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

November 12, 2026

[redacted], DIRECTOR
WYNCOTE AID II OPCO LLC
[redacted]

RE: WYNCOTE PLACE
240 BARKER ROAD
WYNCOTE, PA, 19095
LICENSE/COC#: 14254

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/07/2026, 10/08/2026 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**: *WYNCOTE PLACE* **License #**: *14254* **License Expiration**: *04/05/2027*

**Address**: *240 BARKER ROAD, WYNCOTE, PA 19095*

**County**: *MONTGOMERY* **Region**: *SOUTHEAST*

## Administrator

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

## Legal Entity

**Name**: *WYNCOTE AID II OPCO LLC*

**Address**: [redacted]

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

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *07/02/1997* **Issued By**: *COPA L&I*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *94* **Waking Staff**: *71*

## Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *10/08/2026*

## Inspection Dates and Department Representative

*10/07/2026 - On-Site:* [redacted]

*10/08/2026 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *60* **Residents Served**: *47*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Entire Home* **Capacity**: *60* **Residents Served**: *47*

### Hospice

**Current Residents**: *8*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *46*

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

**Have Mobility Need**: *47* **Have Physical Disability**: *4*

## Inspections / Reviews

**10/07/2026 Full**

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/06/2026*

## Inspections / Reviews *(continued)*

**11/12/2026 POC Submission**

**Submitted By:** [redacted]
**Date Submitted:** *11/12/2026*
**Reviewer:** [redacted]
**Follow Up Type:** *Bypass Document Submission*

**11/12/2026 Bypass Document Submission**

**Submitted By:** [redacted]
**Date Submitted:** *11/12/2026*
**Reviewer:** [redacted]
**Follow Up Type:** *Not Required*

## 15a - Resident Abuse Report

**1. Requirements**

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

**Description of Violation**

*On 07/01/26, at 2:00 pm, there was a resident-to-resident altercation in which a resident slapped another resident in the face. This incident was reported to staff person A on 07/2/26 at 11:30 am. However, this allegation of abuse was not reported to the local area agency on aging.*

**Plan of Correction** ***Accept ( [redacted] - 11/10/2026)***

*On 10/9/26 The Executive Director reviewed the DHS reg. 2600.15(a) regarding suspected abuse reporting to the Older Adults Protective Services Department with the Resident Wellness Director (RWD) and the Assistant Wellness Director (AWD). (Exhibit A)*

*At that time a copy of the reporting procedure has been given to the RWD and the AWD.*
*Beginning 11/16/26the ED will review staff reported incidences of resident-to-resident abuse to ensure the reports were reported to AAA in addition to DHS. Reports will be audited weekly x 1 month, then monthly x 2. (Audit tool #1)*

*Results of the audit will be discussed at the monthly QI meeting. The QI committee will determine if continued auditing is necessary based upon the completion and compliance of the audit tool*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ( [redacted] - 11/12/2026)***

## 18 - Compliance With Laws

**2. Requirements**

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

**Description of Violation**

*CARE FACILITY CARBON MONOXIDE ALARMS STANDARDS ACT - ENACTMENT Act of Jun. 23, 2016 Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.*

*There was no carbon monoxide detector within 15 feet of the gas dryer in the laundry room.*

**Plan of Correction** ***Accept ( [redacted] - 11/10/2026)***

*On 10/9 2026 The ED reviewed with the Maintenance Manager and Housekeeping Supervisor regulation 2600. 18 specifically regarding the need for a CO detector within 15 feet of the gas dryer in the basement laundry room. (Exhibit B)*

*On 10/9 the Maintenance Manager installed a new combination CO and smoke detector in the laundry room within 15 feet of the gas dryer. (Exhibits B1& B2)*

**Licensee's Proposed Overall Completion Date:** *11/04/2026*

***Implemented ( [redacted] - 11/12/2026)***

## 54a - Direct Care Staff

**3. Requirements**

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

**Description of Violation**

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

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

*Repeated Violation - 10/15/2025*

**Plan of Correction** ***Accept ([redacted] - 11/10/2026)***

*On 10/9/26 The ED re-educated the Business office Manager, the RWD and the AWD the required documentation necessary for new hires as per DHS reg. 2600.54(a). (Exhibit C).*

*In addition, on 10/9, the ED re-educated the BOM, RWD and AWD, the DHS policy regarding the necessity for all Non US secondary school graduates who work as direct care staff require a waiver for employment, (Exhibit D)*

*On 10/19 All required documentation for Employee C [redacted], US verification, DHS Cares course, family letter of notification and DHS waiver request) sent to [redacted] for approval. Still awaiting response. (Exhibit E)*

*On 10/30 All required documentation for employee B ([redacted], US verification, DHS Cares course, family letter of notification and DHS waiver request) sent to [redacted] for approval. Still awaiting response. (Exhibit F)*

*Beginning 11/16, The ED, or [redacted] designee, will audit all new hires weekly x 2 weeks, biweekly x 2 weeks and monthly x 1 to ensure compliance with DHS reg. 54.(a) (Audit tool # 2).*

*Results of the audit tool will be discussed at the monthly QI meeting. The committee will determine if further auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 65a - FS Orientation 1st Day

**4. Requirements**

2600.

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

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**

*Staff person C, whose first day of work was [redacted] did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.*

**Plan of Correction** ***Accept ([redacted] - 11/10/2026)***

*On 10/9/26 the BOM, RWD and the AWD were re educated on the orientation process for all new hires. (Exhibit G).*

*Staff member C did complete all [redacted] trainings as indicated by [redacted] initials and trainer's initials, however, all failed to date trainings or sign their signature on the final page of the training record indicating the completion of the orientation*
*(Exhibit H)*

*Beginning 8/19/26 10/23/26 all staff completed the 40 hours of mandatory annual trainings. Exhibit H 1 indicates staff C's annual training record.*

*Beginning 11/16, The ED or [redacted] designee, will audit all new hire files weekly x 2 weeks, biweekly x 2 weeks and monthly x1 to ensure all trainings are completed accurately and completely. (Audit Tool # 3).*

*Results of the audit will be discussed at the monthly QI meeting. The committee will determine if further auditing is necessary based upon the completion and compliance of the tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 65b - Rights/Abuse 40 Hours

**5. Requirements**

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

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

*Staff person C completed [redacted] 40th scheduled work hour on [redacted] However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.*

**Plan of Correction** ***Accept ([redacted] - 11/10/2026)***

*On 10/9/26 the BOM, RWD and the AWD were re-educated on the orientation process for all new hires. (Exhibit I).*

*Staff member C did complete all [redacted] trainings as indicated by [redacted] initials and trainer's initials, however, all failed to date trainings or sign their signature on the final page of the training record indicating the completion of the orientation (Exhibit H)*

*Beginning 8/19/26 -10/23/26 all staff completed the 40 hours of mandatory annual trainings. Exhibit H-1 indicates staff C's annual training record.*

*Beginning 11/16, The ED or [redacted] designee, will audit all new hire files weekly x 2 weeks, biweekly x 2 weeks and monthly x1 to ensure all trainings are completed accurately and completely. (Audit Tool # 3).*

*Results of the audit will be discussed at the monthly QI meeting. The committee will determine if further auditing is necessary based upon the completion and compliance of the tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 88a Surfaces

**6. Requirements**

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*On 10/07/26, at approximately 9:30 am, the concrete on the ramp at the front entrance of the facility was in*

## 88a Surfaces (continued)

*disrepair. The concrete was broken in pieces causing a tripping hazard for residents.*

**Plan of Correction** ***Accept ( - 11/10/2026)***

*ED contacted [redacted] Contractors on 10/19. [redacted] into community on 11/3 to estimate needed repairs. Work to begin on 11/16/26. (Exhibit J)*

**Licensee's Proposed Overall Completion Date:** *11/17/2026*

***Implemented ( - 11/12/2026)***

## 101j5 - Bedside Table/Shelf

**7. Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

**Description of Violation**

*There is no bedside table or shelf beside resident #1's bed in bedroom [redacted]*

**Plan of Correction** ***Accept ( - 11/10/2026)***

*On 10/9 the Maintenance Director moved the resident's bedside table from [redacted] previous on the first floor to [redacted] current room on the second floor. (Exhibit K ).*

*On 10/9 the ED re educated the MM and the HK Supervisor the DHS regulations 101 (j (5) and 101 J (7) and the importance of moving the entire bedroom at one time should a resident's room change. ( Exhibit L)*

*Beginning 11/16/26 the ED, or [redacted] designee, will audit 5 resident rooms weekly x 7 days x2 weeks, Biweekly x 7 days x 2 weeks then monthly x 1. (Audit Tool # 4 ).*

*Results of audit tool will be discussed at the QI monthly meeting. The committee will determine if further auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ( - 11/12/2026)***

## 101j7 - Lighting/Operable Lamp

**8. Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

*Resident #1 does not have access to a source of light that can be turned on/off at bedside.*

**Plan of Correction** ***Accept ( - 11/10/2026)***

*On 10/9 the Maintenance Director moved the resident's lamp from [redacted] previous room on the first floor to [redacted] current room on the second floor. (Exhibit K ).*

*On 10/9 the Ed re educated the MM and the HK Supervisor on the DHS regulations 101 (j (5) and 101 J (7) and the importance of moving the entire bedroom at one time should a resident's room change. (Exhibit M)*

## 101j7 - Lighting/Operable Lamp (continued)

*Beginning 11/16/26 the ED, or [redacted] designee, will audit 5 resident rooms weekly x 7 days x2 weeks, Biweekly x 7 days x 2 weeks then monthly x 1. (Audit Tool # 5).*

*Results of audit tool will be discussed at the QI monthly meeting. The committee will determine if further auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 103d - Storing Food Off Floor

**9. Requirements**

2600.
103.d. Food shall be stored off the floor.

**Description of Violation**

*On 10/07/26, at 10:30 am, three boxes of carrot cake, brussels sprouts, and unknown box was stored on the floor in the walk-in freezer.*

**Plan of Correction** ***Accept ([redacted] - 11/10/2026)***

*On 10/7/26 All food delivered by Sysco that morning was immediately removed from the floor of the walk-in freezer upon discovery by the inspector (Exhibit N).*

*On 10/9 The ED and Dietary Manager re-educated all kitchen staff regarding DHS reg. 103(d) All Food shall be stored off the floor (Exhibit O).*

*Beginning 11/16, The Dietary Manager will audit the walk - in freezer and walk -in refrigerator to ensure no food is stored on the floor. The audit will be daily x 2 weeks, daily biweekly x 2 weeks, then monthly x 1 (Audit Tool # 6 ).*

*Results of the audit will be discussed at the QI monthly meeting. The committee will decide if continued auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 103i - Outdated Food

**10. Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

**Description of Violation**

*On 10/07/26 at 11:30am, 12 cans of chicken noodles with expiration date of 09/24 and 12 cans of vegetables noodles with expiration date of 02/22 were found in the emergency food pantry.*

**Plan of Correction** ***Accept ([redacted] - 11/10/2026)***

*On 10//7/26 the dietary manager immediately removed all dented and outdated cans of food from the emergency*

## *103i Outdated Food (continued)*

*storage room.*

*On 10/9//26 the ED and Dietary Manager re educated kitchen staff regarding DHS reg. 103(i) Outdated or spoiled food or dented cans may not be used. (Exhibit P)*

*On 10/12 Delivery of emergency food received from Sysco (Exhibit Q)*

*Beginning 11/16, The Dietary Manager, or [redacted] designee will audit the emergency food supply for outdated or dented cans weekly x 4 , bi weekly x 2 and monthly x 1 month to ensure compliance with reg, 103(i). (Audit Tool #7)*

*Results of the audit tool will be discussed at the monthly QI meeting. The committee will decide if further auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 107c - Food/Water 3 Day Supply

**11. Requirements**

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

**Description of Violation**

*On 10/07/26, the home served 47 residents, requiring 141 gallons of emergency drinking water. However, the home had only 48 gallons. The home does not have a contract with a local bottled water supplier that includes 24 hours delivery in case emergency.*

**Plan of Correction** ***Accept ([redacted] - 11/10/2026)***

*On 10/9/26 The ED and the Dietary Manager re educated the kitchen staff on Reg. 107(c), a home shall maintain a 3 day supply of non perishable food and drinking water. (Exhibit R).*

*Additional water delivery received on 10/12/26 (Exhibit S).*

*Beginning 11/16, the Dietary Manager, or [redacted] designee, will ensure that the emergency food storage closet maintains a minimum 3 day supply of bottled water. The water supply will be monitored weekly x 4 weeks, bi weekly x 2 and monthly x 1 (Audit tool # 8).*

*Results of the audit tool will be discussed at the monthly QI meeting. The committee will decide if further auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 121a - Unobstructed Egress

**12. Requirements**

2600.

## 121a Unobstructed Egress *(continued)*

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

**Description of Violation**

*On 10/07/26, at 9:15 am, there was a stop sign on the exit door leading to the home's front entrance.*

*On 10/07/26, at 11:00 am, there were chairs and a utility cart blocking the exit door from the home's basement exit that leads to the exterior.*

**Plan of Correction** ***Accept ( [redacted] - 11/10/2026)***

*On 10 /7 the Maintenance Manager immediately removed the utility cart that was blocking the exit door in the basement (Exhibits T1 & T2)*

*On 10/7 the stop sign picture was immediately removed from the sign on the French doors leading into the lobby (Exhibit T3)*

*On 10/9 The ED re educated the MM & HK Supervisor on DS Reg. 121(a), egress routes from rooms and the building must be unblocked and unobstructed. (Exhibit U).*

*Beginning 11/16, the ED or [redacted] designee, will audit all egress routes from rooms and the building to ensure routes are unblocked and unobstructed. The audit will be weekly x 4, biweekly x 2 and monthly x1. (Audit Tool #9)*

*Results of the audit tool will be discussed at the QI meeting. The committee will determine whether continued auditing is necessary based on the completion and compliance of the audit.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ( [redacted] - 11/12/2026)***

## 131f - Fire Extinguisher Inspection

**13. 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**

*The fire extinguisher near the Fox Therapy's room on the second floor did not have a tag indicating when it was last inspected by a fire safety expert.*

**Plan of Correction** ***Accept ( [redacted] - 11/10/2026)***

*On 10/9 the ED reviewed with the MM and HK supervisor the DHS reg 131.(f) (Exhibit U)*

*On 10/12/26 the missing inspection tag was replaced on the extinguisher.*
*(Exhibit V)*

## *131f Fire Extinguisher Inspection (continued)*

**Licensee's Proposed Overall Completion Date:** *11/05/2026*

***Implemented ( - 11/12/2026)***

## 162c - Menus Posted

**15. 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**

*The home's menu for the week of 10/4/26 was posted. However, the menu for the following week was not posted in a conspicuous and public place in the home.*

**Plan of Correction** ***Accept ( - 11/12/2026)***

*On 10/8 an additional weekly menu was posted on the menu board in the lobby of the community (Exhibit A 1).*

*On 10/9/26 The ED reviewed with the concierges the DHS reg. 162(c) requiring two weeks of menus to be posted. (Exhibit A 2 ).*

*Beginning 11/16, The ED or designee will monitor the menu board daily x 2 weeks, biweekly x 2 weeks and monthly x 1 to ensure compliance.*
*(Audit tool# 11).*

*Results of the audit tool will be discussed at the QI meeting. The committee will determine whether continued auditing is necessary based on the completion and compliance of the audit.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ( - 11/12/2026)***

## 183e - Storing Medications

**16. Requirements**

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

**Description of Violation**

*On 10/08/26, Morphine Sulfa Oral Syringe; take .25ml (5mg) under the tongue every 3 hours as needed for pain prescribed for resident #3, was in the home's medication cart; however, the medication expired on 07/19/26.*

*On 10/08/26, a pill pack of Loratadine 10 mg tablet scheduled for administration on 10/9/26 at 9:00 am prescribed for resident #4, was ripped open and taped closed with the pill still in the pack.*

## 183e Storing Medications (continued)

**Plan of Correction** ***Accept ( [redacted] - 11/12/2026)***

*1. On 10/8 The RWD immediately removed and destroyed the expired medication.*
*On 10/8 the RWD reordered the medication from the pharmacy.*

*2. On 10/8 The taped single dose pack was removed from the med cart by the RWD.*
*On 10/8, The pharmacy was notified by the RWD requesting replacement dose.*

*On 10/9 The RWD and the ED re educated the nurses and Med Techs regarding DHS reg 26009.185(e) (Exhibit B 1)*

*Beginning 11/16, The RWD, or [redacted] designee, will audit all med carts daily x 2 weeks, daily bi weekly x 2 and monthly x1 to ensure the med carts are maintaining sanitary conditions and that there are no expired meds within the carts. (Audit Tool # 12).*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ( [redacted] - 11/12/2026)***

## 185a - Implement Storage Procedures

**17. Requirements**

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

**Description of Violation**

*Resident #4 is prescribed Hyosyne Dro 0.125 ml, Acetaminophen Sup 650 mg, and Atropine Sul 1% as needed.*
*On 10/08/26 these medication(s) were not available in the home.*

**Plan of Correction** ***Accept ( [redacted] - 11/12/2026)***

*On 10/8 the RWD called the pharmacy requesting the comfort pack for resident #4. Medications delivered by pharmacy that afternoon and placed in med cart and refrigerator.*

*On 10/9 the ED and RWD re educated the nurses and Med Techs regarding regulation # 185 (a) specifically, all ordered medications for residents must be available in house. (Exhibit C 1)*

*Beginning 11/16, med carts/refrigerators will be audited daily x 2 weeks, Bi weekly x 2 weeks and then monthly x 1 to ensure all ordered meds are available for the residents. (Audit Tools # 13)*

*Results of the audit tool will determine if further auditing is necessary based upon the completion and compliance of the audit tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ( [redacted] - 11/12/2026)***

## 187a - Medication Record

**18. Requirements**

2600.

## 187a - Medication Record *(continued)*

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 #5 is prescribed NovoLog 100 unit/ml, inject 10 units subcutaneously. Glucose check before meals and at bedtime along w/sliding scale. if BS<150=0 units, 151-200=1 units, 201-250=2 units, 251-300=3 units, 301-350= 4 units and >351=5 units. This medication was administered from October 1, 2026, through October 8, 2026, however, the units given are not included on resident #5's medication administration record.*

**Plan of Correction** ***Accept ([redacted] - 11/12/2026)***

*On 10/10 supplemental documentation for units given was added to EMAR for resident #5. (Exhibit E-1)*

*On 10/9 the RWD re-educated Med Techs and nurses that units given must be documented when administering insulin per reg. 187(a). (Exhibit E-2)*
*Beginning 11/16, the RWD, or [redacted] designee, will audit compliance by printing the blood glucose and insulin administration record x 4 weeks and monthly x 2 months to ensure unit given are documented in EMAR.*

*Results of the audit will be discussed at the monthly QI meetings. The committee will determine if further auditing is necessary based upon the completion*
*and compliance of the tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 227d - Support Plan Medical/Dental

**19. 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.

## 227d Support Plan Medical/Dental *(continued)*

**Description of Violation**

*The support plan, dated [redacted] for resident #2 does not address the need for transferring and turning in/out of bed/chair correctly. Resident #1 has a bedside mobility device that is not address in the resident support plan.*

**Plan of Correction** ***Accept ([redacted] - 11/12/2026)***

*On 10/9, the RWD updated the support plan for resident # 1 and #2. (Exhibit F)*

*On 10/9, The ECD re educated the RWD and AWD on regulation 227 (d) (Exhibit G).*

*Beginning 11/16, The ED or [redacted] designee, will audit 5 resident support plans weekly x 4 weeks and monthly x 2 months to ensure compliance with 227 (d). (Audit Tool #14)*

*Results of the audit will be discussed at the QI monthly meeting. The committee will determine if continued auditing is necessary based upon the completion and compliance of the tool.*

**Licensee's Proposed Overall Completion Date:** *01/18/2027*

***Implemented ([redacted] - 11/12/2026)***

## 233c - Key-Locking Devices

**20. 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 locking mechanism are not conspicuously posted near the dining room center door in the Secure Dementia Care Unit (SDCU).*

*Repeated Violation 10/15/2025*

**Plan of Correction** ***Accept ([redacted] - 11/12/2026)***

*On 10/9 The ED re educated the MM and the HK supervisor the procedure for ensuring the codes posted on the doors match the codes needed to unlock the door as per DHS reg. 233 (c) ( Exhibit G 1 ).*

*On 10/9 the correct code was printed and posted on door #2, first floor.*
*(Exhibit G2).*
*On 10/12, The ED checked all keypads to ensure posted codes match the codes needed to exit the door. (Audit Tool # 16)*

**Licensee's Proposed Overall Completion Date:** *11/05/2026*

***Implemented ([redacted] - 11/12/2026)***