pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MSA PLYMOUTH MEETING OPERATING, LLC**
LEGAL ENTITY

To operate **THE PINNACLE AT PLYMOUTH MEETING**
NAME OF FACILITY OR AGENCY

Located at **215 PLYMOUTH ROAD, PLYMOUTH MEETING, PA 19462**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **138**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 19**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 23, 2024** until **June 23, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **150231**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 23, 2024

[redacted]
Authorized Signer
[redacted]
[redacted]
[redacted]

RE: The Pinnacle at Plymouth Meeting
215 Plymouth Road
Plymouth Meeting, Pennsylvania 19462
License #: 150231

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection March 7, 8, 15, and 21, April 12, 19, and 25, and May 3 and 6, 2024, June 3, 4, and 5, 2024, and August 1, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 15023 dated January 16, 2024 to January 16, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated January 16, 2024 to January 16, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 23, 2024 to June 23, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL 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.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED], Workload Manager
Pennsylvania Department of Human
Services Bureau of Human Services
Licensing
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

This decision is final 11 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.

[REDACTED]
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [REDACTED], Office of General Counsel
[REDACTED], Director, Human Services Licensing
[REDACTED], Director of Operations
[REDACTED], Regional Director, Human Services Licensing

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

Facility Information

Name: *THE PINNACLE AT PLYMOUTH MEETING* **License #**: *15023* **License Expiration**: *01/16/2025*

Address: *215 PLYMOUTH ROAD, PLYMOUTH MEETING, PA 19462*

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

Administrator

Name:

Legal Entity

Name: *MSA PLYMOUTH MEETING OPERATING, LLC*

Address:

Certificate(s) of Occupancy

Type: *I 1* **Date**: *07/02/2020* **Issued By**: *Plymouth Township*

Type: *I 2* **Date**: *07/02/2020* **Issued By**: *Plymouth Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *111* **Waking Staff**: *83*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *06/05/2024*

Inspection Dates and Department Representative

06/03/2024 On Site:

06/04/2024 On Site:

06/05/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *19* **Residents Served**: *13*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *28* **Have Physical Disability**: *0*

Inspections / Reviews

06/03/2024 Full

Lead Inspector: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *07/08/2024*

07/19/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/08/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *07/24/2024*

12/06/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/24/2024*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

12/09/2024 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], staff person A overheard staff person B yell at resident #1 to be quiet. Resident #1 was interviewed by staff person A after this incident; resident #1 stated that they asked staff person B to assist with putting on a jacket that morning, Staff person B threw the jacket at the resident and told the resident to put it on themself.

Plan of Correction ***Accept [redacted] - 07/29/2024)***

1. Executive Director or designee will in-service all employees on resident rights, dignity and respect by 7/19/24.
2. Training on resident rights, dignity and respect to continue monthly during staff townhall for the next 6 months by [redacted] or designee
3. Staff person B was immediately separated from resident and was asked to leave the premises immediately.
4. Resident was interviewed to make sure her wellbeing was addressed. Family was contacted.
4. Staff person b was terminated.

Proposed Overall Completion Date: 01/24/2025

Licensee's Proposed Overall Completion Date: *01/24/2025*

42s - Privacy

2. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

During an inspection on June 3rd, 4th, and 5th, 2024, video recording devices were identified by the home's main entrance, in the mailroom, at the entrances/exits to the secured dementia care unit (SDCU), in common areas of the SDCU and on each floor of the home's stairwells/fire towers. There were no signs in these areas indicating images are being recorded. Additionally, the resident contract indicates only that "the Community may utilize video surveillance at entrances and exits to further enhance security of the building".

Plan of Correction ***Accept [redacted] - 07/26/2024)***

1. Corrected June 5, 2024: Community posted signs indicating video recording is taking place near main entrance/exit, in the mailroom, at the entrances/exits to the secured dementia care unit (SDCU) and on each floor of the home's stairwells/fire towers.
2. During daily community walk-through Maintenance Team or designee will ensure all signs remain in place.
3. July 5, 2025: Resident contract was updated to reflect the use of surveillance recording at main entrance, in the mailroom, at the entrances/exits to the secured dementia care unit (SDCU), and on each floor of the home's stairwells/fire towers entrance/exits of community,
4. The community has disconnected the video recording of the home's common areas as of 7/24/24 done by Facilities manager.

Proposed Overall Completion Date: 07/24/2024

42s - Privacy *(continued)*

Licensee's Proposed Overall Completion Date: *07/24/2024*

Not Implemented (█ 12/06/2024)

52 - Hiring Staff

3. Requirements

2600.

52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons 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) and other applicable regulations.

Description of Violation

Staff member C's date of hire is █, staff member C's criminal background check request was not completed until █.

Plan of Correction ***Accept (█ - 07/19/2024)***

1. Executive Director (ED), or designee, will audit all new employee charts prior to first day of work to ensure community is in compliance with The Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) for the next 6 months.
2. Regional Director or designee will audit the audit completed by the ED for all new hires from July 8, 2024, through October 31, 2024, to ensure community is in compliance with The Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102).

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented █ - 12/06/2024)

63a - First Aid/CPR Training

4. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 05/31/24 from 11:00 PM to 7:00 AM on 06/01/24, approximately 83 residents were present in the home. During this time there were no staff persons present in the home certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept (MJ - 07/26/2024)***

1. Corrected on June 4th, 2024, by reviewing the current schedule to make sure we had at least one staff person for every 50 residents
2. ED or designee will audit wellness staff employee files to ensure all CPR training certificates are up to date by July 22, 2024.
3. CPR was completed on July 17,2024 and next class is scheduled for July 24, 2024. Community will host another class in August 2024.
4. Ed or designee will do a monthly audit of the CPR spreadsheet to ensure that nursing staff are all CPR certified and up to date

63a First Aid/CPR Training (continued)

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented (MJ - 12/06/2024)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 06/03/24, an unattended, unlocked cleaning cart was found in the hallway of the Memory Care unit. On the cart was a bottle of "ECOLAB Acid Bathroom Cleaner" with a warning label indicating "For Industrial Use Only", "Do Not Drink", "Keep Out Of Reach Of Children", "Wash thoroughly after handling. Get medical attention if symptoms appear", and a bottle of ZEP Zepvue RTU Glass Cleaner with a warning lab indicating "If swallowed, do not induce vomiting. Contact a physician immediately. Get medical attention.". Not all the residents of the memory care unit have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 07/29/2024)***

1.Staff was immediately educated on 6/3/24 by ED on the importance of locking and securing poisonous material
2. ED or designee will in service all staff on the regulation that poisonous materials are to remain locked and secured in the memory care unit by July 19, 2024.
3. Housekeeping employees will be in serviced by Facilities manager or designee on the requirement to lock housekeeping carts, particularly when stepping away for a moment, or when the cart is outside a unit that is currently being cleaned by July 19, 2024
4. A weekly audit will be completed x4 by Facilities manager or designees to assure all carts are locked and poisonous materials are secured. Audit to be reviewed at QA meeting to assure 100% compliance.

Proposed Overall Completion Date: 08/16/2024

Licensee's Proposed Overall Completion Date: *08/16/2024*

Not Implemented (- 12/06/2024)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 06/03/24 between 9:45 and 10:00 AM the trash cans in the 3rd and 4th floor Men's bathrooms were not covered.

Plan of Correction ***Accept (- 07/19/2024)***

1. Corrected June 4, 2024: All bathroom trash receptacles in kitchens and bathrooms had covers.

85d - Trash Receptacles (continued)

2. ED or designee will in service all staff to the requirement that trash in kitchens and bathrooms shall be kept in covered trash receptacles to prevent the penetration of insects and rodents. In service will include staff's responsibility to reporting any missing covers immediately to management. July 19, 2024.

Licensee's Proposed Overall Completion Date: *07/19/2024*

Implemented (- 12/06/2024)

96a - First Aid Kit

9. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the second floor nurse's station and in the home's Lincoln SUV contained expired Alcohol Prep Pads.

Plan of Correction ***Accept (- 07/29/2024)***

1. Corrected on June 5, 2024.
2. Effective July 2024, all first aid kits will be audited monthly to ensure all items are present and not expired to be done by Wellness director or designee
3. Executive Director or designee will in-service all staff that first aid kits include nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers by July 19, 2024.
4. All staff to be in-service to check all contents of first aid kits to ensure no items are expired to include alcohol prep pads and triple antibiotic ointment.

Proposed Overall Completion Date: 07/24/2024

Licensee's Proposed Overall Completion Date: *07/24/2024*

Not Implemented - 12/06/2024)

101j7 - Lighting/Operable Lamp

10. 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 (- 07/29/2024)***

1. June 5, 2024, ED confirmed with the resident that the resident's preference was to have her bedside lamp on the table that is located at the foot of the bed (rather than the side and within arm's reach). Community will install a push light on the wall by the bedside by July 19, 2024.

101j7 - Lighting/Operable Lamp (continued)

2. ED or designee will in-service all-staff to the regulation that an operable lamp or other source of lighting that can be turned on my bedside is available for all residents by July 19, 2024.

3. Housekeeping and wellness staff will audit all resident's units by July 31, 2024, to ensure compliance with this regulation.

4. Weekly audits to be done by housekeeping staff and report to Facilities manager or designee, if any apartment is observed without a lighting source.

Proposed Overall Completion Date: 07/31/2024

Licensee's Proposed Overall Completion Date: *07/31/2024*

Not Implemented [redacted] - 12/06/2024)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 06/03/24 at 10:26 AM the temperature in the Memory Care Kitchenette's refrigerator and freezer were 54 and 50 degrees Fahrenheit respectively, at 10:31 the temperatures were 58 and 48 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 07/29/2024)***

1. Corrected on 6/3/24 by Dining director.

2. ED or designee will in-service all-staff on the proper refrigerator and freezer temperatures by July 19, 2024.

3. Dining director or designee will audit temp log starting on 7/26/24 weekly x 4 until 100% compliance and review QA meeting. Designated staff will alert Dining Director or designee if any temperature is not at the regulated temperature.

Proposed Overall Completion Date: 08/23/2024

Licensee's Proposed Overall Completion Date: *08/23/2024*

Not Implemented [redacted] - 12/06/2024)

107a - Emergency Preparedness

12. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person C does not have a copy of the emergency preparedness plan for the local municipality.

Plan of Correction ***Accept ([redacted] - 07/29/2024)***

1. Corrected on June 5,2024 by Ed. The community received a copy of the emergency preparedness plan from Plymouth Meeting Township.

107a - Emergency Preparedness (continued)

2. Ed or designee will be sure to reach out to the township 60 days prior to the end of the year to prevent a lapse in obtaining the emergency preparedness plan
3. ED or designee will also place a calendar reminder to prevent this occurrence from being missed in the future by 7/24/24

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented (█ - 12/06/2024)

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 safety inspection tag for the fire extinguisher in the memory care hallway is missing. The last inspection by a fire safety expert for this fire extinguisher cannot be determined.

Plan of Correction ***Accept (█ - 07/29/2024)***

1. Corrected on June 5, 2024.
2. ED or designee will in-service all-staff that the safety inspection tags from fire extinguishers can be removed or fall off and for staff to be observant of the tags, or lack thereof, for all fire extinguisher in the community by July 26, 2024.
3. Effective July 2024 and ongoing, the Facility Manager or designee will ensure all tags are in place during the monthly Fire Drill.
4. The ED or designee will keep documentation of all fire extinguisher inspections to present upon request of the Department.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (█ - 12/06/2024)

132c - Fire Drill Records

14. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the home's fire drills do not include;

- *The exact time of the fire drill,*
- *The amount of time to evacuate (in minutes and seconds),*
- *The exit routes used to evacuate.*

Plan of Correction ***Accept (█ - 07/19/2024)***

1. ED will in-service the Facility Manager by July 19, 2024, that fire drill records must include: the exact time of the

132c - Fire Drill Records (continued)

drill; the amount of time used to evacuate (in seconds and minutes) and identify the exit route used.
1. 2. Effective with the July 2024 Fire Drill and ongoing, the ED will review monthly fire drills to ensure the exact time of fire drill, amount of time to evacuate and exits routes is listed on fire log for next 3 months, until 100% compliance

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented - 12/06/2024)

181f - Record of Medication

15. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 06/05/24, resident #2's, who self medicates, record did not include a current list of medications. The list in the resident's record included the following:

-
-
- ,

Further, Resident #2's record did not include which the resident takes before dental appointments.

Plan of Correction ***Accept (- 07/19/2024)***

1. Corrected June 6, 2024. During this inspection, a review of resident #2 medication was conducted by the nurse and orders were received by her MD.
2. On or before July 26, 2024: All residents who self-medicate will receive an audit of all medications and be re-educated to report any new medications or medication order changes; responsible parties will continue to do perform quarterly self-medication assessment regulation by wellness director or designee.

Proposed Overall Completion Date: 07/26/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 12/06/2024)

225a - Assessment 15 Days

16. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

- Resident #3 was admitted on ; however, the resident's assessment was not completed until .

225a Assessment 15 Days (continued)

- Resident #4 was admitted on 02/28/23; however, the resident's assessment was not completed until 07/25/23.

Plan of Correction ***Accept (MJ - 07/19/2024)***

1. Current management company assumed management of community on 4/1/2023. Audits were completed of all current resident charts to identify any missing assessments. Overdue and or missing assessments were completed by 8/2023 and schedules were developed based upon new timeline.
2. ED or designee will audit all new admission files weekly x 4 and review at quarterly QA meeting until 100% compliance to assure the initial assessment is completed within 15 days of admission

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented (MJ - 12/06/2024)

227a - Support Plan 30 Days

17. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #3 was admitted on [redacted]; however, the resident's initial support plan was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 07/19/2024)***

1. Current management company assumed management of community on 4/1/2023. Audits were completed of current all resident charts to identify any missing assessments. Overdue and or missing assessments were completed by 8/2023 and schedules were developed based upon new timeline.
2. ED or designee will audit all new admission files weekly x 4 and review at quarterly QA meeting until 100% compliance to assure all residents have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented [redacted] 12/06/2024)

227d - Support Plan Medical/Dental

18. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #1, dated [redacted], indicates the resident has a need for "Transferring in/out of bed/chair" marked "D" and "Turning and positioning in bed/chair" marked "C". Under the Plan to Meet Service Need column "Staff to assist resident..." is listed. However; on [redacted], the home added an "Assessment and Support Plan Updates and

227d - Support Plan Medical/Dental (continued)

Changes" form indicating the resident uses a Bed Mobility Device and lists the resident's specific need for the device, the intended use and that physical therapy (PT) assessed the resident's ability to safely use the device.
The Resident Support Plan does not indicate the following:

- *Any risks associated with the device,*
- *Identification of the specific device to be used,*
- *If a cover is required to meet FDA guidelines.*

Plan of Correction ***Accept (- 07/29/2024)***

1. The Resident #1 Support Plan was updated on to include any risk associated with use of the Bed Mobility Device, identification of the specific device used and that the cover meets FDA requirements.
2. ED or designee will audit all Resident Support Plans by August 2,2024 of resident's who are utilizing Bed Mobility Devices to ensure that the care plan includes any risk associated with use of the Bed Mobility Device, identification of the specific device used and that the cover meets FDA requirements.
3. Wellness director or designee to in-service nursing staff on FDA guidelines surrounding bed enabler usage by 7/26/24

Licensee's Proposed Overall Completion Date: *08/02/2024*

Not Implemented - 12/06/2024)

234a - Admission Support Plan

19. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept - 07/19/2024)***

1. Current management company assumed management of community on 4/1/2023. Audits were completed of all current resident charts to identify any missing assessments. Overdue and or missing assessments were completed by 8/2023 and schedules were developed based upon new timeline.
2. ED or designee will continue to audit all new admission files to assure the initial assessment is completed within 15 days of admission weekly x 4 until 100% compliance.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented - 12/06/2024)

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

Facility Information

Name: *THE PINNACLE AT PLYMOUTH MEETING* **License #**: *15023* **License Expiration**: *01/16/2025*

Address: *215 PLYMOUTH ROAD, PLYMOUTH MEETING, PA 19462*

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

Administrator

Name:

Legal Entity

Name: *MSA PLYMOUTH MEETING OPERATING, LLC*

Address:

Certificate(s) of Occupancy

Type	Date	Issued By
I 2	*07/02/2020*	*Plymouth Township*
I 2	*07/02/2020*	*Plymouth Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *117* **Waking Staff**: *88*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *10/04/2024*

Inspection Dates and Department Representative

09/04/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *81*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SCDU* **Capacity**: *19* **Residents Served**: *16*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *81*

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

Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

09/04/2024 - Partial

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *10/20/2024*

10/30/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/29/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *11/04/2024*

11/06/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/29/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/30/2024*

12/09/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/29/2024*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home 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

Resident 1 reported a missing checkbook to staff person A, the home's administrator. This incident was not reported to the local area agency on aging.

Plan of Correction ***Accept (█ 10/30/2024)***

1. All Department Heads and all-staff will be in-serviced on 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) be Executive Director or designee on before November 8, 2024
2. Home will implement the use of a shared electronic grievance and incident log (EGIL) by 10/28/24.
3. Management Team and Concierges will be in-serviced on use of the EGIL on or before October 28, 2024.
4. The Executive Director, designee, weekend Manger on Duty will review the EGIL during 9am daily morning meeting to ensure all grievances and incidents reported by the front desk are addressed and reported in accordance with Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27

Proposed Overall Completion Date: 11/08/2024

Licensee's Proposed Overall Completion Date: *11/08/2024*

Not Implemented (█ - 12/06/2024)

15d Resident Abuse Notification

2. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

The home received a report of suspected financial abuse involving resident 1 for their missing checks. The home did not notify Resident 1's designated person.

Plan of Correction ***Accept █ - 10/30/2024)***

5. The home contests this violation. The Administrator notified the resident's designated person of the allegation of missing checks at 2:10pm on 8/27/24
6. All Department Heads and all-staff will be in-serviced on 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) be Executive Director or designee on before November 8, 2024
7. The Executive Director, designee, weekend Manger on Duty will review the EGIL during 9am daily morning meeting to ensure all grievances and incidents reported by the front desk are addressed and reported in

15d - Resident Abuse-Notification (continued)

accordance with Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27

Proposed Overall Completion Date: 11/08/2024

Licensee's Proposed Overall Completion Date: *11/08/2024*

Not Implemented - 12/06/2024)

16c - Written Incident Report

3. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident 1 reported a missing checkbook to staff person A the home's The home did not report this incident to the Department.

Plan of Correction ***Accept (10/30/2024)***

1) All Department Heads and all-staff will be in-serviced on 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) be Executive Director or designee on before November 8, 2024
2) Home will implement the use of a shared electronic grievance and incident log (EGIL) by 10/28/24.
3) Management Team and Concierges will be in-serviced on use of the EGIL on or before October 28, 2024.
4) The Executive Director, designee, weekend Manger on Duty will review the EGIL during 9am daily morning meeting to ensure all grievances and incidents reported by the front desk are addressed and reported in accordance with Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27

Licensee's Proposed Overall Completion Date: *10/28/2024*

Not Implemented (- 12/06/2024)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On , resident 2's brother reported to staff person B that resident 2 received a bank statement with checks being cashed that resident 2 did not write. Check was written out for the amount of and was deposited and cleared the bank on was written out for the amount of and was deposited and cleared the bank on Resident 2 did not write these checks and states they were taken from the home. These checks were not in the residents handwriting, nor did they recognize the individuals that the checks were written pay

42b Abuse (continued)

to the order of.

Plan of Correction ***Accept (10/30/2024)***

1) The home was compliant with reporting this incident to department of aging, the Department and Plymouth Township Police Department.
2) The home and the Plymouth Township Police Department were not able to substantiate the checks were stolen at the home or by any of the home's staff.
3) Effective 10/28/24 and on going all new residents will be informed of the locked drawer in every unit and the home will ensure that keys to this drawer are provided to the resident during the resident's admission. Residents will be encouraged to utilize this drawer to store their valuables. The Facility Manager will create a Key Log to document the resident received both a key to their apartment and a key to the locked drawer.
4) The Executive Director, or designee, will audit the Key Log weekly from 11/1/24 to 11/30/24.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented - 12/06/2024)

42c - Treatment of Residents

5. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On , staff person C and staff person D both witnessed staff person E trying to clear the table from dinner when resident 3 would not release the cup and swung it at staff person E. Staff person C and staff person D heard staff person E tell resident 3 "If you hit me with the cup, I will smack the shit out of you."

Plan of Correction ***Accept (- 11/06/2024)***

1) Executive Director or designee will in service all employees on resident rights, dignity and respect by 10/28/24.
2) Effective 11/1/2024, ending 4/30/25 resident rights, dignity and respect will be a training topic for monthly all staff Town Halls
3) Staff person E employment was terminated immediately after the incident was reported on 8/18/24

Proposed Overall Completion Date: 04/30/2025
Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Not Implemented - 12/06/2024)

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

Staff person E completed their 40th scheduled work hour on 7/20/2024. However, this staff person did not complete training in the following topics: mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Plan of Correction ***Accept [redacted] - 10/30/2024)***

1) The home contests this violation and will submit training record with this POC
2) Staff person E completed Abuse, Neglect, and Exploitation in the Elder Care Setting on June 15, 2024, during initial 40 scheduled hours of work
3) The home's orientation has been approved by the Department
4) All new employees complete Orientation utilizing approved Relias modules during their first 40 hours of scheduled work.

Proposed Overall Completion Date: 10/31/2024

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented ([redacted] - 12/06/2024)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 9/4/2024, at 12:45 pm, in resident room 103 there was a bathroom cabinet with a broken handle.

Plan of Correction ***Accept ([redacted] 10/30/2024)***

1) Bathroom cabinet handle was repaired on 9/4/24
2) Memory Care Coordinator and Facility Manger will in-service staff who work in memory care to complete and hand in a work order to report any furniture or equipment that is not in good repair, broken or dirty by 10/28/24
3) Effective 10/28/24 the home will utilize TELS work orders to track all reports of furniture or equipment that is not in good repair, broken or dirty

Proposed Overall Completion Date: 10/28/2024

95 - Furniture and Equipment *(continued)*

Licensee's Proposed Overall Completion Date: *10/28/2024*

Implemented - 12/06/2024)

96a - First Aid Kit

8. Requirements

141a 1-10 Medical Evaluation Information

9. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 4's initial medical evaluation did not include a list of current medications.

Plan of Correction ***Accept - 11/06/2024)***

1) The home contests this violation please see the signed list of current medications the home has on record from

141a 1-10 Medical Evaluation Information (continued)

this resident's admission.
2) Wellness Coordinator or designee will review all pre-admission medical evaluations prior to admission of new resident to ensure a list of current medications are included. Audit will be documented effective any new admission starting 10/28/24 and continue till 12/31/2024

Proposed Overall Completion Date: 12/31/2024
Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 12/06/2024)

225a - Assessment 15 Days

10. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident 4, who was admitted to the home on [redacted]

An assessment was not completed for resident 5, who was admitted to the home on [redacted]

Plan of Correction ***Accept [redacted] - 11/06/2024)***

1) Resident 4 assessment was completed on [redacted]
2) Resident 5 assessment was completed on [redacted]
3) Wellness Coordinator or designee will audit assessments of all new residents within 5 working days of the resident's admission to ensure all new resident assessments are completed within 15 days of admission. Audit will be documented effective any new admission starting 10/28/24 and continue till 12/31/2024

Proposed Overall Completion Date: 12/31/2024
Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Not Implemented ([redacted] - 12/06/2024)

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

225c - Additional Assessment *(continued)*

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

Description of Violation

Resident 3's most recent assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 11/06/2024)***

1) The home will conduct weekly RISK meetings starting 11/1/24 and ongoing to document significant changes and ensure that any resident identified as having a significant change has a new assessment completed within 5 working days
2) Weekly Risk Meeting reviews will be reviewed monthly during monthly Quality Assurance Meetings
3) In the event the Department notifies the home that they have cause to believe an assessment update is required, the assessment will be completed within 5 working days of the request and this resident will be added into the weekly Risk Meeting and Monthly QA review

Proposed Overall Completion Date: 12/31/2024
Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Not Implemented ([redacted] - 12/06/2024)

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

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

Description of Violation

Resident 2's assessment, dated [redacted], does not include the area engaging in social activities.

Plan of Correction ***Accept ([redacted] - 11/06/2024)***

1) Resident 2's assessment was updated to include the area engaging in social activities
2) Wellness Coordinator or designee will review all completed assessments to ensure all areas of the assessment have been completed effective 10/28/24 and ongoing
3) Assistant Executive Director will audit 10% of all assessment that take place between 11/1/24 through 12/31/24 to ensure all areas of assessment have been completed.

Proposed Overall Completion Date: 12/31/2024
Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Not Implemented ([redacted] - 12/06/2024)

227a - Support Plan 30 Days

13. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 4 was admitted on [redacted]; however, the resident's initial support plan was not completed.

Plan of Correction ***Accept ([redacted] - 10/30/2024)***

1) Resident 4's support plan was completed [redacted]

2) Wellness Coordinator or designee will audit written support plans of all new residents within 15 working days of the resident's admission to ensure all new residents have a written support plan within 30-days of admission. Audit effective 10/28/24 and continue till 12/31/2024

Proposed Overall Completion Date: 10/31/2024

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented ([redacted] - 12/06/2024)

231c Preadmission Screening

14. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, resident 3's written cognitive preadmission screening was not completed.

Plan of Correction ***Accept ([redacted] - 10/30/2024)***

1) Nursing staff will be re-trained on this regulation (231c) by Assistant Executive Director or designee by 10/28/24

2) Effective 9/9/2024 and until 12/1/2024 audits of new admission pre-screen are completed by the Assistant Executive Director or designee.

Proposed Overall Completion Date: 11/09/2024

Licensee's Proposed Overall Completion Date: *11/09/2024*

Implemented ([redacted] - 12/09/2024)