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

November 19, 2026

[redacted], ADMINISTRATOR
HAVEN AT SPRINGWOOD OPCO LLC
2321 FREEDOM WAY
YORK, PA, 17402

RE: SEATON SPRINGWOOD
2321 FREEDOM WAY
YORK, PA, 17402
LICENSE/COC#: 33503

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/22/2026, 09/23/2026 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: *SEATON SPRINGWOOD* **License #**: *33503* **License Expiration**: *11/04/2026*

Address: *2321 FREEDOM WAY, YORK, PA 17402*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HAVEN AT SPRINGWOOD OPCO LLC*

Address: *2321 FREEDOM WAY, YORK, PA, 17402*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/20/2004* **Issued By**: *Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *139* **Waking Staff**: *104*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *09/23/2026*

Inspection Dates and Department Representative

09/22/2026 - On-Site: [redacted]

09/23/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *123* **Residents Served**: *108*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Beacon Place* **Capacity**: *13* **Residents Served**: *12*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *108*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

09/22/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/26/2026*

10/27/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/18/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/20/2026*

Inspections / Reviews *(continued)*

11/19/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/18/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted] for Resident #1 indicates the resident requires moderate supervision in the home and needs attendance when outside the home. The resident also wears a wander guard for safety and direct care staff are to provide regular checks on the resident as well as check the resident's wander guard for placement. On [redacted] at approximately 3:00PM, the resident did not receive this assistance as required. Resident #1 was upset because [redacted] was separated from [redacted]. Then the resident exited the home onto the lower-level patio area, which lead to an open grassy area that led to a tall fence. The resident climbed over the fence which was over 5 feet tall. Staff found the resident after [redacted] had already climbed over the fence. The resident has experiencing suicidal ideation. As a result, the home contacted the police and the fence to be cut to get the resident back to the home. The resident was then sent to the emergency room for evaluation.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: On [redacted] Resident was sent to the hospital for change in mental status. The Executive Director or Director of Health and Wellness reviewed the support plan of the residents to identify supervision or assistance needed to ensure their safety. Any identified discrepancies between assessed needs and current supervision practices were corrected, and support plan was updated on 7/1/26

Training: On [redacted] the Executive Director will educate the Director of Health and Wellness and the Assistant Director of Health and Wellness on regulation 2600.23a, to include resident supervision requirements, compliance with individual support plans, elopement prevention, and the importance of responding when a resident is missing or attempts to exit the home. Training will emphasize maintaining appropriate supervision and recognizing potential elopement risks.

Ongoing: Beginning 10/28/26, the Executive Director or Director of Health and Wellness will conduct and document random audits of 5 residents' supervision and compliance with support plans weekly for 4 weeks then monthly for 2 months. Any identified concerns will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept for review

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

51 - Criminal Background Check

2. Requirements

2600.

51 - Criminal Background Check *(continued)*

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

Staff Member A's first day of paid work is [redacted] however, a Pennsylvania State Police Criminal Background check was not requested for Staff Member A until [redacted]

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: The Executive Director immediately reviewed all employee files to verify compliance with criminal background check requirements. Any missing documentation or outstanding requirements were addressed immediately.

Training: By 11/2/26 the Executive Director will educate the leadership team on regulation 2600.51, education will include verifying required criminal background checks, maintaining supporting documentation, and ensuring that all applicable requirements are met before an individual begins providing services to residents.

Ongoing: Beginning 10/28/26, the Business Office Manager audit personnel files weekly for 4 weeks, then monthly for 2 months to verify that required criminal background checks are completed and documented. All newly hired personnel will be reviewed as part of the onboarding process before providing services to residents. Any identified concerns will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

81b - Resident Personal Equipment

3. 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

On 9/23/26, at 10:06AM, Resident #2's bedside mobility device was not securely installed onto the bed, creating a potential safety hazard.

On 9/23/26, at 4:00PM, Resident #3's bedside mobility device was not securely installed onto the bed, creating a potential safety hazard.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

ction: On 9/23/26, the Maintenance Director conducted an audit of resident rooms to identify bedside mobility devices and other assistive devices that may not be securely installed or positioned. Any identified concerns were corrected immediately to ensure devices were safe and appropriate for resident use.

Training: By 10/28/26, the Executive Director educated the Maintenance Director on regulation 2600.81b, to include the importance of ensuring that bedside mobility devices are properly installed, secured, and maintained according

81b Resident Personal Equipment (continued)

to manufacturer instructions. Staff were also instructed to report any loose, unstable, damaged, or improperly installed equipment immediately and to sure that devices are safe before residents use them.

Ongoing: Beginning 11/2/26, the Maintenance Director or Designee will conduct and document weekly audits of resident rooms with bedside mobility devices for 4 weeks then monthly for 2 months, to verify that bedside mobility devices are securely installed and safe for use. Any identified concerns will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed at the Quality Assurance meeting monthly for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

82a - Poisonous Materials

4. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 9/22/26, at 2:57PM, there were two spray bottles of liquid which did not have the original manufacturer's labels. These bottles were located in the housekeeping closet. Housekeeping staff identified the liquids as Windex and a fragrance spray.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: Immediately upon identification, all unlabeled spray bottles were removed from use. Any unidentified substances were safely disposed of in accordance with facility procedures. Spray bottles were replaced with properly labeled containers that identify the contents and comply with manufacturer requirements.

Training: By 11/2/26, the Executive Director educated all housekeeping, maintenance, and all other applicable staff on regulation 2600.82a, emphasizing that poisonous materials must be stored in their original containers. Staff were instructed to use manufacturer provided spray bottles and labels and not to use unidentified or improperly labeled containers.

Ongoing: Beginning 10/28/26, the Maintenance Director or designee will conduct and document audits of the housekeeping carts, maintenance areas, and chemical storage areas weekly for 4 weeks, then monthly for 2 months. Any identified deficiencies will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 9/23/26, at 1:21PM, mold and mildew was present on the duct vent above a resident's bed in resident room # W4A and B.

On 9/23/26, at 3:01PM, a handheld urinal containing urine was laying sideways on the bed in resident room #127.

On 9/23/26, at 3:04PM, feces was present on personal care wipes and on the right side of the bathroom toilet in the bathroom located in resident room #127. Multiple care wipes that were heavily soiled with bowel movement were located in the trash next to toilet, contributing to a pungent odor in bathroom.

Repeated Violation - 7/8/25, et al.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: Upon identification, the feces present on the toilet, and the soiled garbage were immediately removed, and the affected surfaces were thoroughly cleaned and disinfected. The urinal containing urine was removed from the bed, emptied, cleaned and disinfected. The linens were inspected and cleaned as necessary. The duct vent containing mold and mildew was reported to maintenance for prompt cleaning and remediation. The affected area will be inspected to ensure the mold has been appropriately addressed and the area is sanitary.

Training: By 11/2/26, the Executive Director will educate all staff on regulation 2600.85a, emphasizing the importance of sanitary conditions throughout the home. Training will include proper cleaning, disinfection of toilets and other surfaces, prompt removal of feces and urine, appropriate handling and storage of urinals, and immediate reporting of mold or other environmental concerns.

Ongoing: Beginning 10/28/26, the Maintenance Director or Designee will conduct and document weekly environmental sanitation audits of 10 rooms x 4 weeks, then monthly for 2 months. Audits will include resident bathrooms, toilets, trash receptacles, resident rooms, urinal storage practices, and ventilation areas to verify that sanitary conditions are maintained. Any identified concerns will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

89a - Water Pressure

6. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

89a Water Pressure *(continued)*

Description of Violation

The home did not have hot running water that was sufficient to meet the bathing needs of residents in the home. On 9/23/26, at 3:04PM, the maximum hot water temperature in the bathroom located in resident room #127 measured at 75.6 degrees Fahrenheit. The maximum hot water temperature in the shower measured at 90 degrees Fahrenheit. On 9/23/26, at 3:51PM, the maximum hot water temperature in the bathroom located in resident room #215 measured at 74.8 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: On 9/24/26, the Maintenance Director tested the water temperature and replaced the sink and shower valve to rectify the hot water concern.

Training: By 11/2/26, the Executive Director educated the Maintenance Director or designee on regulation 2600.89a, emphasizing the importance of maintaining adequate hot water supply to meet the resident's bathing, cleaning, and sanitation needs. The home implemented routine monitoring of the hot water system, including prompt reporting of inadequate water temperature, pressure, or supply.

Ongoing: Beginning 10/28/26, the Maintenance Director or Designee will twice a week document checks of the hot water supply in 10 resident rooms, kitchen, and laundry areas for 4 weeks, then monthly for 2 months. Any identified concerns will be reported immediately and corrected promptly. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

92 - Windows

7. 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 9/23/26, at 3:29PM, two windows in resident room #132 were not securely screened while the windows were open approximately 2".

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

On 9/25/26, the Maintenance Director replaced the screen in the window.

Training: By 11/2/26, the Executive Director will educate Maintenance director and housekeeping staff on regulation 2600.92, emphasizing the importance of ensuring that all windows are securely screened and that damaged, loose, or missing screens are reported promptly for repair or replacement.

Ongoing: Beginning 10/28/26, the Maintenance Director or Designee will conduct and document inspections of 10

92 - Windows (continued)

rooms windows and screen twice weekly for 4 weeks, then monthly for 2 months to verify that screens are securely installed. Any identified concerns will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

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 9/23/26, at 2:17PM, the door to the rehabilitation room was locked. This door is identified as an exit from the rehabilitation room to the outside of the building.

Repeated Violation - 1/29/26

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Upon identification of the violation, the Maintenance Director ensured that door to the rehabilitation room was unlocked and accessible to allow for safe and immediate egress. The door and locking mechanism were inspected to ensure proper operation and compliance with applicable fire safety requirements. The Maintenance Director inspected all exit doors, hallways, stairways, doorways, and other egress routes throughout the home to ensure that they were unlocked, unobstructed, and accessible for emergency evacuation.

Training: By 11/2/26, the Executive Director will educate all staff on regulation 2600.121a, emphasizing that exit routes must remain unlocked and unobstructed to ensure residents can safely evacuate during an emergency. Staff were instructed to immediately report any door or locking mechanism that interferes with safe egress.

Ongoing: Beginning 10/28/26, the Maintenance Director or designee will conduct and document inspections of all exit doors and egress routes daily for 30 days and then weekly for 8 weeks. Any identified concerns will be corrected immediately. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed during the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

141a - Medical Evaluation

9. Requirements

2600.

141a Medical Evaluation *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #9 was admitted to the home on [redacted] However, the resident's medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: The Director of Health and Wellness will audit all current resident records to ensure that all residents have a completed medical evaluation within the required timeframe of 60 days prior to admission or 30 days after admission, as applicable. The Director of Health and Wellness contacted the resident's PCP to obtain clarification and ensure the medical evaluation is complete and confirmed the resident's needs can safely be met in the personal care home. Any identified deficiencies will be corrected promptly.

Training: By 11/2/26, the Executive Director will educate the clinical leadership team on regulation 2600.141a, with emphasis on verifying that each resident's medical evaluation meets the required timeframe before admission or is completed within the permitted period after admission. The Executive Director also included an emphasis on the importance of reviewing medical evaluations for completeness before admission and ensuring that all required information is documented. Clinical leadership will also be educated on the importance of verifying that the residents' needs can be met safely within the services provided by the home before admission.

Ongoing: Beginning 10/28/26, the Director of Health and Wellness will audit all new admissions medical evaluations weekly for 4 weeks, then monthly for 2 months to ensure compliance and completeness. Any identified deficiencies will be corrected promptly. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

141a 1-10 Medical Evaluation Information

10. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #4's initial medical evaluation, dated [redacted] does not include whether the resident's needs can be met safely in a personal care home.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: 9/23/26 Upon identification, the Director of Health and Wellness contacted the resident's PCP to obtain clarification and ensure the medical evaluation is complete and accurately documents the resident's status and needs. The residents' ability to have their needs safely met in the personal care home will be evaluated, and the resident's assessment and support plan will be updated as indicated.

Training: By 10/28/26, the Executive Director will educate the clinical leadership team on regulation 2600.141a, to include emphasis on the importance of reviewing medical evaluations for completeness before admission and ensuring that all required information is documented. Clinical leadership will also be educated on the importance of verifying that the residents' needs can be met safely within the services provided by the home.

Ongoing: Beginning 10/28/26, the Director of Health and Wellness will review all new resident medical evaluations weekly for 4 weeks, then monthly for 2 months to ensure all required information is present. Any identified deficiencies will be addressed promptly. Any additional training or corrective action will be implemented as necessary. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

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 9/23/26, at 2:05PM, at tube of Preparation H was observed unlocked, unattended,and accessible in Resident #2's room. Resident has not been assessed to be able to self-administer this medication.

183b Meds and Syringes Locked (continued)

On 9/23/26, at 3:51PM, a tube of Voltaren Gel was unlocked, unattended and accessible in Resident #7's room. Resident #7 has not been assessed to be able to self administer this medication.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: 9/24/26 Upon identification, the medications found unlocked and unattended in the named residents' rooms were immediately secured and locked in a medication storage area. The Director of Health and Wellness verified that all medications were secured in accordance with regulatory requirements.

Training: By 11/2/26, the Director of Health and Wellness will educate all staff responsible for medication administration on regulation 2600.183b, with emphasis that all medications and syringes must remain secured in a locked area or container, including when stored in a resident's room. Staff were instructed to not leave medications unsecured or unattended and to immediately secure medications after use.

Ongoing: Beginning week of 10/26/26, the Executive Director or Director of Wellness will conduct and document audits of medication storage areas and resident rooms weekly for 4 weeks, then monthly for 2 months to ensure ongoing compliance. Any identified deficiencies will be corrected immediately, and additional staff education will be provided as needed. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

*Resident #2 is prescribed Venclexta 100mg. The resident's September 2026 Medication Administration Record (MAR) states to take 1 tablet orally in the morning with meals. Do not mix in cup with other meds *specialty pharmacy med* (leukemia). However, the pharmacy label states take 1 tablet by mouth once daily in the morning with meals. Avoid Grapefruit products, Seville oranges, and starfruit.*

Repeated Violation 1/29/26, 9/10/25, et al.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

ction: Upon identification, the Director of Health and Wellness immediately reviewed the medication label and the

184a - Resident's Meds Labeled (continued)

MAR to identify the discrepancy. The prescribing provider and the pharmacy were contacted to verify the current medication order. The medication and the MAR were reconciled to ensure that the information accurately reflects the authorized prescription.

Training: By 11/2/26, the Director of Health and Wellness educated all medication administration personnel on regulation 2600.184a, emphasizing the importance of verifying that medication labels accurately reflect the prescribed medication, dosage, and administration instruction. Staff were instructed to report discrepancies immediately and not administer medications when the label and current authorized order conflict until the discrepancy has been clarified.

Ongoing: Beginning 10/28/26 the Director of Health and Wellness or Designee will audit 10 residents' medication labels against current prescriber orders and MARs weekly for 4 weeks, then monthly for 2 months. Any discrepancies identified will be addressed immediately, and additional education or corrective action will be implemented as needed. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

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

On 9/22/26, at 9:43AM, there were two oxygen tanks sitting directly on the floor in resident room #211. The oxygen tanks were not restrained in order to prevent tipping.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: Upon identification, the oxygen tanks were immediately removed from the floor and placed in an appropriate, secure oxygen tank holder to ensure they are stored safely and securely in accordance with oxygen storage requirements and manufacturer recommendations. The Director of Health and Wellness conducted an audit of all resident rooms to identify any additional oxygen tanks that were improperly stored. Any identified concerns were immediately addressed.

Training: By 11/2/26, the Director of Health and Wellness will educate all staff on regulation 2600.185a, to include nursing and direct care staff, on proper storage and handling of oxygen tanks to ensure tanks remain properly

185a - Implement Storage Procedures (continued)

secured in designated holders when not in use.

Ongoing: Beginning 10/28/26, the Health and Wellness will conduct weekly audits of oxygen tank storage for 4 weeks, then monthly for 2 months. Any discrepancies will be corrected immediately. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #13 is prescribed slow-release Iron 45mg with orders to take 1 tablet orally daily at least one hour before or after calcium for anemia. From 9/3/26 to 9/5/26 and from 9/10/26 to 9/16/26, this medication was not administered to the resident because the medication was not available in the home.

Repeated Violation - 1/29/26, 7/8/25, et al.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: The medication was promptly requested from the pharmacy, and the prescriber was notified as appropriate. The medication was administered on 9/19/26 until current. The resident was assessed for any adverse effects related to the missed or delayed dose, and all necessary follow-up actions were completed and documented.

Training: By 11/2/26, the Director of Health and Wellness educated all med passers on regulation 2600.187d, with emphasis on ensuring medications are available before scheduled administration times and following prescriber's orders. Staff were instructed to promptly notify the Director of Health and Wellness and pharmacy when medications are unavailable, obtain further instructions from the prescriber when indicated, and document all missed or delayed doses and interventions according to facility policy.

Ongoing: Beginning 10/26/26, the Director of Health and Wellness or Designee will conduct weekly medication administration record to medication cart audits for 4 weeks, then monthly for 2 months. Any identified concerns will be corrected immediately. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

224a - Preadmission Screen Form

15. 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 #11's preadmission screening form, dated [redacted] does not indicate if the needs of the resident can be met by the home.

Plan of Correction ***Accept ([redacted] - 10/27/2026)***

Action: On 9/26/26, the Director of Health and Wellness reviewed the resident's preadmission screening and supporting documentation to determine whether the resident's needs can safely be met by the home. The preadmission screening was updated to accurately reflect the residents' needs and the home's ability to meet those needs.

Training: By 10/28/26, the Executive Director educated all staff responsible for completing and reviewing preadmission screenings on regulation 2600. 224a, to include documenting a clear determination of whether the resident's needs can be met by the home before admission and ensuring all required screening elements are completed and reviewed.

Ongoing: Beginning 10/26/28, the Executive Director or Director of Health and Wellness will conduct an audit of 100% of new preadmission screenings for 4 weeks, then monthly for 2 months. Any identified deficiencies will be corrected immediately. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented ([redacted] - 11/19/2026)

227d - Support Plan Medical/Dental

16. 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

Resident #2 utilizes a bedside mobility device to aid in transferring in/out of bed. However, Resident #2's current support plan, dated [redacted] does not include the following:

- *The specific need for the device.*
- *Any risks associated with the device.*
- *The resident's ability to use the device safely for the intended purpose.*

Resident #6 utilizes a bedside mobility device to aid in transferring in/out of bed. However, Resident #6's current support plan, dated [redacted], does not include the following:

- *The specific need for the device.*
- *Any risks associated with the device.*

227d Support Plan Medical/Dental (continued)

- *The resident's ability to use the device safely for the intended purpose.*

Repeated Violation 4/9/26, 9/10/25, et al., 7/8/25, et al.

Plan of Correction ***Accept (- 10/27/2026)***

On 9/26/26, the Director of Health and Wellness reviewed the resident's current assessment and support plan to ensure the resident's bed mobility needs and use of bed mobility device were accurately documented. The RASP was updated to include the use of the bed mobility device, any assistance required for safe use, and applicable interventions to support the resident's bed mobility and safety.

Training: By 11/2/26 the Executive Director educated all nursing staff responsible for completing and updating RASPs on regulation 2600.227d, to include the importance of documenting all bed mobility devices used by residents and identifying any assistance or supervision required for safe use. Staff were also instructed to update the RASP whenever a resident's needs changed.

Ongoing: Beginning 10/28/26, the Executive Director or Director of Wellness will conduct weekly audits of RASPs for residents using bed mobility devices for 4 weeks, and monthly for 2 months to ensure compliance. Any identified deficiencies will be corrected immediately. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented (- 11/19/2026)

227g -Support Plan Signatures

17. 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 #14 participated in the development of support plan on . However, the resident did not sign the support plan.

Repeated Violation - 4/9/26

Plan of Correction ***Accept (- 10/27/2026)***

Action: 9/23/26 The Director of Health and Wellness reviewed the resident's RASP. The resident has since been discharged from the community since .

Training: By 11/2/26, the Executive Director educated all staff responsible for completing and maintaining resident support plans on regulation 2600.227g, to include the requirement to obtain and document the residents' signature

227g -Support Plan Signatures (continued)

as applicable. Staff were instructed to verify that the required signatures are obtained following a review of the support plan and before the documentation is considered complete.

Ongoing: Beginning 10/28/26, the Executive Director or Director of Health and Wellness will audit 10 residents' support plans weekly for 4 weeks then monthly for 2 months to ensure required signatures are obtained and documented. Any identified deficiencies will be immediately corrected. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented (- 11/19/2026)

233c - Key-Locking Devices

18. 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

The directions for operating the home's Secure Dementia Care Unit (SDCU) locking mechanism were posted at the side exit door from TV area and porch gate from the side exit door. However, the instructions for their operation were difficult to understand, preventing immediate egress from these areas.

Repeated Violation - 4/9/26

Plan of Correction ***Accept (- 10/27/2026)***

Action: On 9/24/26, the Memory Care Director immediately reviewed the directions for operating the secured dementia care unit locking mechanism. The directions were revised or replaced with clear, easy-to-understand instructions to ensure staff could operate the locking mechanism safely and efficiently. The revised directions were posted in an appropriate, readily accessible location near the locking mechanism.

Training: By 10/28/26, the Executive Director educated the Memory care director on regulation 2600.233c, with emphasis on proper operation of the secured dementia care unit locking mechanism and reviewed the revised instructions with staff to ensure understanding. A process was implemented to routinely review posted operating instructions to ensure they remain clear, accurate, legible, and accessible to staff.

Ongoing: Beginning 10/28/26, the Memory Care Director will inspect the locking mechanism and posted operating instructions weekly for 4 weeks, then monthly for 2 months to ensure continued compliance. Any identified deficiencies will be immediately corrected. Audits will be reviewed monthly at the Quality Assurance meeting for 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *11/20/2026*

Implemented (- 11/19/2026)