Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: OCTOBER 6, 2026

[redacted]
Holland Care LLC
[redacted]

RE: Fairfields' Liberty Hall
License/COC #: 457171

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 11, 2026, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 457171) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and misconduct in operating the facility, and is made pursuant to 62 P.S. § 1026 (b)(1);(4) and 55 Pa. Code § 20.71(a)(2); (6) (relating to conditions for denial, nonrenewal or revocation).

As a separate and independent basis for revocation of the license, the Department is not satisfied that you are a responsible person pursuant to 62 P.S. §1007.

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

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

| 55 Pa. Code Chapter 2600 Section: | Class of Violation | Census at Inspection | Fine Per resident X Per day | Calculated Fine = Per day | Mandated Correction Date (to avoid Fine) |
|---|---|---|---|---|---|
| 65(a) | III | 8 | $3 | $24 | 15 calendar days from mailing date of this letter |
| 65(b) | III | 8 | $3 | $24 | 15 calendar days from mailing date of this letter |
| 185(a) | II | 8 | $5 | $40 | 5 calendar days from mailing date of this letter |
| 187(a) | III | 8 | $3 | $24 | 15 calendar days from mailing date of this letter |

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

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

If you disagree with the decision to REVOKE/REFUSE TO RENEW your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 30 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street

Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Fairfields' Liberty Hall is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

## Facility Information

**Name**: *FAIRFIELDS' LIBERTY HALL* **License #**: *45717* **License Expiration**: *11/06/2026*

**Address**: *27 KYLE AVENUE, FAIRCHANCE, PA 15436*

**County**: *FAYETTE* **Region**: *WESTERN*

## Administrator

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

## Legal Entity

**Name**: *HOLLAND CARE LLC*

**Address**: [redacted]

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

## Certificate(s) of Occupancy

**Type**: *C-3 SP* **Date**: *11/13/1981* **Issued By**: *Labor & Industry*

## Staffing Hours

**Resident Support Staff**: *1* **Total Daily Staff**: *10* **Waking Staff**: *8*

## Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *08/28/2026*

## Inspection Dates and Department Representative

*08/11/2026 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *8* **Residents Served**: *8*

### Secured Dementia Care Unit

**In Home**: *No* **Area**: **Capacity**: **Residents Served**:

### Hospice

**Current Residents**: *4*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *7*

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

**Have Mobility Need**: *1* **Have Physical Disability**: *0*

# Inspections / Reviews

### 08/11/2026 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/11/2026*

### 09/23/2026 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *09/11/2026*

**Reviewer**: [redacted] **Follow-Up Type**: *Bypass Document Submission*

## 5a1 - DHS Access

**1. Requirements**

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

**Description of Violation**

*Throughout the inspection, staff person A, the operator/administrator, consistently demonstrated a level of misconduct and hostility that's irresponsible for the administration and management of the home. Staff person A berated agents of the Department by repeatedly cursing, making derogatory comments about their posture and appearance, and stated [redacted] dislike for female agents of the Department in addition to [redacted] overall disdain for the Department. Staff person A failed to provide full access by refusing to answer basic staffing questions and [redacted] adversarial and contentious interactions inhibited the inspection process.*

**Plan of Correction** ***Directed [redacted] - 09/23/2026)***

*PLAN OF CORRECTION*
*55 Pa. Code §2600.5(a)(1) – Access to Home, Residents and Records*

*Regulation:*
*55 Pa. Code §2600.5(a)(1) – The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to agents of the Department.*

*Description of Violation*

*During the Department's inspection, the Department documented concerns regarding the Administrator's interactions with Department representatives and stated that the Administrator's conduct and interactions inhibited the inspection process.*

*Corrective Action Taken*

*Upon receipt and review of the Department's finding, the Administrator reviewed the requirements of 55 Pa. Code §2600.5(a)(1) and the responsibility of the Administrator and staff to cooperate fully with authorized representatives of the Department during inspections.*

*Fairfields' Liberty Hall will ensure that Department representatives are provided immediate access to the home, residents, records, and information requested within the scope of their inspection responsibilities.*

*The Administrator and all staff will cooperate with Department representatives and maintain professional, respectful, and appropriate communication throughout the inspection process.*

*The Administrator will ensure that questions regarding staffing, residents, records, policies, procedures, or the operation of the home are addressed to the best of the Administrator's or staff member's knowledge. If additional information or records are needed to answer a question, the Administrator or designee will obtain and provide the requested information.*

*If the Administrator disagrees with a Department representative regarding an inspection matter, the concern will be handled through the appropriate Department review, appeal, or Plan of Correction process and will not interfere*

## 5a1 - DHS Access (continued)

*with or delay the Department's inspection.*

*Staff and Administrator Education*

*The Administrator will review inspection cooperation and professional conduct expectations with all employees.*

*Staff will be reminded that Department representatives are authorized to conduct inspections and that employees are expected to:*

** Provide appropriate access to the home, residents, and records.*
** Cooperate with Department representatives.*
** Answer questions truthfully and to the best of their knowledge.*
** Direct questions requiring additional information to the Administrator or designee.*
** Maintain professional and respectful communication.*
** Avoid conduct or communication that could interfere with the inspection process.*
** Follow the Administrator's direction regarding the production of records and information.*

*The Administrator will also attend a **Zoom training course provided by the Pennsylvania Department of Human Services on October 6, 2026, titled "Embracing Compliance Best Practices."** The training will provide additional education regarding regulatory compliance and best practices for maintaining compliance with applicable Personal Care Home requirements.*

*Documentation of the Administrator's completion of the training will be maintained with the home's compliance records.*

*Prevention of Recurrence*

*Fairfields' Liberty Hall will incorporate Department inspection cooperation into its ongoing compliance practices.*

*Prior to and during future Department inspections, the Administrator or designee will ensure that:*

*1. Department representatives are provided immediate access to the home.*
*2. Residents and resident records are made available as requested and permitted by applicable requirements.*
*3. Requested facility records and documentation are provided promptly.*
*4. Staff understand their responsibilities during a Department inspection.*
*5. The Administrator or designee is available to assist with questions and requests.*
*6. Questions that cannot immediately be answered will be followed up on promptly.*
*7. Disagreements regarding inspection findings will be addressed through the appropriate Department process rather than interfering with the inspection.*
*8. Professional and respectful communication is maintained throughout the inspection.*

*Monitoring*

*The Administrator will monitor compliance with this requirement monthly through **December 2026**.*

## 5a1 - DHS Access (continued)

*Monitoring will include review of:*

** Staff understanding of Department access requirements.*
** Availability and accessibility of required facility and resident records.*
** Staff understanding of their responsibilities during Department inspections.*
** Administrator/designee availability to respond to Department requests.*
** Professional and cooperative communication during any Department interaction.*

*Any concern identified through monitoring will be addressed immediately through counseling, additional training, or other appropriate corrective action.*

*Responsible Person*

[redacted] *Administrator*
*09/03/2026*

*Supporting Documentation*

** Staff acknowledgment/training documentation regarding Department inspection requirements*
** Documentation of Administrator review of §2600.5(a)(1)*
** Documentation of Administrator's completion of the **"Embracing Compliance Best Practices"** Zoom course on 10/06/2026*
** Monthly compliance monitoring documentation*
** Additional training documentation, if applicable*

*Proposed Overall Completion Date: 09/10/2026*

*Directed: Within 15 days of receipt of the plan of correction - The administrator will obtain documentation from a physician indicating that he's free from a medical condition that would limit* [redacted] *from performing duties with reasonable skill and safety in accordance with Chapter 2600.53(h). Documentation shall be kept in the administrator's personnel records.*

*Directed: Within 30 days of receipt of the plan of correction - The administrator will complete at least 12 hours of anger management courses by an accredited or certified agency.*

*Proposed Overall Completion Date: 10/23/2026*

**Directed Completion Date:** *10/23/2026*

## 17 - Record Confidentiality

**2. Requirements**

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

## 17 - Record Confidentiality *(continued)*

**Description of Violation**

*At approximately 10:13 a.m., the privacy coding form for the inspection dated [redacted] was posted with the LIS that was posted on the bulletin board in the home's dining room.*

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

*Immediately upon identification of the violation, the privacy coding form was removed from the dining room bulletin board and secured with the home's confidential resident records. The Administrator reviewed the requirements of 55 Pa. Code §2600.17 with all staff members to reinforce that resident records and documents containing resident identifying information, privacy codes, or other confidential information must remain secure and may only be accessible to individuals authorized under the regulation.*

*The Administrator will ensure that documents containing resident confidential information are not posted in common areas or otherwise made accessible to unauthorized individuals. Any documents required for inspection or administrative purposes will be maintained in a secure location accessible only to authorized individuals.*

*The Administrator will conduct a review of bulletin boards and other areas where documents are posted to ensure that no confidential resident information is displayed. Staff will be instructed to immediately notify the Administrator if confidential information is found in an unsecured or public area.*

*Date of Correction: 01/12/2026*

*Responsible Person: Administrator, [redacted]*

*Monitoring:*
*The Administrator will review posted documents monthly and during routine quality management reviews to ensure continued compliance with 55 Pa. Code §2600.17. Any identified concern will be corrected immediately and addressed with the responsible staff member.*

**Licensee's Proposed Overall Completion Date:** *09/02/2026* Not Implemented [redacted] - 9/23/26)

## 51 - Criminal Background Check

**3. Requirements**

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

**Description of Violation**

*Direct care staff person B was hired [redacted]. A Pennsylvania criminal background check was requested for direct care staff person B on [redacted]; however, the background check indicates "request under review for control". The home never received and reviewed the results, and direct care staff person B has been working unsupervised in the home.*

*Repeat Violation [redacted] et al.*

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

*Description of Corrective Action*

*The home recognizes the importance of maintaining complete and verifiable criminal history documentation for all*

## 51 - Criminal Background Check (continued)

*applicable employees in accordance with the Older Adult Protective Services Act and applicable Department regulations.*

*The employee identified in the citation, [redacted] has been employed by the home for approximately 27 years. The home had maintained criminal history documentation in [redacted] personnel record and had relied upon the documentation previously maintained in the file. Upon review of the record during the current inspection, it was determined that the Pennsylvania criminal history request dated 09/24/2014 reflected a status of "request under review for control" and did not provide a completed criminal history result for the home to review.*

*To correct the deficiency, the home obtained a new Pennsylvania criminal history check for [redacted] on 09/02/2026. The completed result was received and reviewed by the home and indicated "No Record."*

*A copy of the completed criminal history check is being maintained in the employee's personnel record and is being provided as supporting documentation with this Plan of Correction on 09/10/2026.*

*Immediate Corrective Action*

*The administrator reviewed the criminal history documentation for [redacted] and obtained a new Pennsylvania criminal history check on 09/02/2026.*

*The result was received and reviewed by the administrator and indicated No Record.*

*The completed criminal history documentation has been placed in the employee's personnel file and is attached to the POC documentation.*

*Date Criminal History Check Obtained: 09/02/2026*
*Date Result Reviewed: _____*
*Result: No Record*
*Date Documentation Attached to POC: 09/10/2026*

*Systemic Corrective Measures*

*To prevent recurrence, the administrator will implement the following procedures:*

*The administrator will ensure that required criminal history documentation is obtained and reviewed before an applicable employee is permitted to work in accordance with applicable requirements.*
*A criminal history tracking system will be maintained identifying each applicable employee, the date the criminal history check was requested, the date the result was received, the result, and the date the administrator reviewed the result.*
*The administrator will verify that a criminal history request has resulted in an actual completed result before considering the requirement satisfied. A status such as "under review," "pending," or similar incomplete status will not be considered a completed criminal history check.*
*Existing personnel files will be reviewed to identify any criminal history documentation that is incomplete, unclear, outdated, or does not demonstrate that the required result was received and reviewed.*
*Any employee file identified as having incomplete criminal history documentation will be corrected and*

## 51 Criminal Background Check (continued)

*documented by the administrator.*
*The administrator will maintain documentation of the review in the employee's personnel file and in the home's criminal history tracking system.*
*Monitoring to Ensure Continued Compliance*

*The administrator will conduct a review of applicable employee personnel files monthly for three (3) months to verify that required criminal history documentation is present, complete, and appropriately documented.*

*The administrator will specifically verify:*

*A criminal history check is documented for each applicable employee.*
*The documentation reflects a completed result rather than a pending or incomplete status.*
*The result has been received and reviewed by the administrator/designee.*
*The date of review is documented.*
*Any required follow up has been completed.*
*New employees are not permitted to work in a manner inconsistent with applicable criminal history requirements.*

*After the initial three month monitoring period, criminal history documentation will continue to be reviewed as part of the home's personnel file compliance audits and whenever a new employee is hired.*

*All monitoring documentation will be maintained and made available to the Department upon request.*

*Responsible Person*

*Responsible Person: Administrator / Operator*

*The administrator is responsible for obtaining, reviewing, documenting, and monitoring criminal history compliance for applicable employees.*

*Completion Date*

*Corrective Action Completed: 09/02/2026*

*Documentation Attached to POC: 09/10/2026*

*Administrator Signature:*

*Date:*

**Licensee's Proposed Overall Completion Date:** *09/10/2026* Not Implemented [redacted] 9/23/26)

## 53c - Administrator Duties

**4. Requirements**

2600.

## 53c - Administrator Duties *(continued)*

53.c. The administrator shall be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

**Description of Violation**

*Throughout the inspection, staff person A, the operator/administrator, consistently demonstrated a level of misconduct and hostility that's irresponsible for the administration and management of the home. Staff person A berated agents of the Department by repeatedly cursing, making derogatory comments about their posture and appearance, and stated [redacted] dislike for female agents of the Department in addition to [redacted] overall disdain for the Department. Staff person A failed to provide full access by refusing to answer basic staffing questions and [redacted] adversarial and contentious interactions inhibited the inspection process.*

**Plan of Correction** ***Directed [redacted] 09/23/2026)***

*Description of Corrective Action*

*The home recognizes that the administrator is responsible for maintaining effective administration and management of the home and for ensuring that the home's operations remain consistent with the requirements of Chapter 2600.*

*To address the Department's findings regarding the administrator's conduct and interactions during the inspection, the administrator will implement and maintain a formal **Administrator Professional Conduct and Department Inspection Compliance Procedure**.*

*The administrator has reviewed the requirements of **55 Pa. Code §2600.53(c)** and **§2600.5(a)(1)** and has reviewed the expectations associated with professional conduct, cooperation with Department representatives, inspection readiness, access to the home, residents, and records, and overall regulatory compliance.*

*The administrator will maintain professional and respectful communication with Department representatives and will ensure that inspections are not unnecessarily delayed, impeded, or disrupted. The administrator will respond to inspection-related questions in a professional and appropriate manner and will direct any disagreement regarding an inspection request or regulatory matter through the appropriate Department process rather than allowing the disagreement to interfere with the inspection.*

*Systemic Corrective Measures*

*The following corrective measures have been implemented or will be implemented:*

*1. The administrator will maintain and follow the written **Administrator Professional Conduct & Department Inspection Compliance Procedure**.*

*2. The administrator will review **55 Pa. Code §2600.53(c)** and **§2600.5(a)(1)** and document completion of the review.*

*3. The administrator will complete the **"Embracing Compliance Best Practices"** Zoom course scheduled for **10/06/2026**. Documentation of attendance/completion will be maintained in the home's compliance records.*

*4. Staff will receive training regarding Department inspection requirements, including appropriate communication, cooperation with Department representatives, notification of the administrator/designee, and the requirement to*

## 53c - Administrator Duties (continued)

*avoid conduct that could interfere with an inspection.*

*5. The administrator will ensure that Department representatives are provided immediate access to the home, residents, and records as required by applicable regulations.*

*6. The administrator will maintain professional conduct during all Department interactions, including refraining from profanity, derogatory or personal comments, intimidation, argumentative behavior, or other conduct that could interfere with the inspection process.*

*7. If the administrator has a disagreement with a Department representative, the concern will be addressed through professional communication and the appropriate Department appeal, clarification, or complaint process rather than through conduct that disrupts the inspection.*

*Monitoring to Ensure Continued Compliance*

*The administrator will conduct and document **monthly compliance monitoring for six (6) months** to ensure continued compliance with §2600.53(c) and the related inspection requirements.*

*The monthly review will include:*

** Review of administrator compliance with professional conduct expectations.*
** Review of Department inspection procedures.*
** Verification that required access to the home, residents, and records can be provided without unnecessary delay.*
** Review of staff understanding of Department inspection requirements.*
** Review of any concerns, complaints, or incidents involving interactions with regulatory representatives.*
** Documentation of any corrective action or additional training required.*

*The results of each monthly review will be maintained in the home's compliance records and will be available for review upon request.*

*Responsible Person*

*Responsible Person: Administrator / Operator*

*The administrator is responsible for implementation of the corrective measures, completion of required training, staff education, and ongoing monitoring of compliance.*

*Completion Date*

*Implementation Date:_____*

*First Monthly Monitoring Date:_____*

*Administrator Signature:_____*

## *53c Administrator Duties (continued)*

*Date:*

*Supporting Documentation Maintained*

*The following documentation will be maintained as evidence of compliance:*

** Administrator review of §2600.53(c) and §2600.5(a)(1)*
** Administrator Professional Conduct & Department Inspection Compliance Procedure*
** Certificate/attendance documentation for "Embracing Compliance Best Practices"*
** Staff inspection requirements training acknowledgments*
** Monthly compliance monitoring documentation*
** Additional training documentation, if applicable*

*Directed: Within 15 days of receipt of the plan of correction The administrator will obtain documentation from a physician indicating that he's free from a medical condition that would limit [redacted] from performing duties with reasonable skill and safety in accordance with Chapter 2600.53(h). Documentation shall be kept in the administrator's personnel records.*

*Directed: Within 30 days of receipt of the plan of correction The administrator will complete at least 12 hours of anger management courses by an accredited or certified agency.*

**Directed Completion Date:** *10/23/2026*

## 65a - FS Orientation 1st Day

**5. Requirements**

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

*Direct care staff person B hired on [redacted] did not receive general orientation in general fire safety and emergency preparedness that included the following:*
*(1) Evacuation procedures.*
*(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.*
*(3) The designated meeting place outside the building or within the fire safe area in the event of an actual fire.*
*(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.*
*(5) The location and use of fire extinguishers.*

## 65a - FS Orientation 1st Day (continued)

(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

Direct care staff person C hired on [redacted] did not receive general orientation in general fire safety and emergency preparedness that included the following:
(1) Evacuation procedures.
(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
(5) The location and use of fire extinguishers.
(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

Direct care staff person D hired on 10/22/25, did not receive general orientation in general fire safety and emergency preparedness that included the following:
(1) Evacuation procedures.
(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
(5) The location and use of fire extinguishers.
(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

Repeat Violation [redacted] et al, [redacted]

**Plan of Correction** ***Accept [redacted] 09/23/2026)***

PLAN OF CORRECTION
Upon identification of the violation, the Administrator reviewed the fire safety and emergency preparedness orientation requirements with the identified direct care staff persons. Each identified staff person completed the home's Fire Safety and Emergency Preparedness Orientation form, including review of all required topics under 55 Pa. Code § 2600.65(a)(1)-(7). Staff initiated each required section and the Administrator reviewed and signed the completed forms.
The required orientation topics include evacuation procedures; staff duties and responsibilities during fire drills and emergency evacuations; the designated meeting place; smoking safety procedures and the home's smoking policy; location and use of fire extinguishers; smoke detectors and fire alarms; and telephone use and notification of emergency services.
The home's smoking policy was updated effective March 27, 2026, and the current policy remains in effect. All employees have been provided with and have acknowledged the current smoking policy by signature. A copy of the current smoking policy with employee signatures is attached to this Plan of Correction as supporting documentation.
The completed and signed Fire Safety and Emergency Preparedness Orientation forms are maintained in the employees' personnel/training records as verification of completion.
Going forward, the Administrator will ensure that all direct care staff persons, ancillary staff persons, substitute personnel, and volunteers receive the required general fire safety and emergency preparedness orientation prior to or during their first work day. The Administrator will review the orientation documentation for each newly hired

## 65a FS Orientation 1st Day (continued)

*applicable staff person to verify that all required topics have been completed and documented.*
*Monthly monitoring will be conducted by the Administrator through December 2026 to verify that required fire safety and emergency preparedness orientation documentation is complete and maintained for applicable staff. Any deficiency identified during monitoring will be corrected immediately.*
*Date of Correction: 09/03/2026*
*Responsible Person: [redacted] Administrator*
*Method of Monitoring: Review of staff orientation records and monthly compliance monitoring.*
*Supporting Documentation Attached:*
*1. Completed Fire Safety and Emergency Preparedness Orientation Forms*
*2. Current Smoking Policy with Employee Signatures*

**Licensee's Proposed Overall Completion Date:** *09/03/2026* Not Implemented [redacted] 9/23/26)

## 65b - Rights/Abuse 40 Hours

**6. 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**

*Direct care staff person B hired on [redacted], and as of [redacted] had worked more than 40 hours but did not receive an orientation that included 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.*

*Direct care staff person C hired on [redacted], and as of [redacted] had worked more than 40 hours but did not receive an orientation that included 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.*

*Direct care staff person D hired on [redacted], and as of [redacted] had worked more than 40 hours but did not receive an orientation that included the following:*
*(1) Resident rights.*
*(2) Emergency medical plan.*

## 65b - Rights/Abuse 40 Hours (continued)

*(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.*

*Repeat Violation [redacted] et al.; [redacted]*

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

*PLAN OF CORRECTION*
*55 Pa. Code §2600.65(b) – Staff Orientation*

*Violation*
*Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel, and volunteers shall receive an orientation that includes resident rights, the emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions.*

*Corrective Action:*
*Upon identification of this deficiency, the Administrator reviewed the orientation requirements with the identified staff persons. Staff B, C, and D completed the home's existing Staff Orientation Form covering all required topics under §2600.65(b). Each staff person initialed the applicable sections, and the Administrator reviewed and signed the completed forms.*

*The required orientation topics include:*

*1. Resident rights*
*2. Emergency medical plan*
*3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act*
*4. Reporting of reportable incidents and conditions*

*The completed orientation documentation will be maintained in each employee's personnel/training record.*

***Prevention of Recurrence:***
*Going forward, all applicable direct care staff, ancillary staff, substitute personnel, and volunteers will receive the required orientation within their first 40 scheduled working hours. The Administrator will review the existing Staff Orientation Form for each new employee to verify that all required topics have been completed, initialed, and signed.*

*The Administrator will also track the employee's hire date and orientation completion date to ensure the 40-scheduled-working-hour requirement is met.*

*Monitoring*
*The Administrator will conduct a monthly review of personnel and training records through December 2026 to verify that required §2600.65(b) orientation was completed within 40 scheduled working hours and that all four required topics are documented. Any deficiency identified during monitoring will be corrected immediately.*
*Date of Correction: 09/03/2026*

*Responsible Person: [redacted] Administrator*

## 65b - Rights/Abuse 40 Hours (continued)

*Method of Monitoring:*
*Monthly review of employee personnel/training records and existing Staff Orientation Forms to verify timely completion and documentation of all required orientation topics.*

*Supporting Documentation:*

** Completed Staff Orientation Forms for identified employees*
** Monthly orientation compliance monitoring*

**Licensee's Proposed Overall Completion Date:** *09/03/2026* **Not Implemented [redacted] 9/23/26)**

## 131f - Fire Extinguisher Inspection

### 7. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

**Description of Violation**

*On [redacted] at approximately 10:20 a.m., the fire extinguisher in the laundry room had no inspection tag attached to the unit and had no verification that it been inspected by a fire safety expert.*

*Repeat Violation [redacted] et al.*

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

*PLAN OF CORRECTION*
*The fire extinguishers at the home were inspected by Veteran's Fire and Safety on 08/08/2026. The fire extinguisher located in the laundry room was included in the inspection; however, the inspection tag was inadvertently not placed on the unit by the technician at the time of the inspection.*
*Upon identification of the missing inspection tag on 08/11/2026, the Administrator contacted Veteran's Fire and Safety regarding the missing tag. The company confirmed that the laundry-room fire extinguisher had been inspected on 08/08/2026 and that the tag had been inadvertently omitted. Veteran's Fire and Safety promptly sent a technician to the home, and the required inspection tag was placed on the laundry-room fire extinguisher while the inspection issue was being addressed.*
*The Administrator verified that the inspection date is now documented on the fire extinguisher and that documentation of the annual inspection by Veteran's Fire and Safety is maintained at the home.*
*Going forward, the Administrator will verify after each annual fire extinguisher inspection that every fire extinguisher has a current inspection tag attached to the unit and that the inspection date is clearly visible. The Administrator will also maintain the service documentation provided by the fire safety company as verification of the annual inspection.*
*The Administrator will conduct monthly monitoring through December 2026 to verify that all fire extinguishers have a current inspection tag and that the inspection date is clearly visible. Any missing or incomplete inspection documentation will be addressed immediately with the fire safety company.*
*Date of Correction: 08/11/2026*
*Responsible Person: [redacted] Administrator*
*Method of Monitoring: Monthly visual inspection of all fire extinguishers and review of annual fire extinguisher inspection documentation.*

## 131f Fire Extinguisher Inspection (continued)

*Supporting Documentation Attached:*
*1. Veteran's Fire and Safety Inspection Documentation dated 08/08/2026*
*2. Verification of the inspection tag placed on the laundry room fire extinguisher*
*3. Monthly Fire Extinguisher Monitoring Log*

**Licensee's Proposed Overall Completion Date:** *09/02/2026* Not Implemented [redacted] 9/23/26)

## 162c - Menus Posted

**8. Requirements**

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

**Description of Violation**

*On [redacted] at approximately 10:00 a.m. the menus posted on the refrigerator in the kitchen were dated for weeks [redacted] and [redacted]. There were no menus displayed for the current week or the week in advance.*

**Plan of Correction** ***Accept ( [redacted] - 09/23/2026)***

*PLAN OF CORRECTION*

*Upon identification of the violation on [redacted], the Administrator reviewed the menu posting requirements with staff. The menus posted on the refrigerator were dated for the weeks of 07/27/2026 and 08/03/2026 and did not include the current week or the following week.*

*The home utilizes a four week rotating menu. The Administrator reviewed the current four week menu rotation and ensured that the appropriate menu for the current week and the following week was prepared and posted in the designated conspicuous and public location in the home. The posted menu identifies the specific food items to be served at each meal.*

*Staff were reminded that the four week rotating menu is to be followed and that the applicable weekly menu must be posted one week in advance in accordance with 55 Pa. Code § 2600. Any necessary substitutions or changes to the posted menu will be documented appropriately.*

*Going forward, the Administrator will ensure that the four week rotating menu remains current and that the applicable weekly menu is posted at least one week in advance in a conspicuous and public location in the home. The Administrator or designated staff member will verify the posted menu each week to ensure that the correct week is displayed and that the menu identifies the specific food being served at each meal.*

*The Administrator will conduct weekly monitoring through December 2026 to verify compliance with the menu posting requirements. Any deficiency identified during monitoring will be corrected immediately.*

***Date of Correction:** 08/11/2026*

***Responsible Person:** [redacted] Administrator*

*Method of Monitoring: Weekly review of the posted menu and four week menu rotation to verify that the*

## 162c - Menus Posted (continued)

*appropriate weekly menu is posted at least one week in advance and is available for staff and residents to view.*

*Supporting Documentation Attached:*

*1. Current Four Week Rotating Menu*
*2. Posted Weekly Menu*
*3. Weekly Menu Monitoring Log*

**Licensee's Proposed Overall Completion Date:** *09/03/2026* **Not Implemented [redacted] - 9/23/26)**

## 185a - Implement Storage Procedures

**9. 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**

*The home's policy for medication administration includes "narcotics will be counted daily by shift nurse and or additional staff."*

*Resident [redacted] is prescribed the following medications and no narcotic counts are being completed:*
- *[redacted]., Take contents of 1 syringe (0.5 ML) by mouth or under tongue every hour as needed for severe pain/air hunger.*
- *[redacted]., Take contents of 1 syringe (0.25 ML) by mouth or under tongue every hour as needed for severe pain/air hunger.*
- *[redacted] take 1 tablet by mouth sublingual or rectally every 4 hours as needed for anxiety or agitation.*

*Resident [redacted] is prescribed [redacted] tablet take 1 tablet by mouth under tongue or rectally every 4 hours as needed for anxiety/agitation. The blister pack card had 11 pills, but the narcotic count sheet indicated 12 pills as the number of pills remaining. The narcotic card was signed by Staff person C, as if a pill may have been administered; however, the date, time, amount counted, amount recorded, amount given and amount remaining were left blank.*

*Repeat Violation [redacted] et al.*

**Plan of Correction** ***Accept [redacted] 09/23/2026)***

*End-of-Life Kits and Controlled Substances*
*Violation:*
*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.*
*CORRECTIVE ACTION*
*Upon identification of this deficiency, the Administrator reviewed the circumstances involving the controlled substance contained in the resident's end-of-life medication kit.*
*On 08/14/2026, the Administrator met with representatives from Amedisys to review the requirements regarding end-of-life medication kits, controlled substances, medication administration, and documentation.*
*Also, on 08/14/2026, all medications identified as being in the affected end-of-life kits were destroyed/removed from Fairfields' Liberty Hall in coordination with the responsible care agency.*

185a Implement Storage Procedures (continued)

The Administrator identified that the home needed a specific written procedure addressing end of life medication kits and controlled substances supplied by outside care agencies. A new End of Life Kit & Controlled Substance Policy was developed and implemented.

NEW PROCEDURE

The new policy applies to Amedisys and all hospice, home health, or other care agencies entering Fairfields' Liberty Hall that provide, prescribe, supply, manage, or maintain an end of life medication kit for a resident.

The policy establishes that:

• End of life kits may be maintained at Fairfields' Liberty Hall while a resident is actively dying or receiving end of life care.

• Medications contained in an end of life kit must be used only according to current medical orders.

• Controlled substances contained in end of life kits must be appropriately secured, accessed, administered, and documented.

• The responsible care agency shall provide current Medication Administration Records (MARs) to Fairfields' Liberty Hall each month for as long as the end of life kit remains stored inside the home.

• If a resident's medical condition improves and the resident is no longer actively dying or receiving end of life care, the ordering/responsible care agency shall discontinue the medications as appropriate.

• When an end of life kit is no longer medically indicated, the ordering/responsible care agency shall arrange for the medications to be removed from Fairfields' Liberty Hall and properly destroyed/disposed of according to applicable requirements.

• End of life medications shall not remain stored at Fairfields' Liberty Hall when they are no longer medically indicated.

• Any controlled substance discrepancy shall be reported immediately to the Administrator and the care agency responsible and shall be investigated and documented.

STAFF AND AGENCY EDUCATION

The Administrator reviewed the new procedure with the responsible care agency and will provide the policy to all outside care agencies that provide end of life medication kits to residents of Fairfields' Liberty Hall.

Staff responsible for medication administration will be educated regarding the proper handling and documentation of controlled substances contained in end of life kits, including the requirement to accurately document medication administration and any applicable controlled substance activity.

PREVENTION OF RECURRENCE

The Administrator will monitor all end of life medication kits stored at Fairfields' Liberty Hall to ensure that:

1. The kit is for a resident who is actively dying or receiving end of life care.
2. Current MARs are received from the responsible care agency each month while the kit remains in the home.
3. Medication orders and documentation remain current.
4. Controlled substances are appropriately secured and accounted for.
5. Changes in the resident's medical condition are communicated to the care agency responsible.
6. Medications are discontinued and removed from the home when they are no longer medically indicated.

MONITORING

The Administrator will conduct weekly reviews through November 2026 of any end of life medication kits maintained in the home to verify compliance with the new policy.

Beginning in December 2026, monitoring will continue monthly for one year.

Any deficiency identified during monitoring will be addressed immediately with the care agency responsible and documented by the Administrator.

DATE OF CORRECTION

09/03/2026

## 185a Implement Storage Procedures (continued)

*RESPONSIBLE PERSON*

[redacted] *Administrator*

*SUPPORTING DOCUMENTATION*

- *End of Life Kit & Controlled Substance Policy*
- *Documentation of the 08/14/2026 meeting with Amedisys*
- *Documentation of medication destruction/removal dated 08/14/2026*
- *Monthly MARs received from responsible care agencies*
- *End of Life Kit Monitoring Log*
- *Controlled Substance Documentation, as applicable*

**Licensee's Proposed Overall Completion Date:** *09/03/2026* Not Implemented [redacted] - 9/23/26)

## 186a - Authorized Prescriber

**10. Requirements**

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

**Description of Violation**

*There was no discontinue order and no current physician order for [redacted] solution for resident [redacted] in the home.*

*There was no physician prescription order for [redacted] tablet and no current medication list for resident [redacted] in the home.*

*There was no physician order for [redacted] for resident [redacted] in the home.*

*There was no physician prescription order for [redacted] tablet and no current medication list for resident [redacted] in the home.*

*There was no physician order for [redacted] for resident [redacted] in the home.*

*There was no physician prescription order for [redacted] and no current medication list for resident [redacted] in the home.*

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

*55 Pa. Code §2600.187(b) Medication Administration Record*

*Regulation:*
*55 Pa. Code §2600.187(b) The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.*
*Description of Violation*

*Resident [redacted] had an end of life medication kit containing the following medications prescribed for PRN use:*

* [redacted] *suppository every 4 hours as needed for mild pain or fever.*

186a Authorized Prescriber (continued)

* [redacted] every 3 hours as needed for increased secretions.
* [redacted] every 4 hours as needed for agitation.
* [redacted] 0.5 mL every hour as needed for severe pain/air hunger.
* [redacted] 0.25 mL every hour as needed for severe pain/air hunger.
* [redacted] every 6 hours as needed for nausea/vomiting.

These medications were part of the resident's end of life kit and were intended for use on an as needed basis if the resident required end of life symptom management.

At the time of the inspection, the MARs maintained in the home for these end of life medications were from **March 2026 through April 2026**. The medications had not been administered or used, and therefore there were no medication administration entries for these medications.

Fairfields' Liberty Hall was not aware that an updated MAR was required monthly for end of life medications that remained stored in the home even when the medications had not been used. This resulted in the August 2026 MAR not containing the listed end of life kit medications.

Corrective Action Taken

Upon identification of the deficiency, the Administrator reviewed the end of life medication kit procedures with the responsible care agency and reviewed the medication orders for Resident [redacted]

Fairfields' Liberty Hall subsequently established a written **End of Life Kit & Controlled Substance Policy** addressing medications stored in end of life kits, including the requirement for current MARs while the kit remains stored in the home.

The policy applies to **any and all care agencies entering Fairfields' Liberty Hall**, including hospice, home health, pharmacy, and other agencies responsible for providing or managing end of life medications.

The responsible care agency will provide Fairfields' Liberty Hall with **current MARs each month for as long as an end of life kit remains stored in the home**.

If an end of life medication is administered, staff will document the administration on the current MAR at the time the medication is administered, as required.

If an end of life medication is not administered, no administration entry will be made; however, the current MAR will still be maintained in the home so that the medication is properly accounted for and available for documentation if administered.

Prevention of Recurrence

Fairfields' Liberty Hall will implement the following procedures:

1. Each resident with an end of life medication kit will have a current medication order and current MAR maintained in the home.

## 186a - Authorized Prescriber (continued)

*2. Current MARs for end-of-life kits will be obtained from the responsible care agency **monthly** for as long as the kit remains stored at Fairfields' Liberty Hall.*

*3. The Administrator or designated staff will review the current MAR against the medications and orders in the end-of-life kit.*

*4. Staff will document administration of any end-of-life medication on the current MAR **at the time the medication is administered**.*

*5. PRN medications that are not administered will not be documented as administered.*

*6. Staff will not use an outdated MAR for medication administration.*

*7. If a resident's end-of-life medications are discontinued, the responsible care agency will be notified and will arrange for the medications to be removed and appropriately destroyed/disposed of according to applicable requirements.*

*8. If a resident's condition improves and the resident is no longer actively dying or receiving end-of-life care, the responsible care agency will review the medications, discontinue them as appropriate, and arrange for their removal from Fairfields' Liberty Hall.*

*9. Any discrepancy between the medication order, medication physically present, and current MAR will be reported to the Administrator and responsible care agency and corrected promptly.*

*Monitoring*

*The Administrator will conduct weekly MAR/end-of-life-kit audits through November 2026.*

*Each audit will verify:*

** A current MAR is present for each end-of-life medication kit.*
** The MAR corresponds with current medication orders.*
** The MAR is current for the month.*
** Medications in the kit correspond with the current orders/MAR.*
** Any medication administered has been documented at the time of administration.*
** Unused PRN medications have not been incorrectly documented as administered.*
** Discontinued medications have been removed through the responsible care agency.*
** Any discrepancy is corrected immediately.*

*Beginning in **December 2026**, monitoring will continue **monthly through December 2027**.*

*### Responsible Person*

** [redacted] Administrator**

## 186a - Authorized Prescriber (continued)

*### Date of Compliance*

***09/03/2026***

*### Supporting Documentation*

** End-of-Life Kit & Controlled Substance Policy*
** Current end-of-life medication orders*
** Monthly MARs provided by the responsible care agency*
** End-of-life kit/MAR audit forms*
** Documentation of medication administration, when applicable*
** Documentation of medication discontinuation/removal, when applicable*
** Staff education/acknowledgment of the new policy*

**Licensee's Proposed Overall Completion Date:** *09/04/2026* Not Implemented [redacted] 9/23/26)

## 187a - Medication Record

**11. Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

**Description of Violation**

*Resident [redacted] is prescribed [redacted] Apply topically to affected area (s) twice a day for vaginal dryness and itching was in the medication cart, however, it was not included on resident [redacted] s medication administration record.*

*Resident [redacted] is prescribed [redacted] unwrap and insert 1 suppository rectally every day as needed for constipation was in the medication cart, however, it was not included on resident [redacted] August medication administration record.*

*Resident [redacted] is prescribed [redacted] unwrap and insert 1 suppository rectally every 4 hours as needed for mild pain or fever however, it was not included on resident [redacted] s August medication administration record.*

187a - Medication Record (continued)

Resident [redacted]s August MAR includes [redacted] solution every 4 hours as needed for shortness of breath and wheezing; however, this medication was included not in the home or on the medication cart.

Resident [redacted] is prescribed [redacted] tablet take 1 tablet by mouth/sublingually every 3 hours as needed for increased secretions, however, it was not included on resident [redacted]s August medication administration record.

Resident [redacted] is prescribed [redacted] tablet take 1 tablet by mouth, sublingual or rectally every 4 hours as needed for agitation, however it was not included on resident [redacted] August medication administration record.

Resident [redacted] is prescribed [redacted] Conc take contents of 1 syringe (0.5 ml) by mouth or under tongue every hour as needed for severe pain/air, however, it was not included on resident [redacted]s August medication administration record.

Resident [redacted] is prescribed [redacted] Conc take contents of 1 syringe (0.25 ml) by mouth or under tongue every hour as needed for severe pain/air, however, it was not included on resident [redacted] August medication administration record.

Resident [redacted] is prescribed - [redacted] tablet take 1 tablet by mouth/sublingually or rectally every 6 hours as needed for nausea/vomiting, however, it was not included on resident [redacted] August medication administration record.

Repeat Violation [redacted] et al.

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

55 Pa. Code §2600.187(b) – Medication Administration Record

55 Pa. Code §2600.187(b) – The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [redacted] had an end-of-life medication kit containing the following medications prescribed for PRN use:

* [redacted] – every 4 hours as needed for mild pain or fever.
* [redacted] – every 3 hours as needed for increased secretions.
* [redacted] – every 4 hours as needed for agitation.
* [redacted] – 0.5 mL every hour as needed for severe pain/air hunger.
* [redacted] – 0.25 mL every hour as needed for severe pain/air hunger.
* [redacted] – every 6 hours as needed for nausea/vomiting.

These medications were part of the resident's end-of-life kit and were intended for use on an as-needed basis if the resident required end-of-life symptom management.

At the time of the inspection, the MARs maintained in the home for these end-of-life medications were from **March 2026 through April 2026**. The medications had not been administered or used, and therefore there were no

187a Medication Record (continued)

*medication administration entries for these medications.*

*Fairfields' Liberty Hall was not aware that an updated MAR was required monthly for end of life medications that remained stored in the home even when the medications had not been used. This resulted in the August 2026 MAR not containing the listed end of life kit medications.*

*Corrective Action Taken*

*Upon identification of the deficiency, the Administrator reviewed the end of life medication kit procedures with the responsible care agency and reviewed the medication orders for Resident* [redacted]

*Fairfields' Liberty Hall subsequently established a written **End of Life Kit & Controlled Substance Policy** addressing medications stored in end of life kits, including the requirement for current MARs while the kit remains stored in the home.*

*The policy applies to **any and all care agencies entering Fairfields' Liberty Hall**, including hospice, home health, pharmacy, and other agencies responsible for providing or managing end of life medications.*

*The responsible care agency will provide Fairfields' Liberty Hall with **current MARs each month for as long as an end of life kit remains stored in the home**.*

*If an end of life medication is administered, staff will document the administration on the current MAR at the time the medication is administered, as required.*

*If an end of life medication is not administered, no administration entry will be made; however, the current MAR will still be maintained in the home so that the medication is properly accounted for and available for documentation if administered.*

*Prevention of Recurrence*

*Fairfields' Liberty Hall will implement the following procedures:*

*1. Each resident with an end of life medication kit will have a current medication order and current MAR maintained in the home.*

*2. Current MARs for end of life kits will be obtained from the responsible care agency **monthly** for as long as the kit remains stored at Fairfields' Liberty Hall.*

*3. The Administrator or designated staff will review the current MAR against the medications and orders in the end of life kit.*

*4. Staff will document administration of any end of life medication on the current MAR **at the time the medication is administered**.*

*5. PRN medications that are not administered will not be documented as administered.*

## 187a - Medication Record (continued)

*6. Staff will not use an outdated MAR for medication administration.*

*7. If a resident's end-of-life medications are discontinued, the responsible care agency will be notified and will arrange for the medications to be removed and appropriately destroyed/disposed of according to applicable requirements.*

*8. If a resident's condition improves and the resident is no longer actively dying or receiving end-of-life care, the responsible care agency will review the medications, discontinue them as appropriate, and arrange for their removal from Fairfields' Liberty Hall.*

*9. Any discrepancy between the medication order, medication physically present, and current MAR will be reported to the Administrator and responsible care agency and corrected promptly.*

*Monitoring*

*The Administrator will conduct **weekly MAR/end-of-life-kit audits through November 2026**.*

*Each audit will verify:*

** A current MAR is present for each end-of-life medication kit.*
** The MAR corresponds with current medication orders.*
** The MAR is current for the month.*
** Medications in the kit correspond with the current orders/MAR.*
** Any medication administered has been documented at the time of administration.*
** Unused PRN medications have not been incorrectly documented as administered.*
** Discontinued medications have been removed through the responsible care agency.*
** Any discrepancy is corrected immediately.*

*Beginning in **December 2026**, monitoring will continue **monthly through December 2027**.*

*Responsible Person*

[redacted] *Administrator*

*Supporting Documentation*
** End-of-Life Kit & Controlled Substance Policy*
** Current end-of-life medication orders*
** Monthly MARs provided by the responsible care agency*
** End-of-life kit/MAR audit forms*
** Documentation of medication administration, when applicable*
** Documentation of medication discontinuation/removal, when applicable*
** Staff education/acknowledgment of the new policy*

## 187a - Medication Record (continued)

*There are currently no end-of-life kits stored at Farifields' Liberty Hall*

*Resident [redacted] was prescribed [redacted] twice daily. Staff reported that the medication was being administered; however, the medication was not reflected on the August MAR that was being used at the time. Upon identification, Fairfields' Liberty Hall contacted the pharmacy and obtained an updated MAR/order effective 08/11/2026. The updated MAR identifies Vagisil Cream as a twice-daily medication at 8:00 AM and 8:00 PM, with an order start date of 08/11/2026 and stop date of 08/10/2027. The Administrator subsequently reviewed the September 2026 MAR and confirmed that the Vagisil order remained listed correctly.*

**Licensee's Proposed Overall Completion Date:** *09/03/2026* Not Implemented [redacted] 9/23/26)

## 187b - Date/Time of Medication Admin.

**12. Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

**Description of Violation**

*Resident [redacted] is prescribed [redacted] apply topically to affected area (s) twice a day for vaginal dryness and itching, however, it is not on resident [redacted]s medication administration record. Staff person A and staff person B both indicated that they have been administering the Vagisil cream twice a day to the resident.*

*Repeat Violation [redacted]*

**Plan of Correction** ***Accept [redacted] - 09/23/2026)***

*55 Pa. Code §2600.187(b) – Medication Administration Record Documentation*
*Corrective Action Taken*

*Upon identification of the discrepancy, Fairfields' Liberty Hall contacted the resident's pharmacy and obtained a corrected MAR containing the Vagisil Cream order on 08/12/2026.*

*On 09/01/2026, the Administrator reviewed the new MARs for the month and confirmed that the Vagisil Cream order remained correctly listed on Resident [redacted]s MAR.*

*The Administrator reviewed the resident's medication orders against the current MAR to ensure that all medications being administered are reflected on the MAR and that the medication name, dosage, route, frequency, and instructions are consistent with the current physician/provider order.*

*System to Prevent Recurrence*

*Effective immediately, Fairfields' Liberty Hall will follow the following medication documentation procedure:*

*1. All medications administered to residents must be listed on the resident's current MAR and supported by a current medication order.*

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

2. Staff will verify the medication against the current MAR before administration.

3. Medication administration information required by §2600.187(a)(13) and (14) will be recorded at the time the medication is administered.

4. Staff will not administer a medication that is not reflected on the current MAR unless the medication is addressed through an appropriate current order and the MAR is updated according to applicable medication procedures.

5. When a new medication is ordered, discontinued, changed, or otherwise modified, the Administrator or designated trained staff will verify that the resident's MAR is updated accordingly.

6. The Administrator will review new MARs at the beginning of each month and compare them with the resident's current medication orders to identify missing, discontinued, or changed medications.

7. Any discrepancy between a medication order, the medication physically present, and the MAR will be addressed immediately and documented.

8. Staff will be reminded that signing or documenting medication administration must accurately reflect the medication actually administered and the time it was administered.

Monitoring

The Administrator will conduct weekly medication/MAR audits through November 2026. The audit will include:

* Comparison of current medication orders to the MAR.
* Verification that medications being administered are listed on the MAR.
* Verification that medication administration is documented at the time of administration.
* Review for missing, incomplete, or inaccurate MAR entries.
* Verification that medication changes are reflected on the current MAR.
* Immediate correction and documentation of any discrepancy identified.

Beginning December 2026, medication/MAR compliance will be monitored monthly for one year through December 2027.

Any deficiency identified during monitoring will be corrected immediately and, when necessary, additional staff education will be provided.

Responsible Person

[redacted] Administrator

Date of Compliance
09/03/202

Supporting Documentation

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

* Corrected MAR obtained from the pharmacy on 08/12/2026
* Current Resident [redacted] MAR
* Resident medication orders
* Monthly MAR review documentation
* Weekly/monthly medication audit forms
* Staff education documentation, as applicable

**Licensee's Proposed Overall Completion Date:** 09/03/2026 **Not Implemented [redacted] - 9/23/26)**