

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

June 26, 2025

[REDACTED]
MSA PLYMOUTH MEETING OPERATING, LLC
[REDACTED]
[REDACTED]

RE: THE PINNACLE AT PLYMOUTH
MEETING
215 PLYMOUTH ROAD
PLYMOUTH MEETING, PA, 19462
LICENSE/COC#: 15023

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2025 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: THE PINNACLE AT PLYMOUTH MEETING License #: 15023 License Expiration: 06/23/2025
Address: 215 PLYMOUTH ROAD, PLYMOUTH MEETING, PA 19462
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: MSA PLYMOUTH MEETING OPERATING, LLC
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: 131 Waking Staff: 98

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Incident Exit Conference Date: 03/26/2025

Inspection Dates and Department Representative

03/26/2025 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 138 Residents Served: 96

Secured Dementia Care Unit

In Home: Yes Area: Garden House Capacity: 19 Residents Served: 19

Hospice

Current Residents: xx

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 94
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 35 Have Physical Disability: 0

Inspections / Reviews

03/26/2025 Partial

Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 04/18/2025

05/13/2025 - POC Submission

Submitted By: [Redacted] Date Submitted: 06/07/2025
Reviewer: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 05/18/2025

Inspections / Reviews (*continued*)

05/19/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/07/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/08/2025

06/26/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/07/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

131f - Fire Extinguisher Inspection

1. 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 home's fire extinguishers were serviced in Feb 2024 and they were inspected/serviced on [REDACTED]; however, thirty fire extinguishers throughout the community failed to be approved by a fire safety expert because they passed the 6 year expiration period.

Repeat Violation: [REDACTED]

Plan of Correction

Directed [REDACTED] 05/19/2025)

3/26/25: The 30 fire extinguishers were replaced by the end of the inspection on 3/26/25. The vendor who replaced the 30 extinguishers on 3/26/25 met with the DHS surveyor to confirm they had been replaced and explained they were fully operational, but that after the 6-year manufacturer date they would not approve an extinguisher.

5/14/2025: The facility manager or designee will conduct an audit of 10% of the fire extinguishers each month (approximately 30) to ensure all are tagged and maintain compliance.

5/15/2025: May & June audits will be submitted as part of this POC by July 15,2025. All records will be maintained in Fire Extinguisher Compliance Binder and Electronic Folder.

Licensee's Proposed Overall Completion Date: 04/18/2025

Update: 05/13/2025

All fire extinguishers in the home must be inspected and approved in a much shorter timeframe

5/14/2025: Facility Manager contacted Annual Fire Extinguisher Certification vendor to complete an annual inspection on all-fire extinguishers in the home by June 15, 2025.

5/9/2025: May audit of fire extinguisher complete. Submitted with this revision.

5/15/2025: Community will comply with all steps above.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction:

Within 20 days of the receipt of the acceptable plan of correction, the administrator shall ensure that all fire extinguishers in the home are inspected by a fire safety expert.

Directed Completion Date: 06/08/2025

Implemented [REDACTED] - 06/26/2025)

141b1 - Annual Medical Evaluation

2. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [REDACTED]'s most recent medical evaluation completed on [REDACTED] does not include (9) Health Status/Cognitive Functioning. This part of the form is blank.

141b1 Annual Medical Evaluation (continued)

Plan of Correction

Directed [redacted] - 05/19/2025)

3/7/2025: New DME for Resident [redacted] was obtained.

4/025: An audit for DME compliance of 7 resident records was completed by the Regional Director of Clinical Services.

5/14/2025: Wellness Director, or designee, will audit all incoming admission's DMEs and record compliance on electronic audit tool as an ongoing practice in the community.

5/15/2025: The audit tool will be reviewed during monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current resident medical evaluations must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home's overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

Directed Completion Date: 06/08/2025

Implemented [redacted] 06/26/2025)

224a - Preadmission Screen Form

3. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted] and [redacted] preadmission screening forms, dated [redacted] do not include a determination that the needs of the residents can be met by the services provided by the home.

Plan of Correction

Directed [redacted] - 05/19/2025)

5/14/2025: Wellness Director, or designee, will audit all incoming admission's DMEs and record compliance on electronic audit tool as an ongoing practice in the community.

5/14/2025: The audit tool will be reviewed during monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current resident pre admission screening forms must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home's overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

224a Preadmission Screen Form (continued)

Directed Completion Date: 06/08/2025

Implemented [redacted] - 06/26/2025)

4. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]; however, the resident's preadmission screening form was completed on 12/12/2024.

Resident [redacted] was admitted to the home on [redacted] however, the resident's preadmission screening form was completed on 12/12/2024.

Repeat Violation: [redacted]

Plan of Correction

Directed [redacted] - 05/19/2025)

5/14/2025: Wellness Director, or designee, will audit all incoming admission's DMEs and record compliance on electronic audit tool as an ongoing practice in the community.

5/14/2025: The audit tool will be reviewed during monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current resident pre admission screening forms must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home's overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

Directed Completion Date: 06/08/2025

Implemented [redacted] - 06/26/2025)

227g -Support Plan Signatures

5. Requirements

2600.

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

Description of Violation

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

Plan of Correction

Directed [redacted] - 05/19/2025)

3/27/2025: Wellness Director met with Resident [redacted] to review support plan and documented Resident [redacted] was unable to sign the support plan. 3/29/25: Left message for POA requesting care review and signature.

5/14/2025: Wellness Director, or designee, will audit all new support plans by the last day of each month and

227g -Support Plan Signatures (continued)

record compliance on electronic audit tool as an ongoing practice in the community.

Licensee's Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current resident assessment and support plans must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home's overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

Directed Completion Date: 06/08/2025

Implemented [redacted] - 06/26/2025)

227h - Support Plan Refuse Sign

6. Requirements

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident [redacted] assessment and support plan (RASP) dated [redacted] was not signed by the resident; however, the home did not make a notation regarding the resident's refusal/ability to sign.

Plan of Correction

Directed [redacted] 05/19/2025)

3/27/2025: Wellness Director met with Resident [redacted] to review support plan, documented Resident [redacted] was unable to sign the support plan. 3/29/25: Left message for POA requesting care review and signature.

5/14/2025: Wellness Director, or designee, will audit all new support plans by the last day of each month and record compliance on electronic audit tool as an ongoing practice in the community.

Licensee's Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current resident assessment and support plans must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home's overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

Directed Completion Date: 06/08/2025

Implemented [redacted] - 06/26/2025)

231b - Medical Evaluation

7. Requirements

231b - Medical Evaluation (continued)

2600.

231.b. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident’s diagnosis of Alzheimer’s disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secured Dementia Care Unit (SDCU) on [redacted] however, the resident’s medical evaluation dated [redacted] does not include the resident’s diagnosis of [redacted] or other [redacted]

Plan of Correction

Directed [redacted] - 05/19/2025)

3/7/2025: The community obtained a new medical evaluation including a diagnosis of dementia for Resident [redacted]

4/20/2025: Wellness Director, or designee, will audit all medical evaluations by the last day of each month and record compliance on electronic audit tool as an ongoing practice in the community.

Licensee’s Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current SDCU resident assessment and support plans must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home’s overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

Directed Completion Date: 06/08/2025

Implemented [redacted] - 06/26/2025)

231c - Preadmission Screening

8. 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 [redacted] was admitted to the [redacted] on [redacted]. However, the resident’s written cognitive preadmission screening was completed on [redacted]

Resident [redacted] was admitted to the [redacted] on [redacted]. However, the resident’s written cognitive preadmission screening was completed on [redacted].

Repeat Violation: [redacted]

Plan of Correction

Directed [redacted] - 05/19/2025)

4/17/2025 An audit for DME compliance of 7 resident records was completed by the Regional Director of Clinical Services.

5/1/2025 – 8/1/2025: An audit for DME compliance of 7 resident records will occur 2X per month between the period of 5/1/2025 – 8/1/2025.

5/15/2025: Wellness Director, or designee, will audit all incoming admission DMEs and record compliance on

231c - Preadmission Screening (continued)

electronic audit tool as an ongoing practice in the community.

5/15/2025: The audit tool will be reviewed during monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 08/01/2025

Update: 05/13/2025

An audit of all current SDCU resident cognitive pre-screens must be completed much sooner than the proposed timeframe.

5/14/2025: Audits of all resident charts by National Support Team finalized on May 14, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Plan of Correction: Only the home's overall completion date has been directed to 6/8/25. By this date, the home should be able to demonstrate significant compliance with the acceptable plan of correction.

Directed Completion Date: 06/08/2025

Implemented [REDACTED] - 06/26/2025)

234d - Support Plan Revision

9. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [REDACTED] assessment and support plan (RASP) was completed on [REDACTED]. The resident returned from a hospital with an indwelling catheter on [REDACTED]. The resident's support plan was not updated with these changes.

Plan of Correction

Accept [REDACTED] - 05/13/2025)

March 26, 2025: Hospice provider removed the indwelling catheter. The indwelling catheter was a short-term intervention in place by Hospice provider. Hospice Provider and care staff provided care via daily assignment sheets, communication logs and Hospice Care

April 9, 2025: As changes of conditions are reviewed daily utilizing the Nursing 24-hour report and communication logs, all change of conditions are noted, communicated to the Wellness Director or designee, who will audit the current care plan and add the change of condition and/or interventions to ensure compliance.

April 17, 2025: All-staff in-service on Incident Reporting Policy and the important of Incident Reporting to trigger nurse follow-up and notification of Change of Conditions.

Licensee's Proposed Overall Completion Date: 04/18/2025

Implemented [REDACTED] - 06/26/2025)