

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

October 19, 2026

[REDACTED], PRESIDENT
WELL BL OPCO LLC
[REDACTED]
[REDACTED]

RE: BRANDYWINE LIVING AT
HAVERFORD ESTATES
731 OLD BUCK LANE
HAVERFORD, PA, 19041
LICENSE/COC#: 14433

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/09/2026, 09/10/2026 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: BRANDYWINE LIVING AT HAVERFORD ESTATES

License #: 14433

License Expiration: 05/09/2027

Address: 731 OLD BUCK LANE, HAVERFORD, PA 19041

County: DELAWARE

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: WELL BL OPCO LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 04/05/2000

Issued By: Commonwealth of
Pennsylvania, L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 128

Waking Staff: 96

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Incident

Exit Conference Date: 09/10/2026

Inspection Dates and Department Representative

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

09/10/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 118

Residents Served: 89

Secured Dementia Care Unit

In Home: Yes

Area: Reflections/Serenade

Capacity: 28

Residents Served: 24

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 89

Diagnosed with Mental Illness: 4

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 39

Have Physical Disability: 1

Inspections / Reviews

09/09/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/10/2026

Inspections / Reviews (*continued*)

10/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/19/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/19/2026

10/19/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/19/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

54a - Direct Care Staff

1. Requirements

2600.

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.

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 () - 10/14/2026)

Staff person A was immediately removed from the direct care schedule on 09/10/2026. The Home requested and received a waiver on 9/21/2026 (attached). The Administrator re-educated the Business office manager and wellness director on 2600.54a on 9/15/2026 (attached). By 10/19 the business office manager/designee will complete an audit on team member files to ensure compliance with 2600.54a (attached). Any non-compliant team members will be removed from the direct care schedule and a waiver will be requested from the Department. Beginning 9/15/2026-thereafter, the administrator/designee will confirm compliance with 2600.54a, prior to hire. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.

65.b. 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.

Description of Violation

Staff person B completed 40th scheduled work hour on However, this staff person did not complete training in the following topics: Resident rights.

Repeated Violation - 3/5/2026, 8/18/2025, et al.

Plan of Correction

Accept () - 10/14/2026)

Staff person B is no longer employed by the Home. On 9/15/2026 the administrator re-educated the business office manager on 2600.65b.(attached). By 10/19/2026, the business office manager/designee will review current team member files to ensure compliance with 2600.65b prior to 40 hours (attached). Non-compliant current team member files will be updated during the audit to eliminate future violation. Beginning 10/5/2026, the business manager or

65b Rights/Abuse 40 Hours (continued)

designee will review each new team member file to ensure compliance. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

Implemented () - 10/19/2026)

65e - 12 Hours Annual Training**3. Requirements**

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received only 11.25 hours of annual training in training year 2025.

Direct care staff person B received 0 hours of annual training in training year 2025.

Plan of Correction

Accept () - 10/14/2026)

Direct Care Staff Person A was removed from the direct care schedule on 9/11/2026 and completed training on 9/15/2026 (attached). Staff Person B is no longer employed by The Home. On 9/15/2026 Administrator re educated the Business Office Manager and Wellness Director on 65e (attached). By 10/19/2026, the Business Office Manager or designee will complete an initial direct care staff training audit and monthly for two months, then quarterly times 4. Any non compliant team member on 12/31/2026 will be removed from schedule. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

65f - Training Topics**4. Requirements**

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
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.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

65f Training Topics (continued)

Description of Violation

Direct care staff person A did not receive training in the following during the 2025 training year:

- *Medication self administration training.*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Care for residents with dementia and cognitive impairments*

Plan of Correction

Accept () - 10/14/2026)

Staff person A was removed from the direct care schedule on 9/11/2026. Staff person A completed the training on 9/15/2026 (attached). By 10/19/2026, the Business Office Manager or designee will complete an initial direct care staff training audit and monthly for two months, then quarterly times 4. Any non compliant team member on 12/31/2026 will be removed from schedule. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

81b - Resident Personal Equipment

5. Requirements

2600.

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 #1 was observed to have two bedside mobility devices that were uncovered with an opening measuring approximately 21 inches wide by 31 inches high.

Resident #2 has a bedside device that is uncovered and secured to the bedframe. The bedside mobility device has an opening measuring approximately 12 inches wide by 21 inches high. The bedside mobility device was not securely attached to the bedframe and could be pulled away creating a hazardous zone of approximately 12 inches.

81b - Resident Personal Equipment (continued)

Plan of Correction

Accept () - 10/14/2026)

The maintenance director immediately removed the mobility devices from the beds on 9/10/2026 (attached) The Executive Director notified the family members and residents on the protocol for mobility devices on 9/18/2026 (attached). The wellness team were re-educated on 9/18/2026 to notify the Wellness/Executive Director if a mobility device is observed on a resident's bed. This will allow us to ensure that the device meet the requirements. To ensure compliance is maintained the maintenance director/designee will complete monthly apartment rounds beginning 10/12/2026-12/12/2026 (attached). Any non-compliant devices will be removed immediately and nursing will be notified, to ensure the resident safety. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/12/2026

Implemented () - 10/19/2026)

103g - Storing Food

6. Requirements

2600.

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

Description of Violation

On 9/10/2026, at 11:03 am, the waffles in the main kitchen walk in freezer was opened and unsealed.

On 9/10/2026, at 11:05 am, the package of spaghetti in the home's dry storage area was opened and unsealed.

Plan of Correction

Accept () - 10/14/2026)

The waffles and spaghetti was discarded by the cook on 9/10/2026. On 9/30/2026 the Dining Director re-educated the culinary team on 2600.103g (attached).Beginning 9/14/2026-12/14/2026 the dining director/designee will complete weekly audits to ensure compliance (attached). Any non-compliant items will be discarded and on the spot re-education will be completed. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

Implemented () - 10/19/2026)

103h - Thawing Food

7. Requirements

2600.

103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

On 9/10/2026, at 11:04 am, frozen brussel sprouts and corn were being thawed on a rack in the main kitchen area. It had been thawing there since an unknown time for the dinner service.

103h - Thawing Food (*continued*)**Plan of Correction****Accept () - 10/14/2026)**

The brussel sprouts and corn were discarded by the cook on 9/10/2026. On 9/30/2026 the Dining Director re-educated the culinary team on 2600.103h (attached). Beginning 9/14/2026-12/14/2026 the dining director/designee will complete weekly audits to ensure compliance (attached). Any non-compliant items will be discarded and on the spot re-education will be completed. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or trainings need to be completed.

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

Implemented () - 10/19/2026)

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 9/10/2026, at 11:00 am, there was an approximate .25-inch accumulation of lint in the lint trap of the home's commercial dryer. There were no clothes in the dryer at the time.

Plan of Correction**Accept () - 10/14/2026)**

The maintenance director immediately removed the lint during the walk-through on 9/10/2026. On 9/18/2026, the maintenance director re-educated the housekeeping team on 2600.105g (attached). Beginning 9/14/2026-12/14/2026 the maintenance director/designee will complete daily spot checks and weekly documented audits to ensure compliance with 2600.105g (attached). Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

Implemented () - 10/19/2026)

107c - Food/Water 3 Day Supply

9. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 9/10/2026, the home served 83 residents, requiring 249 gallons of emergency drinking water. However, the home had only 48 gallons of emergency drinking water on site. The home does not have a contract with a local bottled water supplier that includes emergency water delivery within 24 hours.

Plan of Correction**Accept () - 10/14/2026)**

The Home ordered 102 gallons on 8/10/2026, 100 gallons on 9/29/26, and 60 gallons on 10/7/2026, which equals 310 gallons (attached). On 9/30/2026, the Executive Chef re-educated the chef's on 2600.107c (attached). To ensure compliance is maintained, the Culinary Director/designee will audit supply monthly and on an on-going basis beginning 11/2026. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

107c - Food/Water 3 Day Supply (continued)

Implemented () - 10/19/2026)

182b - Prescription Medication

10. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 8/3/2026, at 8:00 pm, staff person C administered medications to Resident #3 to include the following; Melatonin 10 mg tablet and Senna 8.6 mg tablet. Staff person C is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On 8/25/2026, at 8:00 pm, staff person C administered medications to Resident #3 to include the following; Trazodone 50 mg tablet. Staff person C is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction

Accept () - 10/14/2026)

Staff person C was removed from the medication administration schedule on 9/10/2026. On 9/15/2026, the Executive Director re-educated the business office manager and wellness director on 2600.182b (attached), Beginning 9/15/2026 and continuing thereafter, to ensure compliance is maintained, newly hired medication technician's credentials will be sent to regional clinical director for review, prior to administering medications.

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

Implemented () - 10/19/2026)

183b - Meds and Syringes Locked

11. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 9/10/2026, there was over the counter medications such as refresh tears and congestion nasal relief spray were observed in resident's #1 bedroom on bedside table; however resident #1 has not been accessed as capable of

183b Meds and Syringes Locked (continued)

self administering medications.

On 9/10/2026, there were several over the counter medications such as Magnesium Glycinate, Melatonin, Pumpkin Seed Oil, Hair Skin and Nails, Magnesium Complex and Cypress Hemp Hybrid THC Gummies were observed in resident #3's bedroom on [REDACTED] bedside table; however resident #3 has not been accessed as capable of self administering medications.

Plan of Correction**Accepted** [REDACTED] - 10/14/2026)

The Wellness Director received permission on 9/10/2026 to remove the medications from Resident# 1 and #3. The resident's were both re educated by the wellness director on 2600.183b at that time. The wellness team were re educated by the wellness director on 9/18/2026 on 2600.183b (attached). The executive director notified the residents and family members via email on 9/18/2026 (attached). Beginning 10/1/2026 12/31/2026, the executive director or designee will complete monthly apartment audits (attached). Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

Implemented [REDACTED] - 10/19/2026)**183e - Storing Medications****12. 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 #4 is prescribed morphine O/Syr 5mg/0.25ml take 0.25 ml (.5mg) by mouth or under the tongue every 4 hours as needed for pain or shortness of breath. On 9/10/2026, 11 syringes were available on the medication cart with an expiration date of 9/7/2026. The medication was last administered on 9/3/2026.

Resident #4 is prescribed lorazepam O/Syr 0.5mg/0.25ml take 0.25 ml (0.5mg) (1 syringe) by mouth every 4 hours as needed for anxiety or restlessness. On 9/10/2026, 24 syringes were available on the medication cart with an expiration date of 6/22/2026. The medication was last administered on 9/1/2026.

Plan of Correction**Accepted** [REDACTED] - 10/14/2026)

The wellness director immediately removed the expired medications and re ordered medication, which was delivered on 9/10/2026 (attached). The wellness director re educated the wellness team on 2600.183e on 9/18/2026 (attached). Beginning 9/14/2026, the wellness director/designee will complete monthly medication cart audits times three months (attached). Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed

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

Implemented [REDACTED] - 10/19/2026)**185a - Implement Storage Procedures**

13. Requirements

2600.

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

Description of Violation

Resident #3 is prescribed Diphenoxylate- atropine oral tablet 2-5-0.25 mg and Prochlorperazine maleate oral tablet 5 mg as needed. On 9/10/2026, at 12:12 pm, these medications were not available in the home.

Resident #5 is prescribed Glutose 15 gel 40% as needed. On 9/10/2026, at 11:18 am, this medication was not available in the home.

Plan of Correction**Accepted () - 10/14/2026)**

On 9/10/2026, the wellness director immediately re-ordered the medications for resident #3 and #5 (attached). The physician discontinued resident #3 medication on 9/10/2026, due to resident request (attached). The wellness director re-educated the wellness team on 2600.185a on 9/18/2026 (attached). To ensure compliance is maintained beginning 9/14/2026, the wellness director/designee will complete monthly MAR and cart audits times three months (attached). Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed

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

Implemented () - 10/19/2026)**187b - Date/Time of Medication Admin.****14. 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 #1 is prescribed MiraLAX oral powder 17gm/scoop one time per day every day at 8:00 am. Resident #1's August 2026 medication administration record (MAR) does not include the initials of the staff person who administered MiraLAX oral powder 17gm on 8/4/2026 at 8:00 am.

Resident #3 is prescribed Melatonin 10 mg tablet take one tablet by mouth at 8:00 pm. Resident #3's August 2026 MAR does not include the initials of the staff person who administered Melatonin 10 mg tablet on 8/20/2026 at 8:00 pm.

Resident #3 is prescribed Mirtazapine oral tablet 15 mg take one tablet by mouth at 8:00 pm. Resident #3's August 2026 MAR does not include the initials of the staff person who administered Mirtazapine oral tablet 15 mg on 8/11/2026 and 8/20/2026 at 8:00 pm.

Resident #3 is prescribed Quetiapine fumarate 300 mg take one tablet by mouth every night at 8:00 pm. Resident #3's August 2026 MAR does not include the initials of the staff person who administered Quetiapine fumarate 300 mg tablet on 8/20/2026 at 8:00 pm.

Resident #3 is prescribed blood pressure checks three times per day at 8:00 am, 2:00 pm, 8:00 pm. Resident #3's August 2026 MAR does not include the initials of the staff person who administered blood pressure checks on 8/14/2026 at 2:00 pm, 8/14/2026 at 8:00 pm, 8/15/2026 at 2:00 pm, and 8/20/2026 at 8:00 pm.

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

Resident #5 is prescribed Carvedilol 3.125 mg tablet take one tablet by mouth twice daily at 8:00 am and 5:00 pm. Resident #5's August 2026 MAR does not include the initials of the staff person who administered Carvedilol 3.125 mg tablet on 8/3/2026 at 5:00 pm.

Resident #5 is prescribed Montelukast Sod 10 mg tablet take one tablet by mouth daily at 8:00 pm. Resident #5's August 2026 MAR does not include the initials of the staff person who administered Montelukast Sod 10 mg tablet on 8/24/2026 at 8:00 pm.

Resident #5 is prescribed Humalog Kwikpen 100 unit/ML subcutaneous on a sliding scale as follows: 0 units blood sugar glucose 0-200, 2 units into subcutis layer of skin blood sugar glucose 201-250; 4 units subcutis layer of skin blood sugar glucose 250-300; 6 units into subcutis layer of skin blood sugar glucose 301-350; 8 units into subcutis layer of skin blood sugar glucose 351-400; 10 units into subcutis layer of skin blood sugar glucose 401-450 four times a day every day at 6:30 am, 11:30 am, 4:30 pm and 9:00 pm. Notify MD for blood sugar less than 60 or greater than 450. Resident #5's August 2026 MAR does not include the initials of the staff person who administered Humalog Kwikpen 100/ML on 8/25/2026 at 9:00 pm and 8/31/2026 at 4:30 pm.

Resident #5 is prescribed blood sugar checks every day at 6:30 am, 11:30 am, 4:30 pm and 9:00 pm. Resident #5's August 2026 MAR does not include the initials of the staff person who administered blood sugar checks on 8/9/2026 at 11:30 am, 8/22/2026 at 4:30 pm and 8/31/2026 at 4:30 pm.

Resident #6 is prescribed Bumetanide 2 mg tablet take one tablet by mouth twice daily at 8:00 am and 8:00 pm. Resident #6's August 2026 MAR does not include the initials of the staff person who administered Bumetanide 2 mg tablet on 8/23/2026 at 8:00 pm.

Resident #6 is prescribed Eliquis 5 mg tablet take one tablet by mouth every 12 hours. Resident #6's August 2026 MAR does not include the initials of the staff person who administered Eliquis 5 mg tablet on 8/31/2026 at 9:00 pm.

Resident #7 is prescribed Eliquis 2.5 mg tablet take one tablet by mouth twice daily at 9:00 am and 9:00 pm. Resident #7's September 2026 MAR does not include the initials of the staff person administered Eliquis 2.5 mg tablet on 9/2/2026 at 9:00 pm.

Resident #7 is prescribed Pravastatin sodium 80 mg tablet take one tablet by mouth daily at 8:00 pm. Resident #7's September 2026 MAR does not include the initials of the staff person who administered Pravastatin sodium 80 mg tablet on 9/2/2026 at 8:00 pm

Repeated Violation - 8/18/2025, et al.

Plan of Correction**Accepted () - 10/14/2026)**

On 9/18/2026, the wellness director re-educated nurses and medication technicians in properly and timely documentation in the eMar of medication administration at the time of administering, per 2600.187b (attached). Beginning (9/14/2026-12/14/2026), the wellness director/designee will complete weekly eMar audits to ensure compliance with 2600.187b. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

Implemented () - 10/19/2026)

201 - Positive Interventions

15. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #3's progress notes were reviewed since the resident was admitted to the home on [REDACTED]. There have been numerous issues including possible narcotics abuse, resident potentially injuring [REDACTED] in order to obtain stronger and more frequent as needed narcotics. On 4/2/2026, resident #3's family member called the home to inform staff that resident #3 was making suicidal threats through text messages. Staff heard resident #3 stating that [REDACTED] didn't want to live anymore and wanted to die. The home called 911 to have the resident evaluated. On 4/16/2026, resident #3 would not allow staff to clear [REDACTED] call pendant stated that [REDACTED] was waiting on medication and will only allow the nurse to clear the call pendant. On 4/17/2026, resident #3 stormed out of wellness office and cursed because [REDACTED] wanted medication that was not scheduled for the requested time. On 7/4/2026, resident #3 called to the wellness office multiple times saying that someone was knocking on [REDACTED] bedroom door. Staff explained that on one was knocking on the bedroom door. Resident #3 called the police and was taken to the hospital and evaluated for paranoia. Resident #3 is potentially injuring [REDACTED] in order to obtain stronger and more frequent PRN narcotics, countless falls, numerous calls made by the resident to 911. The home has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction

Accept [REDACTED] - 10/14/2026)

On 9/18/2026, the HWD and AWD re-educated the wellness team on 2600.201 and resident #3 updated RASP (attached). Resident #3 RASP was updated on 09/09/2026 to include positive interventions (attached). Resident #3 was given a 30-day notice on [REDACTED] (attached). The Home continues to reinforce the positive interventions until discharge. Beginning 10/05/2026, -1/05/2027 to ensure compliance is maintained, the HWD/designee will review resident incident reports weekly to determine if additional positive interventions need to be implemented or revised (attached). Results will be discussed weekly 10/5/2026-01/05/2027 during clinical stand up.

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

Implemented [REDACTED] - 10/19/2026)

225c - Additional Assessment

16. Requirements

2600.

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

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

Description of Violation

Resident #3's most recent assessment was completed on [REDACTED]. Resident #3 has had a significant change in [REDACTED] behaviors according to the incidents reported since 4/2026 and progress notes provided by the home since admission in [REDACTED].

225c - Additional Assessment (continued)

Repeated Violation - 10/3/2025, 8/18/2025, et al.

Plan of Correction

Accept () - 10/14/2026)

Resident #3 RASP was updated on 09/09/2026 to include positive interventions (attached). Resident #3 was given a 30-day notice on () (attached). The Home continues to reinforce the positive interventions until discharge. On 9/18/2026, the HWD and AWD re-educated the wellness team on 2600.225c and resident #3 updated RASP (attached). By 10/19/2026, the wellness director/designee will complete an initial audit of assessments to ensure compliance with 2600.225c (attached). Beginning 10/20/2026, the wellness director/designee will review nursing report weekly times 3 months for significant changes to ensure compliance with 2600.225.c. Results of the audits/review will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

Implemented () - 10/19/2026)

227d - Support Plan Medical/Dental

17. Requirements

2600.

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

Description of Violation

The assessment for resident #1, dated (), does not indicate the degree of assistance needed with toileting, bladder management, bowel management, and ambulating.

On 9/10/26, a bedside mobility device was observed in resident #1's room; however, the assessment for resident #1, dated () does not indicate that the resident has a need for a bedside mobility device.

The assessment for resident #2, dated () does not indicate the resident has a need for special diet. The resident's most recent medical evaluation dated () states the resident is prescribed a heart healthy diet. However, the resident's support plan, dated () does not document how this need will be met.

The assessment for resident #5, dated () does not indicate the resident has a need for special diet. The resident's most recent medical evaluation dated () states the resident is prescribed a heart healthy diet. However, the resident's support plan, dated () does not document how this need will be met.

Repeated Violation - 3/5/2026, 10/3/2025

Plan of Correction

Accept () - 10/14/2026)

The assessments for residents #1 assessment was updated by the wellness director on 9/10/2026 (attached). Residents #1 and 2 assessments were updated on 9/9/2026 (attached). On 9/18/2026, the executive director re-educated the wellness and assistant wellness director on 2600.227b (attached). By 10/19/2026, the wellness director/designee will complete an initial audit of current assessments (attached) and new assessments monthly 11/26-1/2027 to ensure compliance with 2600.227d. By 10/19/2026, the wellness director/designee will complete an initial audit of current

227d - Support Plan Medical/Dental (continued)

assessments (attached) and then new assessments monthly times 3 (11/26-1/2027) to ensure compliance with 2600.234b. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

227g -Support Plan Signatures**18. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 participated in the development of [REDACTED] support plan on [REDACTED] However, the resident did not sign the support plan.

Repeated Violation - 10/3/2025

Plan of Correction

Accept () - 10/14/2026)

Resident #1 signed [REDACTED] support plan on 9/15/2026 (attached). The executive director re-educated the Wellness Director and Assistant Wellness Director on 2600.227g on 9/18/2026 (attached). By 10/19/2026, the Wellness Director will complete an audit of current support plans to ensure compliance (attached). Beginning 10/20/2026-1/20/2027, the wellness director/designee will audit new support plans to ensure compliance is maintained (attached). Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

234b - Support Plan Needs Elements**19. Requirements**

2600.

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

Description of Violation

The support plan, dated [REDACTED], for resident #8 indicates the resident is independent with ambulation; however, the support plan indicates the resident utilizes a wheelchair and staff to assist with transporting the resident.

Plan of Correction

Accept () - 10/14/2026)

Resident #8 support plan was updated by the wellness director on 9/9/2026 (attached). On 9/18/2026, the executive director re-educated the wellness and assistant wellness director on 2600.234b (attached). By 10/19/2026, the wellness director/designee will complete an initial audit of current assessments (attached) and then new assessments monthly times 3 (11/26-1/2027) to ensure compliance with 2600.234b. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

234b Support Plan Needs Elements (continued)

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

236 - Staff Training**20. 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 A, who works in the Secure Dementia Care Unit (SDCU) had only 3 hours of training in dementia care during the 2025 training year.

Plan of Correction

Accept () - 10/14/2026)

The Wellness Director provided Direct care staff person A with 3 hours of dementia training on 9/16/2026 (attached). On 9/15/2026 Administrator re educated the Business Office Manager and Wellness Director on 236e (attached). By 10/19/2026, the Business Office Manager or designee will complete an initial staff training audit (attached) and monthly for two months, then quarterly times 4. Any non compliant team member on 12/31/2026 will be removed from schedule. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

Licensee's Proposed Overall Completion Date: 10/19/2026

Implemented () - 10/19/2026)

251b - Record Entries Legible**21. Requirements**

2600.

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

Description of Violation

The medication administration time on 9/10/2026 for resident #3's narcotic record for Butalbital APAP Caffeine Oral Capsule 50 235 40 mg was written over with link, making it difficult to read.

Plan of Correction

Accept () - 10/14/2026)

On 9/18/2026, the wellness director re educated the nurses/med tech's on 2600.251b (attached) Beginning 10/5/2026, 01/05/2027, the Wellness Director/designee will audit narcotic records weekly to ensure compliance. Results of the audits will be discussed during the 1st quarter QMP meeting (1/13/2027 at 10am) to determine if additional audits or or trainings need to be completed.

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

251b - Record Entries Legible (*continued*)

Implemented ([REDACTED] - 10/19/2026)