

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

October 2, 2026

[REDACTED] OPERATIONS
ACTS RETIREMENT-LIFE COMMUNITIES INC
[REDACTED]
[REDACTED]

RE: OAKBRIDGE TERRACE AT SPRING
HOUSE ESTATES
728 NORRISTOWN ROAD
LOWER GWYNEDD, PA, 19002
LICENSE/COC#: 13901

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/01/2026, 09/02/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: OAKBRIDGE TERRACE AT SPRING HOUSE ESTATES **License #:** 13901 **License Expiration:** 05/31/2027
Address: 728 NORRISTOWN ROAD, LOWER GWYNEDD, PA 19002
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: ACTS RETIREMENT-LIFE COMMUNITIES INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 06/21/2001 **Issued By:** CWOPA

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 78 **Waking Staff:** 59

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 09/02/2026

Inspection Dates and Department Representative

09/01/2026 - On-Site: [REDACTED]
09/02/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 52 **Residents Served:** 39

Special Care Unit

In Residence: Yes **Area:** Oakbridge Terrace West **Capacity:** 30 **Residents Served:** 23

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 39
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 39 **Have Physical Disability:** 0

Inspections / Reviews

09/01/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/27/2026

Inspections / Reviews (*continued*)

10/02/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/02/2026

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

10/02/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/02/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

17 Record confidentiality**1. Requirements**

2800.

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

Description of Violation

On 9/1/2026, at 10:09 am, the laptop on top of the medication cart in the east was unlocked, unattended, and accessible with a resident's medication information.

Repeated violation - 11/10/2025, 8/20/2025, et al.

Plan of Correction**Accept () - 10/02/2026)**

This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.

The laptop was immediately secured, and staff were reminded of confidentiality and information security requirements. Staff will receive education on 9/4/26. Administrator or designee will implement routine environmental rounds to monitor for unattended devices, visible resident information, and other potential confidentiality breaches. Audits will be conducted weekly for four weeks and monthly thereafter for three months starting 9/4/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)**28e Refund - death****2. Requirements**

2800.

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

Description of Violation

Resident #1 passed away on [REDACTED]. Resident #1's personal belongings were removed from [REDACTED] room on [REDACTED]. However, the residence did not refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room was cleared of the resident's personal property. The refund was paid on [REDACTED].

Plan of Correction**Accept () - 10/02/2026)**

The POA received the reimbursement check on [REDACTED]. Files for deceased residents were reviewed to verify compliance with 30-day timeframe.

The Business Office Manager will be re-educated on the requirements including the timeframes for processing resident refunds following death. Administrator or designee will review the refund audits for resident discharges and deaths to ensure refunds are processed within the required timeframe, and documentation is maintained in the resident record.

28e Refund - death (continued)

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

54a Direct care staff quals

3. Requirements

2800.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.
4. Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident's final support plan under § 2800.227(e) (relating to development of the final support plan).

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept () - 10/02/2026)

Staff Person A's personnel file was immediately reviewed to determine whether qualifying documentation was available. Documentation was obtained and filed, or the staff member was removed from direct care duties until requirements were met. An audit of direct care staff personnel files was conducted on 9/3/26 to verify the presence of required qualifications, including a high school diploma, GED and nurse register. Hiring managers staff will be educated on the requirements. Administrator or designee will audit personnel files monthly for three months to ensure direct care staff meet qualification requirements starting 9/3/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

62 Contact list

4. Requirements

2800.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

() the Administrator, did not have a current staff list. The home shares staff with another community. Staff person C was not on the staff list and worked at the home 2 weeks ago per ()

Repeated violation - 5/14/2026

Plan of Correction

Accept () - 10/02/2026)

The staff list was updated to reflect any sister pool staff. A complete audit of personnel records was conducted on 9/2/26 to verify that staff currently providing services in the community are accurately reflected on the staff list. Administrator or designee will conduct weekly audits of the staff roster for four weeks and monthly audits for three months starting 9/3/26.

62 Contact list (continued)

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

65e Rights/Abuse 40 Hours

5. Requirements

2800.

65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
 - i. Person-centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Description of Violation

Staff person A completed () 40th scheduled work hour on () However, this staff person did not complete training in the following topics:

- Person-centered care.
- Communication problem solving and relationship skills.

Plan of Correction

Accept () - 10/02/2026)

Staff Person A will complete the required core competency training in person-centered care; and Communication, problem solving and relationship skills. Administrator or designee will review the orientation schedule and training records for newly hired or newly oriented personnel to ensure that required training is completed timely.

Administrator or designee will audit new employee orientation records weekly for 90 days to verify required training starting 9/3/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

65j Annual training content

6. Requirements

2800.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).

65j Annual training content (*continued*)

5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert during training year 2025.

Plan of Correction

Accept () - 10/02/2026)

Staff Person D will complete the required annual fire safety training. Administrator or designee will audit the training records of direct care staff persons, ancillary staff persons, substitute personnel, and regularly scheduled volunteers to verify completion of the required annual fire safety training for training year 2025. Administrator or designee will conduct quarterly audits of employee training records for 12 months to verify compliance starting 9/3/26. Audit results will be reviewed during QA.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

69 Dementia training

7. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person A, date of hire () received only 1 hour of dementia-specific training within 30 days of hire.

Plan of Correction

Accept () - 10/02/2026)

Staff Person A will complete the additional three hours of dementia-specific training necessary to meet the minimum four-hour training requirement. Administrator or designee will review the training records for administrative staff, direct care staff persons, ancillary staff persons, substitute personnel, and volunteers to determine whether each applicable individual has completed the required dementia-specific training. Staff responsible for onboarding was educated on 9/3/2026. Administrator or designee will audit newly hired employee training records weekly for 90 days to ensure staff receive a minimum of 4 hours of dementia-specific training within 30 days of hire on 9/3/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

8. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person E, date of hire (), received only 1.5 hours of dementia-specific training during training year 2025.

69 Dementia training (continued)

Plan of Correction

Accept () - 10/02/2026)

Staff Person E will complete the additional 0.5 hour of dementia-specific training necessary. Administrator or designee will conduct an audit of the dementia-specific training records. Staff responsible for onboarding was educated on 9/3/2026.

Administrator or designee will conduct monthly audits of applicable personnel training records to verify compliance starting 9/3/2026.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

81b Resident equip – good repair

9. Requirements

2800.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #2's bedside mobility device is not secured to the bed frame and slides out from beneath the mattress easily when pulled creating an entrapment hazard. The U-shaped covered bedside mobility device consisted of a base that extended approximately 24.1 inches in length and 11.2 inches in width. The device had a top handle measuring approximately 5.2 inches in width, a side handle measuring approximately 8.5 inches in height and a side opening measuring approximately 3.7 inches.

Repeated violation - 5/14/2026

Plan of Correction

Accept () - 10/02/2026)

Resident # 2's bedside mobility device was immediately removed from service. Residents with mobility devices were assessed for safety and proper installation. A preventive maintenance and equipment safety audit will be implemented to ensure resident equipment remains clean, secure, and in good repair. Maintenance director reeducated on 9/18/26 on resident equipment safety, including proper installation, inspection, reporting, and removal of equipment that presents a safety risk. Maintenance Director or designee will conduct weekly audits of resident equipment for four weeks and monthly audits thereafter for three months starting 9/18/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

132a Monthly fire drill

10. Requirements

2800.

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 month of August 2026.

Plan of Correction

Accept () - 10/02/2026)

An unannounced fire drill was conducted upon identification of the missed drill for August 2026. Documentation of the fire drill has been completed and maintained in the community's fire drill records. Maintenance director or designee reviewed fire drill documentation for the previous 12 months to ensure required monthly unannounced

132a Monthly fire drill (continued)

fire drill. Staff responsible for conducting fire drill will be education on 9/4/26. Maintenance director or designee will conduct quarterly audits of fire drill documentation for a period of 12 months to ensure monthly unannounced fire drills are completed and appropriately documented starting 10/1/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

132c Fire drill records**11. Requirements**

2800.

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 residence 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 fire drill record for the drill conducted on 10/16/2025 at 11:20 pm documented 23 residents in West and 21 residents in East present in the residence at the time of the drill. The fire drill record documented 21 residents in the West and 26 residents in the East evacuated the residence. However, the participation log documented 26 residents in West and 22 residents in East. The record also indicated that one resident on hospice in the West did not participate.

The fire drill record for the drill conducted on 12/12/2025 at 8:00 pm documented 25 residents present in West and 21 residents present in East in the residence at the time of the drill. The fire drill record documented 24 residents in the West and 21 residents in the East evacuated the residence. However, the participation log documented 22 residents in the West and 21 residents in the East. The record also indicated that one resident on hospice in the West did not participate. Additionally, the number of staff documented on the fire drill record states 3 in the West and 4 in the East. However, the participation log has 1 staff person in the West and one staff person in the East.

Plan of Correction

Accept () - 10/02/2026)

The fire drill records and participation logs for 10/16/2025 and 12/12/2025 were reviewed. Staff responsible for conducting and documenting fire drills were educated on 9/8/26 regarding the importance of accurate and consistent documentation. Administrator or designee will review all fire drill documentation after each drill to ensure required information is complete, accurate, and consistent with participation records before filing. Administrator or designee will conduct monthly audits of fire drill records for three months to ensure ongoing compliance starting 9/8/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

171b5 Transportation-first aid kit**12. Requirements**

2800.

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

5. The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

171b5 Transportation first aid kit (*continued*)**Description of Violation**

On 9/1/2026, the first aid kit in the 2015 Lincoln used to transport residents does not include a breathing shield.

Repeated violation 8/20/2025, et al.

Plan of Correction

Accept () - 10/02/2026)

A breathing shield was immediately obtained and added to 2015 Lincoln's first aid kit. Transportation manager conducted an audit on 9/10/26 of facility vehicles used for resident transportation to verify that each vehicle contained a complete first aid kit with required supplies. Any identified deficiencies were corrected immediately. Transportation manager or designee will conduct quarterly audits of transportation vehicle first aid kits for a period of 12 months to ensure ongoing compliance with regulatory requirements starting 9/10/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

181c Self-Administer Assessment

13. Requirements

2800.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #3 self administers medications to include Flonase allergy relief suspension 50 MCG/ACT (fluticasone Propionate Nasal); however, resident #3 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self administer and the need for reminders to take medications.

Repeated violation 5/14/2026

Plan of Correction

Accept () - 10/02/2026)

Resident #3's physician was contacted to complete an assessment of the resident ability to safely self administer medications. The resident's assessment and support plan were updated to reflect the resident's medication management needs and abilities. Nursing staff was reeducated on self administer obtaining and maintaining appropriate assessments for residents who self administer medications and ensuring support plans are updated accordingly. Administrator or designee will conduct weekly audits x 4 weeks and monthly audits x 3 months of all residents who self administer medications on 9/3/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

183d Current medications

14. Requirements

2800.

183d Current medications (continued)

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

Description of Violation

On 9/2/2026, Voltaren Arthritis pain topical gel 1% prescribed for resident #3 was in the residence's medication cart in green west; however, the medication administration record (MAR) for August 2026 states the medication is prescribed for 10 days. The medication administration record (MAR) for September 2026 does not include the medication.

Repeated violation - 5/14/2026

Plan of Correction

Accept () - 10/02/2026)

Upon identification of the concern, the medication for Resident #3 was reviewed against the current physician's order and MAR. The medication was removed from the active medication cart and handled in accordance with the residence's medication disposal/return procedures. Resident #3's current medication orders and MAR were reviewed to ensure that medications available for administration were current and properly documented. Staff was reeducated on 9/4/26. A complete audit of resident medications was conducted on 9/4/26 to identify and remove any discontinued, expired, or non-current prescription medications, OTC medications, samples, or CAM therapies. Administrator or designee will implement a monthly medication reconciliation process. Weekly audits of medication carts will be conducted for four weeks and monthly thereafter for three months starting 9/4/26,

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

185a Storage procedures**15. Requirements**

2800.

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

Description of Violation

Resident #2 is prescribed acetaminophen Codeine oral solution 120-12mg/5ml at bedtime and 5ml every 6 hours as needed for pain. On 9/2/2026 the amount remaining was 85-90ml. However, the remaining amount documented on the controlled medication accountability record was 100ml. The control substance sheet for 8/26/2026 at bedtime and 8/28/2026 at 10:14 am and 9/1/2026 at bedtime were not documented on the controlled medication accountability record.

Per the residence's medication policy:

- Staff will document the receipt of controlled substances and the quantities received using the controlled medication accountability record.*
- Maintain a controlled substance log sheet which keeps a running count of the remaining narcotics/controlled substances and the amount that has been distributed. The license nurse and med tech will use the release and acceptance of controlled drug inventory form to determine the amount of controlled substances at the beginning and end of every shift.*

185a Storage procedures (continued)

Resident #2 is prescribed oxycodone 5mg 1/2 tablet twice a day. On 8/27/2026, at 4:00 pm the controlled medication accountability record for 8/27/2026, states one pill was wasted. However, one signature is on the controlled medication accountability record, and the home did not have a medication disposition form completed.

Per the residence's medication policy:

Medication disposition form or a similar form supplied by the contract pharmacy will be completed by the license nurse for each resident having medication discontinued, expired sent with the resident upon discharge, destroyed, discarded or returned to the pharmacy. The medication disposition form shall be completed and maintained as follows:

- *The licensed nurse shall list the name, strength, quality and prescription number of all medications disposed.*
- *The method of disposition must be noted.*
- *The medication disposition form shall be maintained with the resident's health care record.*

Plan of Correction**Accept () - 10/02/2026)**

Upon identification of the deficiency, the controlled medication records for Resident #2 were immediately reviewed. A reconciliation of controlled substances was completed, discrepancies were investigated, and corrective documentation was completed as appropriate. Staff responsible for medication administration was re-education on 9/4/26. Weekly audits of controlled substance records, medication counts, and medication disposition documentation will be completed for four weeks and monthly thereafter for three months by administrator or designee starting 9/4/26. Audit results will be reviewed during Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)**187a Medication record****16. Requirements**

2800.

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).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

187a Medication record (continued)

Description of Violation

Resident #4 is prescribed HumaLOG KwikPen 100 units/ML on a sliding scale. On 8/25/2026, at 5:00 pm, the residents' blood sugar reading was documented as 318 requiring 4 units of HumaLOG KwikPen to be administered. However, resident #4's medication administration record(MAR) for August 2026 does not include the units of insulin administered.

Repeated violation - 8/20/2025, et al.

Plan of Correction

Accepted () - 10/02/2026)

The MAR for Resident #4 was immediately reviewed and corrected as applicable. A review was completed to ensure insulin administration documentation accurately reflected blood glucose results and corresponding insulin doses administered. A comprehensive audit of all residents receiving insulin and other variable-dose medications was conducted to verify that MAR documentation includes the specific dose administered in accordance with physician orders.

The nursing team is being education on the importance of documentation of the blood sugar readings at the time they are taken on 9/4/26. Monthly audits will be started in September and completed for those residents on insulin to ensure blood sugar reading is recorded at the time of completion and medication administration records. Audits will begin 9/26 will be reported to QA monthly for 3 months.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

187b Date/time of med admin

17. Requirements

2800.

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

Description of Violation

Resident #2 is prescribed Oxycodone 5 mg give 0.5 tablet by mouth twice a day for pain . Resident #2's August 2026 medication administration record (MAR) does not include the initials of the staff person who administered Oxycodone 5 mg 0.5 mg tab on 8/19/2026, at 6:30 am.

Resident #3 is prescribed levoxyl oral tablet 150 mcg give one tablet by mouth in the morning for hypothyroid. Resident #3's August 2026 MAR does not include the initials of the staff person who administered levoxyl oral tablet 150 mcg on 8/16/2026, at 6:45 am.

Resident #5 is prescribed Levothyroxine sodium oral tablet 88 mcg give one tablet by mouth one time a day for hypothyroidism. Resident #5's August 2026 MAR does not include the initials of the staff person who administered Levothyroxine sodium oral tablet 88 mcg on 8/15/2026.

Repeated violation - 5/14/2026

187b Date/time of med admin (continued)

Plan of Correction

Accept () - 10/02/2026)

Resident #2 August 2026 MAR was reviewed regarding Oxycodone 5 mg, 0.5 tablet by mouth twice daily for pain. The facility identified the missing staff initials for the 6:30 a.m. administration on 8/19/2026. The MAR was reviewed and corrected in accordance with facility policy and applicable requirements, without altering the original record or creating a false entry. Resident #3 August 2026 MAR was reviewed regarding Levothroxyl 150 mcg administered in the morning for hypothyroidism. The facility identified the missing staff initials for the 6:45 a.m. administration on 8/16/2026. The MAR was reviewed and corrected in accordance with facility policy and applicable requirements, without altering the original record or creating a false entry. Resident #5 August 2026 MAR was reviewed regarding Levothyroxine sodium 88 mcg administered once daily for hypothyroidism. The facility identified the missing staff initials for the 8/15/2026 administration. Administrator reviewed the circumstances surrounding the omitted initials with the staff involved and reinforced the requirement that medication administration documentation be completed at the time the medication is administered. Administrator or designee immediately reviewed the identified medication administration records and re-educated medication administration staff on 9/9/26 on the requirement that medications must be documented at the time of administration, including the initials of the staff person administering. Administrator or designee will conduct weekly audits of medication administration records for four weeks and monthly audits for 12 months starting 9/9/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

227d Support plan – med/dental

18. Requirements

2800.

227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

The assessment for resident #2, dated () indicates the resident has a need for a bedside mobility device for turning and positioning in bed. The resident's support plan, dated () does not indicate the following: a specific need for the device, the intended use, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, identification of the specific device to be used, and if a cover is required to meet FDA guidelines.

Plan of Correction

Accept () - 10/02/2026)

Resident #2's support plan was immediately reviewed and revised to accurately reflect the resident's need for a bedside mobility device. The updated support plan identifies the specific device being used, its intended purpose for turning and positioning in bed, associated safety risks, the resident's ability to use the device safely. The revised support plan was reviewed with care staff responsible for providing services to the resident. Administrator conducted a review of all residents utilizing bedside mobility devices and other assistive equipment to ensure support plans contain all required information. Care staff was education on 9/9/26 regarding support plan requirements and documentation. Administrator and/or designee will audit five resident records monthly for 90 days to ensure support plans accurately reflect all devices and services identified in resident assessments starting 9/9/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

227d Support plan – med/dental (*continued*)*Implemented () - 10/02/2026)*

227e Self administer medication

19. Requirements

2800.

227.e. The resident's final support plan must document the ability of the resident to self administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key locking devices. Strategies that promote interactive communication on the part of and between direct care staff and individual residents shall also be included in the final support plan.

Description of Violation

Resident #3's final support plan, dated () states the resident cannot self-administer medications. During staff interviews, it was disclosed that resident #3 self-administers with staff supervision Flonase allergy relief suspension of 50 MCG/ACT (fluticasone Propionate Nasal).

Plan of Correction*Accept () - 10/02/2026)*

Reviewed medication administration practices and support plans for all residents to ensure the documented level of medication assistance accurately reflects current practice. Staff received education regarding the requirements for support plan accuracy, including documenting whether residents self-administer medications independently on 9/14/26. Administrator or designee will conduct weekly audits of resident support plans and medication administration records for four weeks, then monthly for three months, starting on 9/14/26. Administrator or designee will report to QA quarterly.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

251b Record entries legible

20. Requirements

2800.

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

Description of Violation

The controlled medication accountability record for resident #2's Oxycodone 5 mg tablet was written over with ink on 8/27/2026 at 4:00 pm making the count on hand difficult to read.

Plan of Correction*Accept () - 10/02/2026)*

The controlled medication accountability record for Resident #2's Oxycodone 5 mg tablet was immediately reviewed. The medication count was verified and reconciled to ensure accuracy. Staff involved were instructed on the proper procedure for correcting documentation errors without obscuring original entries and maintaining legible records. Administration re-educated on 9/10/26 all medication administration staff on documentation requirements for resident records, including maintaining records that are permanent, legible, dated, and signed. Administrator or designee will conduct weekly audits of controlled substance accountability records for four weeks and monthly audits thereafter for three months starting 9/10/26.

Licensee's Proposed Overall Completion Date: 09/24/2026

Implemented () - 10/02/2026)

251b Record entries - legible (*continued*)