pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TOWAMENCIN OPERATING COMPANY, LLC**
LEGAL ENTITY

To operate **MORNINGSIDE HOUSE OF TOWAMENCIN**
NAME OF FACILITY OR AGENCY

Located at **900 TOWAMENCIN AVENUE, LANSDALE, PA 19446**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **144**
(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 59**

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 **June 3,** **2025** until **June 3,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **151050**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: June 3, 2025

[redacted]
[redacted]
Towamencin Operating Company, LLC
[redacted]
[redacted]

RE: Morningside House of Towamencin
900 Towamencin Avenue
Lansdale, Pennsylvania 19446
License #: 151050

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on April 9 and 10, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

June 3, 2025

[redacted]
TOWAMENCIN OPERATING COMPANY, LLC
[redacted]

RE: MORNINGSIDE HOUSE OF TOWAMENCIN
900 TOWAMENCIN AVENUE
LANSDALE, PA, 19446
LICENSE/COC#: 15105

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/09/2025, 04/10/2025 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: *MORNINGSIDE HOUSE OF TOWAMENCIN* **License #**: *15105* **License Expiration**: *05/01/2025*

Address: *900 TOWAMENCIN AVENUE, LANSDALE, PA 19446*

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

Administrator

Name: [redacted]

Legal Entity

Name: *TOWAMENCIN OPERATING COMPANY, LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/21/2023* **Issued By**: *Towamencin Township*

Type: *I-1* **Date**: *09/24/2019* **Issued By**: *Towamencin Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *134* **Waking Staff**: *101*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *04/10/2025*

Inspection Dates and Department Representative

04/09/2025 - On-Site: [redacted]

04/10/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *86*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Opal* **Capacity**: *59* **Residents Served**: *27*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

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

Have Mobility Need: *48* **Have Physical Disability**: *0*

Inspections / Reviews

04/09/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/04/2025*

Inspections / Reviews *(continued)*

05/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/20/2025*

06/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/20/2025*

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

130g - Smoke Detector Repair

1. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 4/9/25 at approximately 9:45am, the home's main fire panel displayed an error code and a trouble alarm. The panel's error code had been showing since 4/5/25.

Plan of Correction ***Accept [redacted] - 05/01/2025)***

1. Oliver Fire Protection and Security was contacted and provided a quote to furnish and replace 212 combo co/smoke devices due to end-of-life warning.
2. Installation to begin on May 15, 2025, pending delivery of parts. Installation to be completed by Oliver Fire Protection and security. Fire alarm panel continues to function at full capacity.

Licensee's Proposed Overall Completion Date: *05/15/2025*

Update: *05/01/2025*

Please provide documentation of completion.

Evidence of Completion ***Implemented [redacted] - 06/03/2025)***

See attached.

181f - Record of Medication

2. 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 4/10/25, Resident #1's record did not include a current list of medications. The list in the resident's record did not include Pepcid AC which was found in Resident #1's room.

Plan of Correction ***Accept [redacted] - 05/01/2025)***

1. Director of health and wellness received an order from the Doctor for the Pepcid AC on 4/10/25 and it has been updated on medication list.
2. Director of Health and Wellness, nursing and Med techs was trained on regulation 181f by Executive Director by 4/11/25
3. Director of Health and Wellness has audited all residents' files who self-administer medications to be sure that the medications in their apartment match the medication list on file. Audit started on 4/15/25 and was completed on 4/18/25
4. Director of Health and Wellness or designee will do monthly self-med assessment monthly x 2 months then quarterly thereafter starting on 5/15/25

Licensee's Proposed Overall Completion Date: *05/15/2025*

Update: *05/01/2025*

Please provide documentation of completed monthly audit.

Evidence of Completion ***Implemented [redacted] - 06/03/2025)***

See attached.

183d - Prescription Current

3. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #2 was prescribed Earwax treatment 6.5%- instill 5 drops into each ear at bedtime for 5 days. The drops were started on 4/4/25 and ended on 4/8/25 at which time it was discontinued. The drops were still present in the medication cart on 4/10/25 at 11:30am.

Repeat Violation Date: 6/25/24 et al

Plan of Correction ***Accept [redacted] - 05/01/2025)***

1. Earwax was removed from the cart and destroyed on day of inspection.
2. Director of Health and Wellness, Med Techs and nursing staff were trained on regulation 183d. on 4/11/25. Training was conducted by Executive Director.
3. All med cart to be audited by Director of Health and Wellness or designee. Audit Started on 4/14/25 and will continue until 100% compliant.
4. All medication carts will be audited monthly by the Director of Health & Wellness or designee, starting May 5, 2025

Licensee's Proposed Overall Completion Date: *05/05/2025*

Update: *05/01/2025*

Please provide documentation of completed monthly audit.

Evidence of Completion ***Implemented ([redacted] - 06/03/2025)***

See attached.

183e - Storing Medications

4. 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 4/10/25, the following medication cards were observed to have a punctured blister foil with the medication still present in the spot .

- *Resident #3's Calcium Antacid*
- *Resident #4's Calcium Antacid*
- *Resident #5's Acetaminophen 325mg tab*
- *Resident #6's Lorazepam 0.5mg tab*

Plan of Correction ***Accept [redacted] - 05/01/2025)***

1. Medications that had a foil punctured were destroyed on day of inspection by nurse on duty and Director of Health and wellness.
2. All Med Techs and nursing staff were trained on regulation 183e. on 4/11/25. Training was conducted by Executive Director.

183e - Storing Medications (continued)

3. Nursing staff conducted an audit of all blister medications to check for puncture on 4/11/25. Medication that had a puncture on blister was destroyed.
3. The Pharmacy has changed medication package from a foil back to cardboard back. The change started on 4/24/25. This will prevent accidental medication puncture when meds are being taken in out of the cart.
4. The Director of Health &Wellness or designee will conduct monthly medication audits to ensure there are no punctures on medication packaging. Audit to begin on May 5, 2025 and continue until all blister packs has been changed to a cardboard back.

Licensee's Proposed Overall Completion Date: *05/05/2025*

Update: *05/01/2025*

Please provide documentation of completed monthly audit.

Evidence of Completion ***Implemented [redacted] - 06/03/2025)***

See attached.

225a - Assessment 15 Days

5. 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 #7's initial assessment and support plan dated [redacted]/24 does not indicate the resident's degree of assistance needed with laundry.

Plan of Correction ***Accept ([redacted] - 05/01/2025)***

1. An addendum was added to the RASP by The Health and Wellness director on day of inspection to indicate the residents need with assistance with laundry.
2. RASP audits were completed on 4/10/25 and 4/11/25 by Regional Director of Operations and the Regional Director of Health & Wellness to ensure all every section in each care plan was filled out with the appropriate information.
3. The Health and Wellness Director and Memory Care Director were in-serviced on rasp/ regulation 225a by Regional Director of Operations on 4/10/25. On 4/22/25, the community's electronic medical record system was updated to ensure that the RASP is completed in its entirety before clinical staff is allowed to finalize the RASP. A notification will pop up informing staff that a section is blank, or a box hasn't been selected. This change will prevent omission moving forward. The Executive Director will conduct random RASP audits quarterly to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Evidence of Completion ***Implemented ([redacted] - 06/03/2025)***

See attached.

227d - Support Plan Medical/Dental

6. Requirements

2600.

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

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

Description of Violation

Resident #8's assessment dated [redacted]/24 indicates that resident needs total physical assistance with securing/using transportation. Resident #7's support plan dated [redacted]/24 does not specific how this need will be met.

Repeat Violation Date: 1/16/25

Plan of Correction ***Accept [redacted] - 05/01/2025)***

1. An addendum was added to the RASP by The Health and Wellness director on day of inspection (4/9/25) to indicate the resident need with securing/using transportation and how this need will be met.
2. 2. RASP audits were completed on 4/10/25 and 4/11/25 by Regional Director of Operations and the Regional Director of Health & Wellness to ensure every section in each care plan was filled out with the appropriate information.
3. Health and Wellness Director and Memory Care Director was in-serviced on rasp/ regulation 225a. by Regional Director or Operations on 4/10/25. On 4/22/25, the community's electronic medical record system was updated to ensure that the RASP is completed in its entirety before clinical staff is allowed to finalize the RASP. A notification will pop up informing staff that a section is blank, or a box hasn't been selected. This change will prevent omission moving forward. The Executive Director will conduct random RASP audits quarterly to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Evidence of Completion ***Implemented ([redacted] - 06/03/2025)***

See attached.

233c - Key-Locking Devices

7. 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

On 4/9/25 at approximately 9:45am, the directions for operating the home's locking mechanism on the gate in the courtyard of the Opal Unit were not conspicuously posted near the gate.

Repeat Violation Date: 6/25/24 et al

Plan of Correction ***Accept [redacted] - 05/01/2025)***

1. The directions for operating the home's locking mechanism on the gate in the courtyard of the Opal Unit was posted near the gate on day of inspection on 4/9/25.
2. Maintenance Director was trained on regulation 233.c by Executive director on 4/10/25
3. Maintenance Director or designee will do monthly audit of key locking device to make sure code is posted. Audit to being 5/5/25.

233c - Key-Locking Devices *(continued)*

Licensee's Proposed Overall Completion Date: *05/05/2025*

Update: *05/01/2025*

Please provide documentation of completed monthly audit.

Evidence of Completion ***Implemented [redacted] - 06/03/2025)***

See attached.