack, then repackaged and covered with a "direction change" sticker. Resident [redacted]s hospice nurse noticed the 1 tablet that was repackaged was different than the other 29 tablets and was stamped with "TV 53". According to resident [redacted]s hospice nurse, it was determined this tablet was Buspirone, which is not currently prescribed to resident [redacted] Also, according to the narcotic count sheet for this medication, none of the 30 doses of this medication were administered to resident [redacted] since received from the pharmacy.

Resident [redacted] is currently prescribed [redacted] 1ml syringe topically every 4 hours as needed. On [redacted], 20 prefilled syringes of resident [redacted]s ABHR cream were delivered to the home; however, on [redacted] only 19 syringes were present in the home. According to narcotic count sheet for this medication, no ABHR cream has been administered to resident [redacted] since delivery, and no documentation was present accounting for the missing dose.

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Consultant had the Train the Trainer complete a cart audit on 7/20/2026. This audit was given to the administrator and all medication was ordered on 7/21/2026. This audit will be kept in the POC audit book located in the administrator office for review at all times.

Administrator will audit medication cart weekly for errors, missed medication, medication not listed, refills, proper

185a - Implement Storage Procedures (continued)

documentation. This audit will be completed weekly for 6 months and then monthly for 6 months. Administrator will complete this audit and audit will be kept in the POC book located in the administrators office for review at all time

Consultant put medication policy, narc policy, medication error policy and medication error tracking in place and staff will all be educated 7/24/2026 on the policies by the administrator. Education will be kept in the staff training book located in the administrator office for review at all times.

The weekly medication cart audit will include a review of all residents prescribed narcotics and include a review of the current count sheets and physical supply in the home for each resident to ensure accuracy. The administrator will begin this audit on the first Wednesday of the month beginning 8/5/2026. (DIRECTED: Documentation of the weekly audits shall be kept for 2 months. [redacted]8/6/26).

Glucometer was corrected 7/17/2026 for resident [redacted] and the correct date and time was set. The facility currently doesn't have any other residents require glucometers. (DIRECTED: Beginning on 8/10/26: The administrator/designee shall review all resident glucometers monthly to ensure they are set to the current date and time. [redacted] 8/6/26).

All med techs will be educated on 8/4/2026 on calibrating glucometers monthly and this education will be provided by the administrator and will be kept in the staff training book located in the administrator office for review at all time

A new narcotic policy was created on 7/14/2026 by the consultant and staff was educated on 7/15/2026 by the administrator and education will be kept in the staff training book located in the administrators office for review at all time.

Consultant created and put in place a medication administration policy. All med-techs will be trained on 8/4/2026 by the Administrator on the new policy. This training will be kept in the staff training book located in the administrator office for review at all time.

All med-techs are counting at the change of shift all narcotics and documenting accuracy with the on coming shift. This policy was put in place on 7/14/2026 and staff was educated and audits are completed by the administrator to ensure all med-tech are continue to follow this policy this audit will be kept in the POC book located in the administrator office for review at all time.

A weekly narcotic count audit will be performed by the administrator weekly for 6 months then monthly thereafter. These audits will be kept in the POC book kept in the administrator office for review at all times. 2 months of audits will be kept at all times and these will begin 8/3/2026

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/10/2026*

Not Implemented [redacted] - 08/17/2026)

187a - Medication Record

16. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

On 6/8/26, resident [redacted] s [redacted] tablets were discontinued by the prescriber; however, on [redacted] this medication was still present on resident [redacted] s June 2026 medication administration record (MAR).

Resident [redacted] s June 2026 MAR indicates [redacted] Inject per sliding scale at bedtime; however, resident [redacted] is not currently prescribed [redacted] at bedtime.

Repeated Violation-[redacted]

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Consultant had the Train the Trainer complete a cart audit on 7/20/2026. This audit was given to the administrator and all medication was ordered on 7/21/2026. This audit will be kept in the POC audit book located in the administrator office for review at all times.

Administrator will audit medication cart weekly for errors, missed medication, medication not listed, refills, proper documentation. This audit will be completed weekly for 6 months and then monthly for 6 months
Consultant put medication policy, narc policy, medication error policy and medication error tracking in place and staff will all be educated 7/24/2026 on the policies by the administrator. Education will be kept in the staff training book located in the administrator office for review at all times.

MAR's review was completed on 7/22/2026 by the business office manger to ensure all medication was listed on MAR's and is accurate according to regulations. This review will be completed weekly starting 8/4/2026 for 6 months then monthly for 6 months by the business office manager and this audit will be kept in the POC audit book located in the administrators office for review at all time. (DIRECTED: At least 10 different resident MAR's shall be included in each audit to ensure accurate and complete MAR's are present in accordance with 2600.187a. Documentation of the weekly audits shall be kept for 2 months. [redacted] 8/6/26).

Resident [redacted] was not prescribed Lorazepam 0.5mg on 6/11/2026 and was removed from the cart by the med tech

187a - Medication Record (continued)

on 6/11/2026. Hospice notified pharmacy to remove medication from the MAR's

Resident [redacted] doesn't have an order on the MAR's for Lispro 100 units/ml [redacted] order on the MAR's is for 8am, 12pm and 5pm. These are [redacted] accurate order

DIRECTED: By 8/10/26: The administrator shall review the MAR's for residents [redacted] and [redacted] to ensure accuracy and completeness in accordance with current prescribers' orders. [redacted] 8/6/26

When new orders are received the pharmacy updates the MAR's and the administrator will compare all new orders to the MAR's when they are received. Administrator will initial at the bottom of all orders when they are checked and are accurate. This will be done with all new orders for 6 months with no errors. Staff will be educated by administrator on 8/4/2026 on new orders and MAR's accuracy comparison. This education will be kept in the staff training book located in the administrators office for review at all time

Administrator will review MAR's to the medication weekly for 6 months and then monthly for 6 months. This audit will begin 8/7/2026 and audit will be kept in the POC audit book located in the administrators office for review at all time. (DIRECTED: At least 10 different resident MAR's shall be included in each audit to ensure accurate and complete MAR's are present in accordance with 2600.187a. Documentation of the weekly audits shall be kept for 2 months. [redacted] 8/6/26).

Proposed Overall Completion Date: 08/03/2026

Directed Completion Date: *08/10/2026*

Not Implemented ([redacted] - 08/17/2026)

187b - Date/Time of Medication Admin.

17. 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

Resident [redacted] is currently prescribed Lactulose 10gm/15ml syrup-Take 2 tablespoons by mouth twice a day. On [redacted] at 8:00am, direct care staff person C indicated [redacted] administered this medication to resident [redacted] however, documented the administration on resident [redacted]s June 2026 MAR that the medication was "Held per physician orders waiting on med to come in".

Repeated Violation [redacted]

Plan of Correction ***Accept ([redacted] - 08/06/2026)***

Consultant had the Train the Trainer complete a cart audit on 7/20/2026. This audit was given to the administrator and all medication was ordered on 7/21/2026. This audit will be kept in the POC audit book located in the administrator office for review at all times.

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

Administrator will audit medication cart weekly for errors, missed medication, medication not listed, refills, proper documentation. This audit will be completed weekly for 6 months and then monthly for 6 months

Train the trainer reviewed all resident MAR's for accuracy on 7/20/2026 and the report will be kept in the Poc audit book located in the administrators office for review at all times.

The administrator will educate all med-tech on proper documentation of medication and treatment on the MAR's, what needs done if medication is not available and who to notify about any medication not in house and resident refusal. Administrator will complete this education on 8/4/2026 and education will be kept in the staff education book located in the administrators office for review at all times.
Consultant put medication policy, narc policy, medication error policy and medication error tracking in place and staff will all be educated 7/24/2026 on the policies by the administrator. Education will be kept in the staff training book located in the administrator office for review at all times.
Administrator will review all resident MAR's weekly for 3 months and then monthly for 6 months. The Administrator will complete these audits on the first Wednesday of the month beginning with 8/5/2026. This audit will be kept in the POC audit book located in the administrators office for review at all times.

All med-techs will be educated on 8/4/2026 on proper documentation by the administrator and this will be kept in the staff training book located in the administrators office for review at all time.

Proposed Overall Completion Date: 08/03/2026

Licensee's Proposed Overall Completion Date: *08/03/2026*

Not Implemented ([redacted] - 08/17/2026)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident [redacted] was prescribed [redacted] 1 prefilled syringe topically on inner wrist or back of neck every 4 hours as needed; however, on [redacted], a medication technician administered the [redacted] orally to resident [redacted]

Repeated Violation[redacted]

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Consultant had the Train the Trainer complete a cart audit on 7/20/2026. This audit was given to the

187d Follow Prescriber's Orders (continued)

administrator and all medication was ordered on 7/21/2026. This audit will be kept in the POC audit book located in the administrator office for review at all times.

Administrator will audit medication cart weekly beginning 8/4/2026 for errors, missed medication, medication not listed, refills, proper documentation. Administrator will complete the audit on 3 residents per audit. This audit will be completed weekly for 6 months and then monthly for 6 months. This audit will be kept in the POC audit book located in the administrators office for review at all time

Consultant put medication policy, narc policy, medication error policy and medication error tracking in place and staff will all be educated 7/24/2026 on the policies by the administrator. Education will be kept in the staff training book located in the administrator office for review at all times.

DIRECTED: By 8/15/26: The administrator shall re educate all staff persons qualified to administer medications on the 5 rights of medication administration, as well as the different routes of medication administration to ensure medications are administered in accordance with prescribers' orders, including the proper route of medication administration. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 8/6/26

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/15/2026*

Not Implemented ([redacted] - 08/17/2026)

190a - Completion Medication Course

19. 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

At the time of inspection, the home did not currently have any staff persons that have successfully completed the annual practicum in accordance with the Department approved medications administration course; however, numerous staff persons administered medications to the numerous residents daily, to include the following staff persons:

- *Direct care staff person C administered medications to numerous residents during the 7:00am through 3:00pm shift on [redacted] and [redacted], to include residents [redacted] and [redacted]*
- *Direct care staff person D administered medications to numerous residents during the 3:00pm though 11:00pm shift on [redacted] and [redacted] to include residents [redacted] and [redacted]*
- *Direct care staff person E administered medications to numerous residents during the 3:00pm through 11:00pm shift on [redacted] and [redacted] to include residents [redacted] and [redacted]*

Plan of Correction ***Accept ([redacted] - 08/06/2026)***

All staff will be educated by administrator on 7/23/2026 in regards to the requirements for passing medication. This education will be kept in the staff training book located in the administrators office.

190a Completion Medication Course (continued)

All current staff that is holding a job title of med tech was put in a med training class as all required training was outdated. Staff will complete the entire course and all practicum reviews will be completed in a timely manner. Administrator will keep a chart to track all required documentation and will schedule all training as needed to meet these requirements.

Administrator will keep a log on all training dates and annual reviews on all staff that is certified to pass medication which will include a medication administration training log, CPR certification log and diabetic certification log.

Consultant will educate the administrative staff on 7/21/2026 on these logs and required training timeline to meet the regulations. This training will be kept in the staff training book located in the administrators office for review at all time

Consultant will educate administrator and business office manager on 7/21/2026 on new schedule format that has the med tech and aides separated so it shows a current trained medication staff member is scheduled daily all shifts. This training will be kept in the staff training book located in the administrators office for review at all times.

The home currently doesn't employee a train the trainer. The facility has a outside train the trainer for completing the medication training requirements and [redacted] is available to the facility as needed. All med tech have completed their training again as of 8/4/2026 and are up to date accordance with the department approved medication administration course.

The log will be in place effective 8/4/2026 and will be completed by the administrator. The log will be reviewed weekly and and updated with new residents and any changes by the administrator during these reviews.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Not Implemented ([redacted] - 08/17/2026)

190b - Insulin Injections

20. 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

Direct care staff person C has not successfully completed the Department approved diabetes patient education program since 5/19/25; however, direct care staff person C has administered insulin to numerous residents on numerous dates and times, to include during the 7:00am through to 3:00pm shift on 6/5/26, 6/6/26 and 6/7/26.

190b - Insulin Injections *(continued)*

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

All staff will be educated by administrator on 7/23/2026 in regards to the requirements for passing medication. This education will be kept in the staff training book located in the administrators office.

All current staff that is holding a job title of med-tech was put in a med training class as all required training was outdated. Staff will complete the entire course and all practicum reviews will be completed in a timely manner. Administrator will keep a chart to track all required documentation and will schedule all training as needed to meet these requirements.
Administrator will keep a log on all training dates and annual reviews on all staff that is certified to pass medication which will include a medication administration training log, CPR certification log and diabetic certification log.
Consultant will educate the administrative staff on 7/21/2026 on these logs and required training timeline to meet the regulations. This training will be kept in the staff training book located in the administrators office for review at all time
Consultant will educate administrator and business office manager on 7/21/2026 on new schedule format that has the med-tech and aides separated so it shows a current trained medication staff member is scheduled daily all shifts. This training will be kept in the staff training book located in the administrators office for review at all times.
Diabetic class was completed on 7/17/2026 for staff by a certified diabetic trainer. (DIRECTED: Documentation of the staff training conducted by a certified diabetic educator shall be kept. [redacted] 8/6/26).

Staff person C was trained by a diabetic educator on 7/17/2026 by a diabetic educator

All med-techs records were audited by the administrator on 8/3/2026 to ensure all trained staff have completed the diabetic training by a certified educator. This audit will be kept in the POC audit book located in the administrators office for review at all time.

The tracking log will be implemented on 8/4/2026 and will be reviewed monthly to ensure all staff receives the required training within the regulatory requirements. the administrator will complete this log and will complete all updates monthly. This log will be kept in the staff training manual located in the administrators office for review at all time

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/04/2026*

190b - Insulin Injections *(continued)*

Implemented (- 08/17/2026)

224a - Preadmission Screen Form

21. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident s preadmission screening form, dated 6/1/26, does not include the name of the person who completed the form, level of supervision needed, ability to self-administer medications or ADL/IADL assistance needed. These areas of resident s preadmission screening are blank. Resident was admitted to the SDCU on 6/2/26.

Plan of Correction ***Directed (- 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents.

All staff will be educated by 7/24/2026 on the purpose, the need and the required information for preadmission screening form for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Upon admission the administrator will complete the new resident required paperwork checklist acknowledging that the forms are completed in a timely manner and all information is complete and accurate. ~~This form will be on-going for the next 12 months.~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. DIRECTED: The new admission checklist shall be used indefinitely to ensure timely and complete preadmission screenings are obtained at admission for all newly-admitted residents. Copies of the completed checklists shall be kept in each resident's record. 8/6/26). Consultant will educate administrator on 7/21/2026 on this and the education will be kept in the staff training book located in the administrators office for review at all times.

Resident new preadmission screening was complete 7/13/2026 and is located in the residents file for review at all time.

All residents preadmission screening were audit on 8/4/2026 for completion and compliance. This audit was completed by the administrator and will be kept in the POC audit log located in the administrators office for review at all time.

Administrator will complete all preadmission screenings and these will be kept in the resident file for review at all time.

New Resident required paperwork checklist will be put in place on 8/10/2026 this checklist will be kept in each new admission's record.

224a - Preadmission Screen Form (continued)

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/10/2026*

Implemented (- 08/17/2026)

225a - Assessment 15 Days

22. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident was admitted to the SDCU on ; however, at the time of inspection, only 2 pages (pages 1 and 3) of resident s assessment, dated , were present in the home.

Plan of Correction ***Directed (- 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents.

All staff will be educated by 7/24/2026 on the purpose, the need and the required information for initial assessment for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Upon admission the administrator will complete the new resident required paperwork checklist acknowledging that the forms are completed in a timely manner and all information is complete and accurate. ~~This form will be on-going for the next 12 months.~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. DIRECTED: The new admission checklist shall be used indefinitely to ensure timely and complete assessments are obtained for all newly-admitted residents in accordance with 2600.225a. Copies of the completed checklists shall be kept in each resident's record. 8/6/26). Consultant will educate administrator on 7/21/2026 on this and the education will be kept in the staff training book located in the administrators office for review at all times.

Resident new assessment was completed on 7/14/2026 and will be kept in the residents chart for review at all time.

Audit was performed on all residents charts for required paperwork on 8/4/2026.

All residents current have updated and current assessments located in their files for review at all times.

New Resident required paperwork checklist will be implanted on 8/10/2026. completed checklist will be kept in

225a Assessment 15 Days (continued)

each new admission's record.

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/10/2026*

Not Implemented (- 08/17/2026)

225c - Additional Assessment

23. 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.

Description of Violation

Resident s most recent assessment, dated does not include diagnoses of Hyperlipidemia or mood disorder as indicated on resident s most recent medical evaluation, dated . Also, resident s most recent assessment is documented as both an initial and annual assessment.

Resident s significant change assessment, dated does not include the diagnoses of mood disorder and Depression as indicated on resident s status change medical evaluation, dated .

Resident s most recent assessment, dated , is blank and does not include an assessment of resident s supervision needs and medication needs.

Resident s most recent assessment, dated does not include the diagnoses of coagulation defect, Dementia and sleep disorder as indicated on resident s most recent medical evaluation, dated .

Resident s most recent assessment was completed on

Repeated Violation

Plan of Correction ***Directed (- 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre screen and RASP on all residents.

All staff will be educated by 7/24/2026 on the purpose, the need and the required information for assessments for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

225c - Additional Assessment (continued)

Administrator will complete a monthly audit for 6- months on all RASP to make sure all information is correct and any new information is added. (DIRECTED: The monthly audits shall begin on 8/10/26. [redacted] 8/6/26). Consultant educated administrative staff on the monthly audit form on 7/20/2026 and training will be in the staff training book located in the administrative office for review at all times.

Resident [redacted] (passed away [redacted]
[redacted] Mood disorder and depression was not listed on new DME completed on 7/15/26
[redacted] Supervision need and medication needs are completed according to regulations.
[redacted] Coagulation defect, dementia and sleep disorder was not listed on new DME completed on 7/14/2026
The new assessment for resident [redacted] was completed on 7/13/2026 and was completed by Business office manager the audit was completed on 8/4/2026 by the administrator to ensure all assessments are completed accurate and according to regulations, This audit will be kept in the POC audit book located in the administrator office for review at all time.

All current residents have a completed and current assessment present

Administrator will complete and update resident assessments according to regulations and required timelines.

Administrator will complete a monthly audit on 3 residents on their assessment form to ensure all information is correct and completed in a timely manner. This audit will begin 8/10/2026 and will be kept in the POC audit book located in that administrators office for review at all time.

A tracking form will be started on 8/10/2026 to track all admission required resident forms. This will be completed by the administrator and administrator will review and update the tracking sheet weekly and make any all changes as needed, This tracking form will be kept in the resident required form book located in the administrators office for review at all time.

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/10/2026*

Not Implemented ([redacted] - 08/17/2026)

226a - Mobility Assessment

24. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

The entire home is licensed as a SDCU.

Resident [redacted]s most recent assessment, dated [redacted] indicates resident [redacted] has a minimal mobility need and only requires limited physical and oral assistance to evacuate in an emergency.

Resident [redacted] significant change assessment, dated [redacted], indicates resident [redacted] has a minimal mobility need and

226a - Mobility Assessment (continued)

only requires limited physical and oral assistance to evacuate in an emergency.

Resident [redacted]s most recent assessment, dated [redacted] indicates resident [redacted] has a minimal mobility need and only requires limited physical and oral assistance to evacuate in an emergency.

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre screen and RASP on all residents.
All staff will be educated by 7/24/2026 on the purpose, the need and the required information for assessments for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.
Administrator will complete a monthly audit for 6 months on all RASP to make sure all information is correct and any new information is added. (DIRECTED: The monthly audits shall begin on 8/10/26. [redacted] 8/6/26).
Consultant educated administrative staff on the monthly audit form on 7/20/2026 and training will be in the staff training book located in the administrative office for review at all times.

Resident [redacted] passed away 6/24/2026
[redacted] they are updated on the new RASP completed on 7/15/2026
[redacted] They are updated on the new RASP completed on 7/15/2026
[redacted] completed all these updates on the new Rasp

Administrator or Business office manager will complete and update all residents assessments as required and timely. All residents assessments were reviewed to ensure accuracy and completeness on 8/4/2026 by the administrator and audit will be kept in the POC audit book located in the administrators office for review at all time.

Monthly audit will begin on 8/10/2026 and 3 residents will be reviewed per month for accuracy and completeness, This audit will be completed by the administrator and will be kept in the POC audit book located in the administrators office for review at all time.

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/10/2026*

Not Implemented ([redacted] - 08/17/2026)

231c - Preadmission Screening

26. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the SDCU on [redacted] however, resident [redacted]s cognitive preadmission screening was completed on [redacted]

Repeated Violation-[redacted]

Plan of Correction

Directed ([redacted] - 08/06/2026)

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents.
All staff will be educated by 7/24/2026 on the purpose, the need and the required information for preadmission screening form for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.
Upon admission the administrator will complete the new resident required paperwork checklist acknowledging that the forms are completed in a timely manner and all information is complete and accurate. ~~This form will be on-going for the next 12 months.~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. DIRECTED: The new admission checklist shall be used indefinitely to ensure timely and complete cognitive preadmission screenings are obtained for all newly-admitted residents in accordance with 2600.231c. Copies of the completed checklists shall be kept in each resident's record. [redacted] 8/6/26). Consultant will educate administrator on 7/21/2026 on this and the education will be kept in the staff training book located in the administrators office for review at all times.

Administrator audit all current resident records on 8/4/2026 to ensure all residents have a cognitive screening. This audit will be kept in the POC audit book located in the administrator office for review at all time.

Administrator will complete all preadmission screenings prior to admissions and these screens will be kept in the residents file for review at all time.

The new checklist will be implemented on 8/10/2026 and will be kept in each new admission record for review at

231c - Preadmission Screening (continued)

all time.

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/04/2026*

Not Implemented [redacted] - 08/17/2026)

233c - Key-Locking Devices

27. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On [redacted] at 9:28am, the directions for operating the keypad locking system at the home's 2nd floor emergency exit door in bedroom [redacted] were not posted near the door.

Plan of Correction ***Accept [redacted] 08/06/2026)***

Business office manager posted the directions on 7/16/2026.

Business office manager will audit every key-locking device to ensure the directions are posted Monday-Friday for 3 months then monthly for 6 months. This audit will be kept in the POC audit book that is located i the administrator office for viewing at all times.

The daily audits will begin on 7/15/2026

Licensee's Proposed Overall Completion Date: *08/04/2026*

Not Implemented ([redacted] - 08/17/2026)

234a - Admission Support Plan

28. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [redacted] was admitted to the SDCU on [redacted] however, at the time of inspection, only 2 pages (pages 1 and 3) of resident #[redacted] support plan, dated [redacted] were present in the home.

234a - Admission Support Plan (continued)

Repeated Violation-[redacted]

Plan of Correction ***Directed*** [redacted] ***08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents.

All staff will be educated by 7/24/2026 on the purpose, the need and the required information for medical evaluations for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Administrator will complete the new resident required paperwork checklist to ensure all information is completed timely and accurate for all required forms upon admission. ~~This will be done for 12 months~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. DIRECTED: The new admission checklist shall be used indefinitely to ensure timely and complete support plans are obtained for all newly-admitted residents in accordance with 2600.234a. Copies of the completed checklists shall be kept in each resident's record. LM 8/6/26) and will be kept in the POC audit book in the administrators office for review at all times.

Resident #[redacted]*support plan was completed on 7/14/2026*

Administrator and business office manager completed audit on 7/13/2026 and audit will be kept in the POC audit book located in the administrators office for review at all time.

All resident currently have new support plans competed accurately and according to regulations. These support plans will be kept in the residents file for review at all time.

Administrator will complete all support plans and these will be kept in the residents file for review at all time.

The new checklist will be started on 8/10/2026 completed checklist will be kept in each new admission record.

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/04/2026*

Not Implemented [redacted] ***- 08/17/2026)***

234b - Support Plan Needs Elements

29. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

234b - Support Plan Needs Elements *(continued)*

Description of Violation

Resident [redacted] was admitted to the SDCU on [redacted] however, resident #[redacted]s initial assessment, dated [redacted] does not include an assessment of resident #[redacted] supervision or medication needs. These areas of resident #[redacted]s assessment are blank. Also, resident #[redacted] assessment does not include any of the diagnoses indicated on resident #[redacted]s medical evaluation, dated [redacted] to include [redacted] and [redacted]

Resident #[redacted]s assessment, dated [redacted] indicates resident #[redacted] requires prompting/cueing for bladder management; however, resident #[redacted] support plan, dated [redacted] indicates "N'A" for the plan to meet this service need. Also, resident #[redacted] assessment indicates resident #[redacted] is moderately immobile; however, resident #[redacted]s support plan indicates "N/A" for the description and plan to meet this service need.

Repeated Violation-[redacted]

Plan of Correction ***Directed [redacted] 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents. These will be completed by 7/21/2026 and education will begin with all staff.
All staff will be educated by 7/24/2026 on the purpose, the need and the required information for medical evaluations for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Administrator will complete the new resident required paperwork checklist to ensure all information is completed timely and accurate for all required forms upon admission. This will be done for 12 months and will be kept in the POC audit book in the administrators office for review at all times.

Resident # 8 new support plan was updated on 7/13/2026. Resident received a new support plan on 7/13/2026 and Maryann completed the new support plan to meet regulations and accuracy.

All resident currently have a completed and current support plan to meet regulations and accuracy. these plan are kept in the residents files for review at all time.

Administrator will complete and update all resident support plans

The new checklist will be implemented on 8/10/2026 and completed checklist will be kept in each new admission record.

DIRECTED: Beginning on 8/10/26: The administrator/designee shall review at least 4 different resident support plans each week for 1 month then monthly thereafter to ensure accuracy and completeness. LM 8/6/26

234b - Support Plan Needs Elements (continued)

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/10/2026*

Not Implemented [redacted] - 08/17/2026)

234d - Support Plan Revision

30. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [redacted] most recent assessment, dated [redacted] indicates resident [redacted] requires total physical assistance with bladder management; however, resident [redacted] most recent support plan, dated [redacted] indicates "N/A" for the plan to meet this need.

Resident [redacted] significant change assessment, dated [redacted] indicates resident [redacted] requires some physical assistance with bladder management; however, resident [redacted] significant change support plan, dated [redacted] indicates "N/A" for the plan to meet this need.

Plan of Correction ***Directed ([redacted] - 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents. These will be completed by 7/21/2026 and education will begin with all staff.
All staff will be educated by 7/24/2026 on the purpose, the need and the required information for medical evaluations for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Administrator will complete the new resident required paperwork checklist to ensure all information is completed timely and accurate for all required forms upon admission. This will be done for 12 months and will be kept in the POC audit book in the administrators office for review at all times.

Resident # 8 new support plan was updated on 7/13/2026. Resident received a new support plan on 7/13/2026 and Maryann completed the new support plan to meet regulations and accuracy.

All resident currently have a completed and current support plan to meet regulations and accuracy. these plan are kept in the residents files for review at all time.

Administrator will complete and update all resident support plans

234d - Support Plan Revision (continued)

The new checklist will be implemented on 8/10/2026 and completed checklist will be kept in each new admission record.

DIRECTED: Beginning on 8/10/26: The administrator/designee shall review at least 4 different resident support plans each week for 1 month then monthly thereafter to ensure accuracy and completeness. LM 8/6/26

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/10/2026*

Implemented [redacted] - 08/17/2026)

251c - Standardized Forms

31. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident [redacted] status change medical evaluation, dated [redacted] is not completed on the Department's current medical evaluation form.

Resident [redacted] status change medical evaluation, which is dated on page 1 as being completed on [redacted] and dated on page 2 as being completed on [redacted], is not completed on the Department's current medical evaluation form.

Resident [redacted] most recent medical evaluation, dated [redacted] is not completed on the Department's current medical evaluation form.

Resident [redacted] medical evaluation, dated [redacted] is completed on the Department's Assisted Living Residence's medical evaluation form. The home is licensed as a Personal Care Home.

Plan of Correction ***Directed ([redacted] 08/06/2026)***

Upon auditing all residents files under the new Administrator and with the Business Office Manager no pre-screen, DME and RASP within the last year can be located
Consultant completed a full house assessment of every resident and had the physician complete new medical evaluations on all residents to ensure all information is accurate and effective for quality care of the residents. These medical evaluations will be in residents files and will be used to complete house wide new pre-screen and RASP on all residents. These will be completed by 7/21/2026 and education will begin with all staff.
All staff will be educated by 7/24/2026 on the purpose, the need and the required information for medical evaluations for all residents in a personal care home. This education will be completed by the administrator and will be kept in the staff training book in the administrator office for review at all time.

Resident [redacted] passed away on [redacted]
Resident [redacted] new DME was completed on
Resident [redacted] new DME was completed on
Resident [redacted] new DME was completed on

251c - Standardized Forms (continued)

Administrator will oversee all DME's prior to admission to ensure they are completed accurate and timely to meet regulations.

DIRECTED: By 8/13/26: The home's consultant shall educate the new administrator on all of the Department's current forms, including the Department's current medical evaluation form, to ensure compliance with 2600.251c. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 8/6/26)

DIRECTED: Beginning on 8/15/26: The administrator/designee shall review at least 4 different resident records each month to ensure compliance with 2600.251c. [redacted] 8/6/26

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/15/2026*

Not Implemented ([redacted] - 08/17/2026)

252 - Record Content

32. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

Resident [redacted] ceased to breathe in the home on resident [redacted] date of death; however, a copy of resident [redacted] death certificate was not present in resident [redacted] record at the time of inspection.

Plan of Correction ***Directed [redacted] - 08/06/2026)***

Resident [redacted] death certificate was received and put in the residents closed file.

Administrative staff was educated by the consultant on 7/20/2026 on required information for resident chart when a resident ceased to breathe in the home. This education will be kept in the staff training binder in the administrators office for review at all times.

Administrator will complete the death certificate log for all in house ceased to breathe to make sure all documentation is received and filed to meet regulations. Administrative staff was educated by the consultant on 7/20/2026 on the proper way to use the log and what steps to take to receive the documentation they are required to have. This education will be kept in the staff training book and will be kept in the administrator office for review at all times.

DIRECTED: By 8/13/26: The home's consultant shall educate the new administrator on all requirements specified in 2600.252. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 8/6/26)

DIRECTED: Beginning on 8/15/26: The administrator/designee shall review at least 4 different resident records each month to ensure all items specified in 2600.252 are present in each resident record. [redacted] 8/6/26

252 Record Content (continued)

Proposed Overall Completion Date: 08/04/2026

Directed Completion Date: *08/15/2026*

Not Implemented [redacted] 08/17/2026)