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

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 **September 24,** **2025** until **March 24,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **150232**

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

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 24, 2025

[redacted]
MSA Plymouth Meeting Operating, LLC
[redacted]

RE: The Pinnacle at Plymouth Meeting
215 Plymouth Road
Plymouth Meeting, Pennsylvania 19462
License #: 150232

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 28 and 29, May 12, 13, 14, 16, and 20, 2025 and June 24 and 25, 2025 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. 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 SECOND PROVISIONAL license is enclosed and is valid from SEPTEMBER 24, 2025 TO MARCH 24, 2026.

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.

[redacted]

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
15a	II	84	$5	$420	5 calendar days from mailing date of this letter
42b	II	84	$5	$420	5 calendar days from mailing date of this letter

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

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

[redacted]

If you disagree with the decision to issue a SECOND 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 SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

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.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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**: *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]

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *04/29/2025*

Inspection Dates and Department Representative

04/28/2025 - On-Site: [redacted]
04/29/2025 - On-Site:
05/12/2025 - On-Site:
05/13/2025 - On-Site:
05/14/2025 - On-Site:
05/16/2025 - On-Site:
05/20/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *19* **Residents Served**: *18*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *96*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

04/28/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/19/2025*

07/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/11/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2025*

07/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/11/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/13/2025*

08/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/11/2025*

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

On 3/25/25 at approximately 10:15 AM, Resident 1 and Staff Person A were involved in an altercation that resulted in Resident 1 falling after Staff Person A pushed the resident. Staff Person A admitted to pushing Resident 1 causing them to fall. Staff Person A immediately reported the incident, including the altercation and resident fall, to Staff Person B, however, this allegation of abuse was not reported to Area Agency on Aging.

On 3/27/25 at approximately 1:00 AM, Resident 1, Staff person C and Staff person D were involved in an incident of suspected or alleged abuse. Staff person C promptly reported the incident, including all actions taken, to Staff person E , however, this allegation of abuse was not reported to Area Agency on Aging.

On 5/6/25, Staff Person F was involved an incident of alleged abuse/theft when Staff Person F was observed on a resident owned camera to be present in Resident 2's room without reason and without request for assistance from Staff Person F. Staff Person F entered Resident 2's room while the resident was asleep on the couch in their living room, entered the residents bedroom and closed the door; remaining out of camera view, re-emerging approximately 40 minutes later. The resident's [redacted] also reported a number of resident unauthorized transactions on the residents credit cards back in December of 2024, prompting the installation of the video cameras in the residents room. The home reported the incident on 5/7/25 however, the report did not include information regarding Staff Person F, who was [redacted] on [redacted]/25, pending internal investigation into the incident. This incident was not reported to Area Agency on Aging.

Repeat Violation Date: 9/4/24

Plan of Correction ***Directed [redacted] - 07/15/2025)***

The Pinnacle completed a Mandatory All Staff Inservice on April 17th, 2025, regarding reportable incidents as required by Chapter 2600 regulatory guidelines and The Protective Services Act. This training included mandatory reporting guidelines, identifying abuse and neglect and restrictions on staff persons involved in alleged circumstances.

In acknowledging the importance of compliance with the regulatory standards, The Pinnacle will host this training on a quarterly basis for the next year and upon hire and annually thereafter.

The Pinnacle Management Team will utilize monitoring systems to detect possible resident rights violations or reportable incidents. These systems include the work week review of Grievance Forms, staff meetings and the new Advanced Entry auditing system that queries families and visitors about their experience and the experience of their loved one at each the end of each visit to The Pinnacle. Written communication logs will be replaced with a report from Care Partners to the Medication Technician, or Charge Nurse, for documentation in the 24 formal reports in the electronic health system. This communication will be reviewed daily by Charge Nurse, Wellness Director, Wellness Coordinator, or Designee responsible for the shift.

15a - Resident Abuse Report (continued)

Trainings, grievance responses and Advanced Entry documentation will be reviewed for compliance by The Quality Assurance Team during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory expectations.

Directed Plan of Correction: *In addition to the above plan of correction, the Administrator or Designee shall interview a random sample of at least 5 residents weekly for 4 weeks and then monthly for 2 months to review for protection of resident rights with emphasis on receiving care with dignity and respect, freedom of abuse and theft of property. Interviews shall begin within 14 calendar days from the receipt of this plan of correction. Interview findings shall be documented and kept for review by the Department upon request.*

Directed Completion Date: *07/31/2025*

Not Implemented [redacted] 08/20/2025)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 3/25/25 at approximately 10:15 AM, Resident 1 and Staff Person A were involved in an altercation that resulted in Resident 1 falling after Staff Person A pushed the resident. Staff Person A admitted to pushing Resident 1, causing them to fall. Staff Person A immediately reported the incident, including the altercation and resident fall, to Staff Person B, however, the home did not develop and implement a plan of supervision or suspend Staff Person A.

On 3/27/25 at approximately 1:00 AM, Resident 1, Staff Person C and Staff Person D were involved in an incident of suspected or alleged abuse. Staff Person C promptly reported the incident, including all actions taken, to the Staff Person E. However, the home did not immediately develop and implement a plan of supervision or suspend the staff persons involved in the alleged incident of resident abuse.

On 3/27/25 at approximately 11am, Resident 1 and Staff Person A were involved in an altercation and alleged abuse that resulted in injury to Resident 1, who was transferred to the hospital. The home did not develop and implement a plan of supervision or suspend the staff person.

On 5/6/25, Staff Person F was involved an incident of alleged abuse/theft when Staff Person F was recorded on a resident owned camera in Resident 2's room. Staff Person F entered Resident 2's room while the resident was asleep on the couch in their living room. Staff person F then entered the residents bedroom and closed the door, remained out of camera view and re-emerged approximately 40 minutes later. The resident's family reported that there had been a number of unauthorized transactions on the residents credit cards back in December of 2024, prompting the family to install the video cameras. The home reported the incident on 5/7/25 however, the report did not include information regarding Staff Person F, who was suspended on 5/6/25. Additionally, Staff Person F returned to work on 5/12/25, prior to receiving an approved plan of supervision from the Department.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The Pinnacle summarily [redacted] staff persons A, C, D, and F. Upon the outcome of the investigations of the above incidents, all staff members noted were [redacted].

15b - Supervisor Plan (continued)

Staff person F was returned to active duty at the community on 5/11/25 as The Pinnacle's investigation and pictures demonstrated that this staff member reorganized the resident's closet during the timeframe in the room. However, as a result of the Licensing Inspection on May 12th, 2025 citing this violation, The Pinnacle resuspended and has [redacted] the staff member upon receipt of the Licensing Summary.

The Pinnacle completed a Mandatory All Staff Inservice on April 17th, 2025 regarding suspension protocols related to Chapter 2600 regulations and allegations of abuse.

In acknowledging the importance of compliance with the regulatory standards, The Pinnacle will host this training on a quarterly basis for the next year and upon hire and annually thereafter.

Training will be reviewed for compliance during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Not Implemented [redacted] - 08/20/2025)

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

On 3/25/25 at approximately 10:15 AM, Resident 1 and Staff Person A were involved in an altercation that resulted in Resident 1 falling after Staff Person A pushed the resident. Staff Person A admitted to pushing Resident 1, causing them to fall. Staff Person A immediately reported the incident, including the altercation and resident fall, to Staff Person B, however, this allegation of abuse was not reported to the Department.

On 3/27/25 at approximately 1:00 AM, Resident 1, Staff Person C, and Staff Person D were involved in an incident of suspected or alleged abuse. Staff Person C promptly reported the incident, including all actions taken, to Staff Person E, however, this allegation of abuse was not reported to the Department.

Repeat Violation Date: 9/4/24

Plan of Correction ***Directed ([redacted] - 07/15/2025)***

Staff member B will be trained regarding reportable incident protocols as they relate to the twenty-four hour (24) reportable incident guidelines, secondary to their failure to recognize these issues as abuse. Staff member E is no longer employed by The Pinnacle. This training will be completed by 7/1/25.

The Pinnacle completed a Mandatory All Staff Inservice on April 17th, 2025, regarding reportable incident protocols as related to the twenty (24 hour) guidelines of reporting per Chapter 2600 regulation and allegations of abuse.

In acknowledging the importance of compliance with the regulatory standards, The Pinnacle will host this training

16c - Written Incident Report (continued)

on a quarterly basis for the next year and upon hire and annually thereafter.

The Pinnacle Management Team will utilize several overlapping monitoring systems to detect possible resident rights violations or reportable incidents. These systems include the work week review of Grievance Forms, work week staff meetings and the new Advanced Entry auditing system that queries families and visitors about their experience and the experience of their loved one at each the end of each visit to The Pinnacle. Written communication logs will be replaced with a report from Care Partners to the Medication Technician, or Charge Nurse, for documentation in the 24 formal reports in the electronic health system. This communication will be reviewed daily by Charge Nurse, Wellness Director, Wellness Coordinator, or Designee responsible for the shift.

Trainings, grievance responses and Advanced Entry documentation will be reviewed for compliance by The Quality Assurance Team during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory expectations.

Training will be reviewed for compliance during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory guidelines.

Directed Plan of Correction: *In addition to the above plan of correction, the Administrator or Designee shall interview a random sample of at least 5 residents weekly for 4 weeks and then monthly for 2 months to review for protection of resident rights with emphasis on receiving care with dignity and respect, freedom of abuse and theft of property. Interviews shall begin within 14 calendar days from the receipt of this plan of correction. Interview findings shall be documented and kept for review by the Department upon request.*

Directed Completion Date: *07/31/2025*

Not Implemented [redacted] - 08/20/2025)

16e - Resident Notice

4. Requirements

2600.
16.e. If the home's final report validates the occurrence of the alleged incident or condition, the affected resident and other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation.

Description of Violation

On 4/12/25, the home submitted a final incident report validating the occurrence of financial exploitation of residents, affecting Resident 3, Resident 4, and other residents in the home. As of 4/29/25, the home had not informed the other other residents or their designated persons of the potential harm, until being directed to do so by the Department.

Plan of Correction ***Directed [redacted] 07/15/2025)***

Designated [redacted] involved in the incident on 4/12/25 were informed at the time of the incident's occurrence.

On May 4th, 2025 all Pinnacle residents and [redacted] were notified of the options available for securing

16e - Resident Notice (continued)

personal items and the communities reporting obligations. Residents and families were made aware of an upcoming proactive presentation from The Plymouth Meeting Police Department.

On June 2nd, 2025 the PA Office of the Attorney General and The Plymouth Police Department presented a program called "Scams and How to Avoid Them."

On June 26th, 2025, The Interim Executive Director and Regional Director of Operations met with Township Detectives to implement proactive safety and security strategies unique to The Pinnacle. This included the implementation of a program called "Coffee with a Cop" on July 9th, 2025, and the potential for Bingo with a Cop in the upcoming months.

The regular monthly Resident Council Meeting will include reminders of securing items and other proactive resident safety topics over the next six months.

The Pinnacle Management Team will utilize monitoring systems to detect possible resident rights violations or reportable incidents. These systems include the work week review of Grievance Forms, staff meetings and the new Advanced Entry auditing system that queries families and visitors about their experience and the experience of their loved one at each the end of each visit to The Pinnacle. Written communication logs will be replaced with a report from Care Partners to the Medication Technician, or Charge Nurse, for documentation in the 24 formal reports in the electronic health system. This communication will be reviewed daily by Charge Nurse, Wellness Director, Wellness Coordinator, or Designee responsible for the shift.

Trainings, grievance responses and Advanced Entry documentation will be reviewed for compliance by The Quality Assurance Team during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory expectations.

***Directed Plan of Correction**: In addition to the above plan of correction, the Administrator or Designee shall interview a random sample of at least 5 residents weekly for 4 weeks and then monthly for 2 months to review for protection of resident rights with emphasis on receiving care with dignity and respect, freedom of abuse and theft of property. Interviews shall begin within 14 calendar days from the receipt of this plan of correction. Interview findings shall be documented and kept for review by the Department upon request.*

Directed Completion Date: *07/31/2025*

Not Implemented [redacted] - 08/20/2025)

17 - Record Confidentiality

5. Requirements

2600.

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

17 - Record Confidentiality *(continued)*

Description of Violation

On 5/12/25 at 10:30 am at the Garden House nurse's station, there was a laptop left open, unlocked and accessible to residents and visitors, displaying the electronic healthcare record system and the names and other information of several residents including Resident 5, Resident 6, and Resident 7.

Plan of Correction ***Accept [redacted] - 07/15/2025)***

Polaris Pharmacy provided a Medication Technician and Nurse Training on 6/10/25 to address medication management priorities.

A HIPAA inservice will be provided to all Medication Technicians regarding laptop etiquette on or before 7/15/25.

The Pinnacle has identified the need for additional senior level staff support. The Pinnacle has hired a new Wellness Director, who is a Licensed Personal Care Home Administrator and an Interim Executive Director to work alongside the current management and Regional Team in place at the community.

The Interim Executive Director, Wellness Director, or Designee will make daily rounds during the work week to ensure compliance with computer etiquette and confidentiality for the next sixty days beginning June 10th, 2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 08/20/2025)

25a - Written Contract and Review

6. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident 9 who was admitted [redacted]/2024, did not have a resident-home contract completed until 7/17/24.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The Assistant Executive Director and Move In Coordinator will be inserviced by June 30th, 2025 regarding the documentation mandates of this regulation.

Effective July 1st, 2025 all new admission charts receive a final audit for contract signature compliance by the Assistant Executive Director, or Designee.

Pinnacle's Assistant Executive Director, or Designee, will initiate a comprehensive audit of all resident home contracts to be completed by July 15th, 2025. Audit sheets will be initiated to identify any noncompliant dates. Signatures will be obtained for outstanding documents and Plan of Correction will process will be identified as the reason for the noncompliant dating.

Audit outcomes for the preceding 60 days will be reviewed as part of the Quality Assurance meeting.

25a - Written Contract and Review (continued)

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented (- 08/20/2025)

41e - Signed Statement

7. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 7's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept - 07/07/2025)***

Effective June 1st, 2025, all new admission charts receive a final audit for contract signature compliance by the Assistant Executive Director, or Designee.

Pinnacle's Assistant Executive Director, or Designee, will initiate a comprehensive audit of all resident home contracts to be completed by July 15th, 2025. Audit sheet will be initiated to identify any noncompliant dates. Signatures will be obtained for outstanding documents and Plan of Correction will process will be identified as the reason for the noncompliant dating.

Resident Rights and The Pinnacle's Grievance Policy will be reviewed with the residents and their families via monthly email communication from the Regional Director of Operations, or Designee, prior to July 15th, 2025.

All staff will be trained on The Pinnacle's Grievance Policy on or before July 15th, 2025.

Grievance forms will be made available at the Wellness Station and The Front Desk.

Audit outcomes will be reviewed for the next 60 days as part of the Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented - 08/20/2025)

42b - Abuse

8. 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 /2025, at approximately 10:15 AM, while Staff Person A was attempting to shower Resident 1, the resident became agitated. Resident 1 grabbed Staff Person A by the neck. Staff Person A grabbed Resident 1's hands to remove them from their neck and then pushed Resident 1 away causing Resident 1 to fall against the toilet with enough force

42b - Abuse (continued)

to break the toilet tank. Staff Person A reported the resident's fall to Staff person B.

On 3/27/2025, at approximately 1:00 AM, Staff Person C and Staff Person D were seated in the memory care dining room, eating and talking. Resident 1 who had been sitting on a chair in the dining room, got up and walked to the steam table, and started touching the containers on the table. Staff Person C told Resident 1 to have a seat to have the resident stop touching the containers. Resident 1 responded by saying "Fuck you". Staff Person C then responded back by saying "Fuck me, [Resident 1's name]?", to which Resident 1 responded again saying "fuck you" then balled up their fist and lunged toward Staff Person C. A physical altercation ensued between Staff Person C and Resident 1, where Resident 1 grabbed Staff Person C by the hair. Staff Person D did not call for assistance at this time. but tried to intervene by pulling Resident 1 off of Staff Person C, further escalating the altercation. Staff Person C then grabbed Resident 1's genitals over top of their clothing, attempting to break the hold on Staff Person C's hair. Resident 1 screamed in pain, yelling, "You grabbed my [redacted]", but the resident did not release the staff person. Staff Person C grabbed the resident's genitals a second time, which caused Resident 1 to yell out in pain again, and release Staff Person C's hair. Resident 1 ran towards Staff Person D who then also ran and locked themself in an area across from the dining room, and used the walkie talkie to contact Staff Person G, finally requesting assistance. By the time Staff Person G arrived on the unit, Resident 1 was sitting down in a chair in the hall. Staff Person G escorted Resident 1 to their bedroom and assisted the resident to their bed without incident. Additionally, Police were called by staff of the home to report the incident, however, when police arrived, Resident 1 was reported to be very calm, seemingly unaware of the incident that just occurred, and communicated pleasantly with the Police. Police determined that any intervention on their part was not needed and they left the home.

Later on 3/27/2025, at approximately 11:15 AM, Staff Person A was requested to assist with Resident 1's shower after an episode of incontinence. Upon entering Resident 1's room, Staff Person A stated that Resident 1 was "already on edge". When Staff Person A approached the resident, Resident 1 grabbed Staff Person A by the shirt. Staff Person A pulled away from Resident 1 which caused Resident 1 to fall and hit their head on a wall outside of the bathroom. Staff Person A noticed Resident 1 was bleeding from the head and they left Resident 1's room to get assistance from Staff Person H, who then cleaned the resident up and 9-1-1 was called. EMT's transported the resident to the hospital.

Staff Person B initially reported after the 3/25/25 incident that Resident 1 was not injured during the fall involving the toilet tank however there was no documented evaluation in the resident record. Additionally, there is no documented evaluation of the residents physical condition after the altercation with Staff Persons C and D on the morning of 3/27/25.

Resident 1 was admitted to the hospital on [redacted]/25, with report of having sustained extensive and cumulative injuries as a result of these altercations. Hospital records and physical observation of the resident showed Resident 1 had the following injuries: head laceration on the back of the head requiring 3 staples, fluid on the brain, bruised ribs, bruises on both legs, 2 cuts on the face next to the right ear, large skin tears on both arms in the area of the elbows, a cut on the top of the right foot near the ankle, a wound on the right shin, and a skin tear on top of the big toe on the right foot.

On [redacted]/24, an unauthorized payment of $500.00 to DraftKings Holdings, an online gambling company, using Resident 2's American Express credit card was made. The charge was declined when an automated phone call went to

42b - Abuse (continued)

Resident 2's [redacted] phone seeking authentication. The next day, [redacted]/24, an individual attempted a $130.00 purchase at Footlocker, which was also declined. Shortly after these charges were attempted, Resident 2's [redacted] investigated and found that the resident's American Express card was missing from their room. The card was never recovered. Additionally, there were three unauthorized, later-reversed, charges to DraftKings Holdings made between 12/15/24 and 12/17/24 on Resident 2's account with First National Bank of Omaha. The individual charges were in the amounts of $50, $20, and $20. The resident also had $75.00 in cash which went missing from the residents room on 4/1/25. The resident's driver's license was noticed to be missing on 4/1/25 as well. Resident 2 has expressed that because of these thefts, they now feal afraid and insecure and this has compromised the resident's trust in the staff.

On 4/8/25, Resident 3, reported to a staff person that their credit card had been stolen from their wallet, which was stored inside their bag located in their bedroom closet. The resident stated that an unauthorized purchase attempt was made at the Mt. Airy Acme on 4/7/25; however, the transaction was declined.

On 4/11/25, at approximately 4:00 PM, the family member of Resident 4 informed staff that, earlier in the day, Resident 4 had disclosed that $11 in cash from their wallet and a bank envelope containing $50 in cash, stored in their bag which was kept on top of their bedroom bench, had gone missing. The resident believes the items were taken approximately three or more weeks prior to reporting to family.

Resident 10 has significant needs relating to incontinence as reported by staff since the resident's admission. However, the resident does not wear incontinence briefs and has stated that they do not wish to do so, instead opting to place absorbent pads on their bed at night. The initial assessment and support plan, dated [redacted]/24, did not address any needs related to bladder or bowel management. The resident's assessment and support plan were not updated to reflect the need for incontinence products or the need for assistance with toileting until 4/9/25, despite staff reports and documented occurrences. During the Department's interview on 4/29/25, Resident 10 stated that overnight staff do not provide incontinency checks, despite the updated support plan. Staff also reported that Resident 1 will sometimes agree to wear a brief, but frequently removes them, resulting in repeated episodes of incontinence. It was also noted that overnight staff are expected to perform incontinence care and hygiene checks at least twice overnight, however, these checks are not occurring, as evidenced by the heavily wet/soiled state of resident and bed linens in the mornings. Staff report that the use of absorbent pads are not adequate for the residents level of incontinence, however the resident is not receiving incontinence care overnight to ensure resident remains clean and dry. On 4/28/25, the resident's bed was reported to be so heavily soiled that it was replaced. Resident 10 was subjected to neglect of care related to their unmet incontinence needs.

Resident 11 is immobile and requires staff assistance of 2 for transferring out of bed and toileting, and with dressing. During a Department interview conducted on 4/29/25, the resident reported having two incontinence briefs put on at the same time throughout the day and night. Resident 11 reports that staff do this in an effort to prevent the resident from soiling their clothing or bedding. Multiple staff members report that overnight staff are not consistently checking on incontinent residents, resulting in residents being found heavily soiled or saturated in the mornings. Specifically, Resident 11 is often observed during morning care with saturated briefs, often two saturated briefs. Resident 11 reports that they are not being changed at all during the overnight hours. Resident 11 was subjected to neglect of care related to their unmet incontinence needs.

Resident 12 has a diagnosis of Parkinson's disease. According to the resident's assessment and support plan dated

42b - Abuse (continued)

[redacted]/24, the resident requires set-up assistance with meals, including cutting large pieces and opening packages. The resident also has bladder incontinence and requires help transferring on and off the toilet, as well as frequent toileting assistance. Despite these documented needs, meals are frequently not properly set up and food is not consistently placed within the resident's reach. Additionally, staff reported that the resident is frequently found in heavily saturated briefs in the morning, which staff attribute to insufficient incontinence care during the overnight shifts. Resident 12 was subjected to neglect of care related to their unmet ADL needs.

On 5/8/25, several minutes after 11:20 pm, Staff Person I and Staff Person J were conducting [redacted] first rounds of their shift in Garden House Memory Care, when they found several residents in bed in a state of neglect. The following incidents were reported to have occurred on 5/8/25:

- Resident 5 was observed to be soaked in urine through their clothing and had a bowel movement. Resident 5's support plan dated 3/29/25 indicates the resident requires regular or frequent assistance to and from the bathroom, and assistance with incontinence products.
- Resident 13 was also soiled with urine and feces; the resident had been fidgeting with their incontinence brief, causing it to shift and be ill fitting with feces and urine seeping out and soiling their clothing and bed.
- Resident 14 was observed to have dried feces in their hand which had appeared to have been been left for several hours. Resident 14's support plan, dated 6/9/24, indicates the resident needs staff assistance with toilet use, hygiene and incontinence care.
- Additionally, on 5/8/25, at the end of the 3-11 shift, Residents 14, 15, 16 and 17 who use hospital beds, were left with their beds in a raised position. The beds were at the highest position as described by Staff Persons I and J, which prevented residents from leaving bed and increasing their risk of falling. Resident 14's support plan dated 6/9/24, indicates resident requires assistance with transfers and ambulation. Resident 15's has a documented history of falls and their support plan revised on 3/26/25, indicates that the resident's bed should be in the lowest position at night while the resident is in bed and that resident requires physical assistance from staff for transfers. Resident 16's service plan dated 9/19/24, indicates resident is a fall risk, and requires assistance and reminders to transfer from bed and chair safely. Resident 17's support plan, revised on 3/9/25, indicates resident requires staff assistance with transfers and changing positions in bed and is a fall risk. It is unknown specifically when these residents received care last prior to the 11p-7a shift, however the described state of the residents left in their hospital beds in this manner and the residents who did not receive adequate incontinence care indicates that residents were left in this manner for a prolonged period of time.

On 5/9/25, at approximately 7:20 am, Staff Person K began their shift in Garden House Memory Care and found Resident 8 soaked in urine. The urine had saturated Resident 8's incontinence brief, soaked through the residents bedding and mattress, and formed a puddle on the floor beneath the bed. Staff Person K called for assistance from Staff Person L, who also reported urine soaking through the mattress and pooling on the floor.

Repeat Violation Date: 10/16/24, 9/4/24

Plan of Correction ***Directed [redacted] - 07/15/2025)***

The Pinnacle summarily [redacted]d staff persons A, C, D, H, and L. Upon the outcome of the Licensing Inspection of the above incidents, all staff members were [redacted].

Skin assessments were performed on 5/9/25 for all residents that Staff Persons I and J identified they alleged were

42b - Abuse (continued)

in a state of neglect. All skin was clean and intact with no open areas, which is inconsistent with staff reported negligence.

Resident #10, who has a history of refusing overnight care, has agreed to wear incontinence pads throughout the night. Care plan has been updated, and care refusals are being noted on care logs. The resident's mattress has been replaced.

Resident #11, who is alert and oriented to person, place and time denies ever being double briefed. The Pinnacle is in receipt of an email that resident #11 wears a Poise pad placed inside a brief, by [redacted] *preference, at night and has never been double briefed while at The Pinnacle. This email was sent to the Bureau on 4/29/25. The Pinnacle and the family requested that this allegation/citation be removed.*

Residents impacted by financial losses were reimbursed for the outstanding costs by The Pinnacle. Resident number 3's private duty aide was dismissed by the family related to the financial allegations.

In acknowledging the importance of preventing abuse and neglect, The Pinnacle completed a Mandatory All Staff Abuse and Neglect Identification Inservice on April 17th, 2025.

Behavioral de-escalation and redirection training will be provided at all staff Town Hall meetings for the next three months by the new Wellness Director, or Designee, beginning in June 2025.

An Interim Executive Director, hired specifically to support training on abuse prevention, resident individuality and sensitivity measures will host individual, shift and department specific trainings over the next ninety days to avoid future allegations of abuse/neglect.

The Pinnacle has hired a new Wellness Director with her Personal Care Administrators license to educate and address staff dynamics and the current culture of inaccurate reporting, and lacking staff accountability to prevent neglect and shift to shift blaming or reporting of hearsay.

Resident care needs identified via the Support Plan will be converted to resident specific task completion checklists. Staff members, assigned to the residents, will be required to provide their initials stating that tasks are completed during the shift to which they are assigned. Medication Technicians and Charge Nurses will be responsible for random audits throughout the shift to ensure that tasks, such as incontinence management, are completed.

The new Wellness Director will host care, incontinence management, bed positioning, skin assessment and Support Plan compliance training beginning the week of July 1st, 2025.

The new Dining Service Director will be responsible for training Dining and Care teams regarding meal delivery and service protocol standards to guarantee meal set up and optimal consumption by July 1st, 2025. This training will include ensuring that meals are within reach of the resident and offered, even if the resident is asleep.

On June 2nd, 2025, the PA Office of the Attorney General and The Plymouth Police Department presented a program called "Scams and How to Avoid Them."

On June 26th, 2025, The Interim Executive Director and Regional Director of Operations met with Township

42b - Abuse (continued)

Detectives to implement proactive safety and security strategies unique to The Pinnacle. This included the implementation of a program called "Coffee with a Cop" on July 9th, 2025, and the potential for Bingo with a Cop in the upcoming months.

The Pinnacle will host incident reporting and training on abuse and neglect on a quarterly basis for the next year and upon hire and annually thereafter.

The regular monthly Resident Council Meeting will include reminders of securing items and other proactive resident safety topics over the next six months.

The Pinnacle Management Team will utilize monitoring systems to detect possible resident rights violations or reportable incidents. These systems include the work week review of Grievance Forms, staff meetings and the new Advanced Entry auditing system that queries families and visitors about their experience and the experience of their loved one at each the end of each visit to The Pinnacle. Written communication logs will be replaced with a report from Care Partners to the Medication Technician, or Charge Nurse, for documentation in the 24 formal reports in the electronic health system. This communication will be reviewed daily by Charge Nurse, Wellness Director, Wellness Coordinator, or Designee responsible for the shift.

Trainings, grievance responses and Advanced Entry documentation will be reviewed for compliance by The Quality Assurance Team during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory expectations.

Directed Plan of Correction: *In addition to the above plan of correction, the Administrator or Designee shall interview a random sample of at least 5 residents weekly for 4 weeks and then monthly for 2 months to review for protection of resident rights with emphasis on receiving care with dignity and respect, freedom of abuse and theft of property. Interviews shall begin within 14 calendar days from the receipt of this plan of correction. Interview findings shall be documented and kept for review by the Department upon request.*

Directed Completion Date: *07/31/2025*

Not Implemented [redacted] - 08/20/2025)

65a - FS Orientation 1st Day

9. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

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

Description of Violation

Staff Person M, whose first day of work was [redacted]/24, did not receive orientation on the following topics prior to or during the first work day:

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Repeat Violation Date: 10/16/24

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The Assistant Executive Director will be retrained on Chapter 2600.65a guidelines by the Interim Executive Director on or before July 1st, 2025. This training will be documented.

The Interim Executive Director will contact the service agency to institute a pretraining program prior to agency staff accepting shifts at The Pinnacle. This training program will be instituted prior to July 30th, 2025.

The Director of Human Resources of Meridian Senior Living audited all employee files on June 17th, 2025. An auditing checklist was utilized, and results will be documented and maintained as they relate to this POC.

All employee and ancillary staff files will be audited by The Assistant Executive Director, or Designee, monthly for the next six (6) months.

New hire chart audits will be reviewed for compliance during the Quality Assurance Meeting by Meridian standards and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented [redacted] - 08/20/2025)

65f - Training Topics

10. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics *(continued)*

7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct Care Staff Person D did not receive training in medication self-administration training during training year 2024.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Staff Person D is no longer employed at The Pinnacle.

The Assistant Executive Director will be retrained on Chapter 2600.65f guidelines by the Interim Executive Director by July 1st, 2025.

The Interim Executive Director, or Designee, is scheduling All-Staff Annual Training compliance sessions in accordance with the requirements of 2600.65f to be completed by August 31st, 2025.

The Relias training system will continue to be used to augment this training and ensure regulatory compliance.

The Assistant Executive Director, or Designee, will be responsible for future implementation and maintenance of this standard.

Annual training will be reviewed for compliance during the Quality Assurance Meeting by Meridian standards and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/20/2025)

65g - Annual Training Content

11. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff Person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2024.

Plan of Correction ***Accept [redacted] 07/07/2025)***

Staff Person D is no longer employed at The Pinnacle.

The Assistant Executive Director will be retrained on Chapter 2600.65f guidelines by the Interim Executive Director by July 1st, 2025.

65g - Annual Training Content (continued)

The Interim Executive Director is scheduling All Staff Annual Training compliance sessions in accordance with the requirements of 2600.65f to be completed by August 31st, 2025.

The Relias training system will continue to be used to augment this training and ensure regulatory compliance.

The Assistant Executive Director, or Designee, will be responsible for future implementation and maintenance of this standard.

Annual training will be reviewed for compliance during the Quality Assurance Meeting by Meridian standards and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/20/2025)

66b - Training Plan Content

12. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan for the upcoming year, does not list the staff, the required trainings of each staff person, nor the dates, times, or locations of their scheduled trainings.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Interim Executive Director is creating a staff training plan to reflect the August 2025 annual training sessions which will be provided for all employees.

The Interim Executive Director is scheduling All Staff Annual Training compliance sessions in accordance with the requirements of 2600.65f to be completed by August 31st, 2025.

The Relias training system will continue to be used to augment this training and ensure regulatory compliance.

Attendance and compliance with this initiative will be reviewed at Monthly Town Hall meetings.

The Assistant Executive Director, or Designee, will be responsible for future implementation and maintenance of this standard.

Annual training will be reviewed for compliance during the Quality Assurance Meeting by Meridian standards and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/31/2025*

66b - Training Plan Content *(continued)*

Implemented [redacted] - 08/20/2025)

82c - Locking Poisonous Materials

13. 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 5/12/25 at 10:40 am, tubes of Dermarite PeriGuard Ointment Skin Protectant, with manufacturer's labels warning "Keep out of reach of children. In case of accidental ingestion contact a physician or Poison Control Center right away," were left accessible and unattended on top of Resident 17's bedside table and bathroom shelf. The residents of Garden House, including Resident 17, have not been assessed as capable of recognizing and using poisons safely.

Repeat Violation Date: 6/3/24 et al.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Item identified as Poisonous was removed from the room on 5/12/25.

Locks will be ordered and installed in every SDCU bathroom to avoid the need for one main locking cabinet in the Wellness Station and transporting items to and from the resident's room for all care interventions. Locks will be installed by July 30th, 2025.

The regulatory standard regarding securing poisonous materials will be reviewed at the Monthly Town Hall meeting on 6/26/25. The standard will also be reviewed with team members as they are trained on the installation of the new SDCU room locking system by July 30th, 2025.

On or before 6/30/25 a room check audit sheet, including the locking of all poisonous materials will be developed and utilized to conduct random audits by The Memory Care Director, or Designee to audit all rooms in the SDCU weekly for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/30/2025*

Not Implemented [redacted] - 08/20/2025)

85a - Sanitary Conditions

14. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/12/25 at 10:37 am, there were no paper towels or other method of hand-drying in the common bathroom in Garden House Memory Care unit.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Paper towels were immediately replaced when it was identified that the towels were depleted.

85a - Sanitary Conditions (continued)

Housekeeping staff will be retrained by June 30th, 2025 by the Environmental Services Director/Facility Manager regarding the standard of checking common area restrooms throughout their shift and replenish towels as needed.

Memory Care Director, Environmental Services Director/Facility Manager and weekend Managers on Duty will complete random audits behind the Housekeeping Department to ensure access to clean towels for the next 90 days.

Visual inspections of common bathrooms, and the community at large, will be added to the monthly Quality Assurance rounds checklist. These audits will be reviewed at Quality Assurance meetings for the next 90 days, per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] - 08/20/2025)

85e - Trash Outside Home

15. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/12/25 at 9:27am, the trash dumpsters behind the home were overflowing to the point that the lids would not close fully, with carboard boxes and a brown dresser laying on the ground at the sides of the dumpsters.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

At the time of this Licensing Survey, The Pinnacle's trash vendor picks up refuse six out of seven days a week. On this date the trash vendor arrived for pickup at approximately 10AM after a large event on Mother's Day Sunday.

The Pinnacle has ordered a second 8-yard dumpster, and the cardboard recycling dumpster was moved to another area on the campus. This change added an additional dumpster to our refuse area.

Trash will now be picked up four days per week, since an additional dumpster has been added. This has proven effective in managing this issue.

Housekeeping staff was inserviced on 5/20/25 regarding these changes and the regulatory need to keep receptacles covered to curtail pests.

Environmental Services/Facility Manager immediately implemented twice daily external audits of the refuse area for regulatory compliance. This audit continued for 30 days.

Licensee's Proposed Overall Completion Date: *06/19/2025*

Implemented ([redacted] - 08/20/2025)

88a - Surfaces

16. Requirements

88a - Surfaces *(continued)*

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 5/12/25 at 10:14 am, there was a roughly two-inch streak of a dried, brown substance, smeared on the surface of door to the stairwell on the third floor.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The two-inch streak was immediately cleaned by The Housekeeping Department.

Environmental Director/Facility Manager inserviced the Housekeeping Team regarding surface infection control measures on 5/20/25.

Environmental Services/Facility Manager initiated a thirty-day audit of the stairwell doors to address compliance regarding cleanliness and enforce the regulatory standard.

Visual inspections of stairwell doors, and the community at large, will be added to the monthly Quality Assurance rounds checklist. These audits will be reviewed at Quality Assurance meetings for the next 90 days, per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented [redacted] - 08/20/2025)

91 - Telephone Numbers

17. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 5/12/25, there were no emergency telephone numbers on or by the telephone in room 403.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The phone number magnet was replaced immediately upon identification.

Auditing of the phone number placement for all residents in personal care has been added to the weekly cleaning schedule for Housekeeping Staff.

Managers have initiated monthly quality assurance rounds to audit physical plant, housekeeping and regulatory standards. Phone numbers will be verified as part of the monthly manager auditing process via an audit sheet that will be implemented on or before July 1st, 2025 for the next 90 days.

Results will be reviewed as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/01/2025*

91 - Telephone Numbers *(continued)*

Implemented [redacted] - 08/20/2025)

101j1 - Mattress Fire Retardant

18. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 5/12/25 at 10:39 am, the bed for Resident 18 had no linens, and the mattress had a large, round yellow/brown stain on top measuring approximately two feet wide.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The mattress remained uncovered to allow the liquid to dry completely.

On or before July 1st, 2025, The Pinnacle will confirm that all cloth mattresses are encased in plastic moisture retardant sleeves to prevent soiling.

For The Pinnacle to uphold standard infection control practices, all residents requiring continence care will have their mattresses encased in the moisture retardant sleeve to prevent soiling, including new admissions.

Managers have initiated monthly quality assurance rounds to audit physical plant, housekeeping and regulatory standards. Mattress checks for plastic moisture retardant sleeves to prevent soiling will be added to an audit sheet that will be implemented on or before July 1st, 2025, for the next 90 days.

Results will be reviewed as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] - 08/20/2025)

101j5 - Bedside Table/Shelf

19. Requirements

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

Description of Violation

On 5/12/25 at 10:39 am, there was no bedside table or shelf beside Resident 17's bed.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The rolling bedside table was moved for morning care. The table was immediately rolled back into place when this issue was identified.

Managers have initiated monthly quality assurance rounds to audit physical plant, housekeeping and regulatory

101j5 - Bedside Table/Shelf (continued)

standards. The need for a bedside table will be verified as part of the monthly manager auditing process via an audit sheet that will be implemented on or before July 1st, 2025 for the next 90 days.

The need for a bedside table will also be added to the weekly Housekeeping Department audit form. Identified issues will be immediately addressed.

Results will be reviewed as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] - 08/20/2025)

101j7 - Lighting/Operable Lamp

20. 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

On 5/12/25 at 10:39 am, Resident 17 did not have access to a source of light that could be turned on/off at bedside.

Repeat Violation Date: 6/3/24 et al.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The light source for this room was on a rolling bedside table that was moved for morning care. The table and light source were immediately returned to their original location when this issue was identified.

On or before July 1st, 2025, wall mounted light switches will be purchased for rooms that have movable bedside tables to prevent this issue from occurring again.

Managers have initiated monthly quality assurance rounds to audit physical plant, housekeeping and regulatory standards. The need for a light by bedside will be verified as part of the monthly manager auditing process via an audit sheet that will be implemented on or before July 1st, 2025 and audits will remain in place for 90 days.

The need for a lamp by bedside will also be added to the weekly Housekeeping audit form. Identified issues will be immediately addressed.

Results will be reviewed as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] - 08/20/2025)

102h - Toilet Paper

21. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 5/12/25 at 10:37 am, there was no toilet paper for the toilet in the common bathroom in Garden House Memory Care Unit.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Toilet paper was immediately replaced when it was identified as depleted.

Housekeeping staff will be retrained by June 30th, 2025 regarding the standard of checking common area restrooms throughout their shift and replenish toilet paper as needed.

Memory Care Director, Environmental Services Director/Facility Manager and weekend Managers on Duty will complete random audits behind the Housekeeping Department to ensure access to toilet paper for the next 90 days.

Visual inspections of common bathrooms for toilet paper, and the community at large will be added to the monthly Quality Assurance rounds checklist. These audits will be reviewed at Quality Assurance meetings for the next 90 days, per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented [redacted] - 08/20/2025)

105g - Lint Removal and Duct Cleaning

22. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 5/12/25 at 10:02 am, there was a thick accumulation of lint across the entire lint trap in each of the of two dryers in the third-floor laundry room. The dryers were empty and not in use at the time.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Filter was immediately cleaned once identified.

Staff complete laundry on the 11-7 shift. The Pinnacle was already maintaining a lint removal log, which is being completed and initialed by Care Partners upon use of the dryer.

Housekeeping will now audit the log from 11-7 and verify the cleanliness of the lint filter daily.

Care and Housekeeping staff will be re-inserviced by the Environmental Director/Facility Manager on or before July 1st, 2025 regarding using the logs and the additional check that will now be required to ensure that lint filters are clean for fire prevention.

Results will be reviewed as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations for the next 90 days.

105g - Lint Removal and Duct Cleaning (continued)

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] - 08/20/2025)

109b - Rabies Vaccination

23. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 4/28/25, two cats belonging to Resident 10, were present at the home. However, the home did not have current rabies vaccination certificates on file for either animal.

Plan of Correction ***Accept [redacted]/07/2025)***

Updated vaccination records were obtained the same day, prior to the surveyors Exit Conference.

Vaccination Record binder for all animals residing or visiting the community is at the Reception Desk. Vaccination records are obtained by the Move in Coordinator at time of move in. The Activities Department is responsible for obtaining records for visiting animals.

The Activities Director, or Designee, will be responsible for auditing this binder monthly as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] - 08/20/2025)

121a - Unobstructed Egress

24. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 5/12/25 at 9:24am, a maintenance staff person was unable to open the locked exit gate in the Garden House Memory Care courtyard. The staff person had a key fob that did not work, resulting in a blocked egress from the home and there was no other method to disengage the magnetic lock at the gate.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The SDCU gate is tied to the fire system. The gate currently releases when the fire panel is triggered.

Regional Support Team contacted Innovative Services at the time of the Licensing Inspection to schedule a site visit to review the system.

During unannounced monthly fire drills it will be documented and verified that the SDCU gate releases per regulatory expectations.

121a - Unobstructed Egress (continued)

The gate currently requires specialized key fobs to release when not triggered by the fire system.

The Regional Support Team will work with Innovative Services to transition to a keypad system that will allow posting of the release code per regulatory guidelines.

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

Implemented ([redacted] - 08/20/2025)

125a - Combustible Storage

25. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 5/12/25 at 9:37 am, an aerosol spray can of Electro-Wash PX, a cleaning product labeled "extremely flammable," was left on top of the electrical box directly below the switch for elevator #3, with a warning on the switch box indicating "Danger: hazard of electric shock, explosion, or arc flash" in the elevator control room.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The aerosol can was immediately removed when discovered.

Maintenance and Housekeeping staff will be inserviced by the Environmental Services/Facilities Manager by July 1st, 2025 on the storage of combustible materials in the flammables cabinet housed in the Maintenance Office per regulatory guidelines.

All staff will be inserviced by The Environmental Services Director/Facilities Manager on or before July 30th, 2025 to this regulation for expedient identification and the need to properly store hazardous materials.

This standard will continue to be reviewed as part of the Quality Assurance process per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented ([redacted] - 08/20/2025)

162c - Menus Posted

26. Requirements

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

Description of Violation

On 5/12/25, the home's menus that were posted, were dated for March and April, ending on 4/5/25. The current week and the following week's menus were not posted in a conspicuous location.

162c - Menus Posted *(continued)*

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Proper menus were immediately posted when this lapse was discovered.

A new Dining Services Director has been hired and trained in this standard of practice as a part of [redacted] initial onboarding. The Dining Director is responsible for auditing the community weekly to assure that daily menus and advance weekly menus are posted in the dining areas of Personal Care for the next 90 days.

The Dining Services Director will be responsible for educating all dining staff on or before July 15th, 2025 to this regulatory expectation.

The Interim Executive Director will be responsible for touring the community prior to Quality Assurance meetings to reinforce this standard.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented [redacted] - 08/20/2025)

181c - Self-administration Assessment

27. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 19 self-administers medications, such as Carbidopa/levodopa. However, Resident 19 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications. This section was left blank on the resident's Documentation of Medical Evaluation, dated [redacted]25 and there is no other assessment for ability to self-administer medications in the residents file.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Resident #19 was assessed by Pinnacle staff regarding their ability to self-administer medication. Resident physicians were contacted and documented medical evaluation was updated to reflect physicians' determination of self-medication ability. Community will implement physician's findings.

All residents currently self-medicate will be audited to ensure all components of self-administration are fulfilled per Meridian Senior Living's Self Administration policy and regulatory guidelines. This audit will be completed by July 15th, 2025.

Wellness Director, or Designee, will review all self-medicating residents' documentation monthly for the next six months and transition to biannual reviews per Meridian policy.

Self-medicating residents will be reviewed during Quality Assurance meetings to reinforce regulatory standards.

Licensee's Proposed Overall Completion Date: *07/15/2025*

181c - Self-administration Assessment *(continued)*

Not Implemented [redacted] - 08/20/2025)

181f - Record of Medication

28. 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

Resident 19 self-administers their medications. On 5/14/2025, Resident 19's record did not include a current list of medications. The resident is prescribed Ropinirole and Caltrate, which are not listed on the resident's medication record. The medication record that the home has on file has not been updated to reflect the current prescribed dose for Carbidopa/Levodopa 25-100mg tablets.

Repeat Violation Date: 10/16/24, 6/3/24 et al.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The Wellness Director will meet with all residents by July 15th, 2025, to reassess their ability to self-medicate per state and Meridian Senior Living guidelines. Residents deemed appropriate to self-medicate will have their in-room medication list reviewed with the resident record. The comprehensive list will be sent to the resident's physician for review and signature to assure that the in-room medication matches the list on file.

All self-medicating residents and families will be reminded of the need to update the medication list with all changes and OTC purchases imposed by external physician visits via the monthly communication from the Regional Director of Operations, or Designee.

The Wellness Director, or Designee, will be responsible for this same comprehensive review (room medications to list) monthly for the next six months. Documentation of these audits will be reviewed at the Quality Assurance meetings to reinforce the regulatory standard.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Not Implemented [redacted] - 08/20/2025)

183b - Meds and Syringes Locked

29. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/12/25 at approximately 2:20pm, three white pills belonging to Resident 20 were left in a cup on top of a second-floor med cart. The medication cart was unattended at the time.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Three white pills on the medication cart were immediately secured and discarded when found unattended.

Medication Technicians and Nurses providing medication assistance will be retrained by the Wellness Director, or

183b - Meds and Syringes Locked (continued)

Designee, in safety protocols related to medication distribution on or before July 15th, 2025.

During the monthly Town Hall meeting on June 26th, 2025 all staff will be trained on protocols related to potential errant medications found in the community.
Wellness Director, or Designee, will institute biweekly medication practicum observer audits to ensure medications are being administered according to regulatory standards.

Documentation of these audits will be reviewed at the Quality Assurance meetings to reinforce the regulatory standard for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Not Implemented [redacted] - 08/20/2025)

183d - Prescription Current

30. 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

On 5/12/25 at 1:58 pm, two blister packs containing 5-MG Oxycodone tablets, prescribed to Resident 21, were in the home's medication cart. This medication was discontinued on 11/17/24. Repeat Violation Date: 8/1/24

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

All Nurses and Medication Technicians assigned to the medication cart will be expected to audit their cart daily for three months beginning 7/15/25.

Wellness Director, or Designee, will randomly audit each medication cart weekly for three months beginning 7/15/25.

Results of these audits will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Not Implemented [redacted] 08/20/2025)

183e - Storing Medications

31. 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 5/12/25, an opened insulin pen on the first-floor memory cart for Resident 6 was not labeled with the date it was opened. According to the manufacturer's instructions, the unused medication in the pen should be discarded 28 days after opening.

183e - Storing Medications (continued)

On 5/12/25, on the same cart, an insulin pen for Resident 15 was observed, which had expired on 3/28/25.

Plan of Correction ***Accept [redacted] - 07/15/2025)***

The Pinnacle will audit the medication cart and storage of insulin pens, on or before July 1st, 2025, for medication storage compliance.

The Pinnacle will purchase storage containers for each individual insulin pen to be labeled with the resident's name, room number and date opened by July 15, 2025. This will be in addition to the labeling of the insulin pens.

In unique circumstances where the new holders may not be available, each Medication Cart will be stocked with Ziploc baggies to be used to store the individual pen. Each baggie will be labeled with resident's name, room number and date opened.

This labeling and dating of the actual insulin pens, and storage containers, will be a part of the Medication Cart audit process. All Nurses and Medication Technicians assigned to the medication cart will be expected to audit their med cart daily for three months beginning 7/15/25.

Wellness Director, or Designee, will randomly audit each medication cart weekly for three months beginning 7/15/25.

Results of these audits will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/18/2025*

Not Implemented [redacted] - 08/20/2025)

185a - Implement Storage Procedures

32. Requirements

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

Description of Violation

The blood glucose log for Resident 22 has the following transcription errors:
4/14/25 at 6:38am glucometer reading of 127 was recorded on the glucose log as 125 at 9:04am.
4/16/25 at 8:33pm- glucometer reading of 224 was recorded on the glucose log as 227 at 9:23pm.
5/6/25 at 7:26am- glucometer reading of 116 was recorded on the glucose log as 119 at 6:39am.
5/9/25 at 9:18am- glucometer reading of 225 was recorded on the glucose log as 223.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The 11-7 Med Tech, or Designee, will pull the eMAR glucometer report daily to compare the recorded results physically against the glucometer machine readings.

The Wellness Director, or Designee, will review this report weekly and randomly audit against the physical glucometer readings to ensure compliance.

185a - Implement Storage Procedures (continued)

The Wellness Director, or Designee, will educate the Medications Technicians on or before July 15th, regarding the importance of diabetic management.

Results of this random audit will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented [redacted] - 08/20/2025)

187d - Follow Prescriber's Orders

33. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 1 was prescribed Seroquel 50 mg at bedtime. However, Resident 1 was not administered Seroquel 50 mg from 2/7/2025 through 2/21/2025 at 9:00 PM.

Resident 6 is prescribed to have a True Metrix glucose check four times a day, at 8:00 am, 12:00 pm, 5:00 pm, and 9:00 pm and Lispro Kwikpen insulin injections three times daily, according to sliding scale: 200-250 = 2u, 251-300=4u, 301-350=6u,351-400=8u, 401-500=10u. Scheduled to be administered at 8:00 am, 12:00 pm, and 5:00 pm. However, Resident 6's glucose log did not have recorded readings in the glucometer for 5/1/25 at 8:00 am and 12:00 pm, 5/2/25 at 9:00 pm, 5/3/25 at 12:00 pm, or on 5/4/25 at 12:00 pm and the Lispro Insulin was not administered on 5/1/25 at 8:00 am and 12:00 pm, 5/3/25 at 12:00 pm, and on 5/4/25 at 12:00 pm. The home was unable to determine why the glucose checks or medication were not administered as ordered. Repeat Violation Date: 8/1/24

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The 11-7 Med Tech, or Designee, will pull the Medication Omission report daily and The 24 Hour Report to ensure there are no outstanding omissions of medication administration documentation. Discrepancies will be highlighted and the Wellness Director, or Designee, will research, report and address issues daily.

The Wellness Director, or Designee, will educate the Medications Technicians on or before July 15th,2025, regarding the importance of reviewing the Medication Omission Report and The 24 Hour Report.

Results of these audits will be reviewed for intervention and outcome analysis at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented [redacted] - 08/20/2025)

202 - Prohibitions

34. Requirements

2600.

202 - Prohibitions *(continued)*

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

Resident 1 is a memory care resident admitted on [redacted]/25, with diagnoses of early-onset Alzheimer's disease and aphasia. According to the resident's assessment and support plan dated [redacted]/25, they have a history of behavioral expressions and inappropriate behaviors related to their condition. Staff are directed to explain all care and services prior to initiation and allow the resident adequate time to adjust to changes. Additionally, due to identified mood disturbances, staff are expected to encourage the resident to express their feelings and verbalize concerns during episodes of mood changes or irritability. Staff are to provide sufficient time for the resident to communicate and respond in a non-judgmental, actively engaged manner.

On [redacted]/25, at approximately 1:00 AM, Staff persons C and D were seated in the memory care dining room when Resident 1 approached and stood between them. Staff Person C asked the resident to take a seat, to which the resident responded with "Fuck you". Staff person C then responded back "Fuck me [Resident 1's name]?". Resident 1 responded with both verbal and physical aggression towards Staff Person C and D. A physical altercation ensued and Resident 1 grabbed Staff Person C's hair. In an attempt to get away from Resident 1, Staff Person C grabbed the resident's genitals with the intention of causing pain to stop Resident 1's physical aggressive behaviors. Resident 1 screamed in pain causing further escalation. Staff Person C grabbed Resident 1's genitals a second time, at which point the resident let go.

Positive behavioral interventions were not utilized to redirect or de-escalate the resident's behavior, as outlined in the resident's support plan.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

All staff of The Pinnacle will be trained in the prohibited procedures outlined on 2600.202 on or before 7/15/25.

The Wellness Director, a Personal Care Administrator and Certified Dementia Practitioner, will also train staff in behavioral de-escalation techniques and interventions to redirect and prevent catastrophic resident reactions, on or before July 30th, 2025.

Reports of resident behaviors will be reviewed by the SDCU Director and Wellness Director for Support Plan update and early intervention techniques and universal implementation. Risk Meeting will ensure that interventions are tracked and utilized for the next 90 days.

202 - Prohibitions (continued)

Licensee's Proposed Overall Completion Date: *07/30/2025*

Not Implemented [redacted] 08/20/2025)

225a - Assessment 15 Days

35. 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 12 was admitted on [redacted]/23; however, the resident's assessment was not completed until 10/27/23.

Resident 19 was admitted on [redacted]5; however, the resident's assessment was not completed until 5/12/25.

Repeat Violation Date: 9/4/24, 6/3/24 et al.

Plan of Correction ***Accept [redacted] 07/15/2025)***

The Wellness Coordinator, or Designee, will complete a comprehensive audit of all residents' assessments by August 11th, 2025. The residents' physical, cognitive and holistic needs will be considered, and plans will be updated accordingly in conjunction with primary care physicians. Non-compliant assessments will be addressed via resident and family Care Conferences, as needed to discuss changes.

Each document requiring revision will be identified with a caveat statement concerning the Plan of Correction as the reason for the noncompliant dating or information to prevent further citations.

New residents admitted since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Coordinator, or Designee, for date and completion compliance beginning July 15th, 2025.

Results of the audit will be reviewed at the Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/20/2025)

225c - Additional Assessment

36. 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.

225c - Additional Assessment *(continued)*

Description of Violation

Resident 1 has exhibited several episodes of problematic behavior, including verbal and physical aggression toward staff, on the following dates:

- *3/6/25: While staff were assisting Resident 1 with personal care, the resident became agitated due to a bowel movement. During the shower process, the resident used profane language, was uncooperative, and swung at the care partner. Staff reported significant difficulty redirecting the resident.*
- *3/16/25: While assisting the resident with undressing for a shower, Resident 1 punched a nurse on the left side of their chest. The nurse stepped back and walked away to prevent further escalation.*
- *3/25/25- Resident 1 grabbed at Staff Person A's neck in an attempt to choke them while preparing Resident 1 for a shower. Staff Person A pushed Resident 1 which resulted in Resident 1 falling with enough force that the resident's toilet tank broke.*
- *3/27/25 at approximately 1:00 AM: Resident 1 physically attacked two care partners during the night shift after being asked to sit down. The resident responded by grabbing, punching, and pulling one staff member's hair. Later that same morning, Staff attempted to assist the resident back to their room, the resident became aggressive again and attempted to strike a care partner. During this altercation, the resident fell and sustained a laceration to the left side of their head. Emergency services were called, and the resident was transported and admitted to the hospital with several injuries. Resident 1 did not return to the home after hospital discharge.*

Prior to Resident 1's discharge, their support plan did not adequately reflect the level or degree of need related to residents cognitive and behavioral needs. no additional behavioral assessment or updates to the support plan were documented beyond the most recent annual assessment dated 3/9/25, despite the documented occurrences of increased behavioral needs.

Resident 3's current assessment was completed on [redacted]/23, there is no additional assessment in the residents record.

Resident 10 has significant needs relating to incontinence as reported by staff since resident's admission. However, Resident 10's initial assessment, dated [redacted]/24, did not address any needs related to bladder or bowel management.

Resident 12's current assessment was completed on [redacted]/24. However, the resident's previous assessment was completed on 1[redacted]23.

Resident 16's most recent assessment was completed on [redacted]25. The assessment was not updated for a change in condition when Resident 16 transitioned to hospice care on [redacted]/25.

Resident 17's current assessment was completed on [redacted]/25. However, the resident's previous assessment was completed on [redacted]/23.

Resident 22's current assessment was completed on [redacted]/25. However, the resident's previous assessment was completed on [redacted]/23.

Resident 23's current assessment was completed on [redacted]/25. However, the resident's previous assessment was completed on [redacted]/23.

Resident 24's assessment and support plan, signed [redacted]/25, does not address the resident's mental health or other behavioral needs, nor the resident's ability to obtain seasonal clothing.

225c - Additional Assessment (continued)

Repeat Violation Date: 9/4/24

Plan of Correction ***Accept [redacted] - 07/15/2025)***

The Wellness Coordinator, or Designee, will complete a comprehensive audit of all residents' assessments by August 11th, 2025. The residents' physical, cognitive and holistic needs will be considered, and plans will be updated accordingly in conjunction with primary care physicians. Non-compliant assessments will be addressed via resident and family Care Conferences, as needed to discuss changes.

Each document requiring a revision will be identified with a caveat statement concerning the Plan of Correction as the reason for the noncompliant dating or information to prevent further citations.

New residents admitted since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Coordinator for date and completion compliance by July 15th, 2025.

Results of this audit will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/20/2025)

226a - Mobility Assessment

37. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident 25 uses a bedside mobility device. However, Resident 25's assessment dated [redacted]/25, does not address the resident's need for a bedside mobility device nor how the need will be met.

Plan of Correction ***Accept ([redacted] 07/15/2025)***

The Wellness Coordinator, or Designee, will complete a comprehensive audit of all residents' assessments to ensure mobility is addressed by August 11th, 2025. The residents' physical, cognitive and holistic needs will be considered, and plans will be updated accordingly in conjunction with primary care physicians. Non-compliant assessments will be addressed via resident and family Care Conferences, as needed to discuss changes.

Each document requiring revision will be identified with a caveat statement concerning the Plan of Correction as the reason for the noncompliant dating or information to prevent further citations.

New residents admitted since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Coordinator for date and completion compliance by July 15th, 2025.

Results of this audit will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/31/2025*

226a - Mobility Assessment *(continued)*

Implemented [redacted] 08/20/2025)

227g -Support Plan Signatures

38. 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 9's assessment, dated [redacted]/24, was not signed by the resident. There is no indication that Resident 9 refused or was unable to sign the document.

Resident 23's assessment, dated 3/9/25, was not signed by the resident. There is no indication that Resident 23 refused or was unable to sign the document.

Plan of Correction ***Accept [redacted] - 07/15/2025)***

The Wellness Coordinator, or Designee, will complete a comprehensive audit of all residents' assessments by August 11th, 2025. The residents' physical, cognitive and holistic needs will be considered, and plans will be updated accordingly in conjunction with primary care physicians. Non-compliant assessments will be addressed via resident and family Care Conferences, as needed to discuss changes.

Each document requiring a revision will be identified with a caveat statement concerning the Plan of Correction as the reason for the noncompliant dating or information to prevent further citations.

New residents admitted since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Coordinator for date and completion compliance by July 15th, 2025.

Results of this audit will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/20/2025)

234a - Admission Support Plan

39. 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 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/25. However, the resident's initial support plan was completed on [redacted]/25.

Repeat Violation Date: 6/3/24 et al.

Plan of Correction ***Accept [redacted] 07/15/2025)***

The Wellness Coordinator, or Designee, will complete a comprehensive audit of all SDCU residents' assessments by

234a - Admission Support Plan (continued)

August 11th, 2025. The residents' physical, cognitive and holistic needs will be considered, and plans will be updated accordingly in conjunction with primary care physicians. Non-compliant assessments will be addressed via resident and family Care Conferences, as needed to discuss changes.

Each document requiring a revision will be identified with a caveat statement concerning the Plan of Correction as the reason for the noncompliant dating or information to prevent further citations.

New residents admitted since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Coordinator for date and completion compliance by July 15th, 2025.

Results of this audit will be reviewed at Quality Assurance Meeting per Meridian Senior Living policy and regulatory expectations for the next 90 days.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] 08/20/2025)

236 - Staff Training

40. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct Care Staff Person D, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

The staff training plan for 2025 will be updated by July 1, 2025 to meet and exceed the annual regulatory required training as defined under 2600.236 and 2600.65 and 2600.66.

The Interim Executive Director is scheduling All Staff Annual Training compliance sessions in accordance with the requirements of 2600.65f to be completed by August 31st, 2025.

The Wellness Director, a Personal Care Administrator and Certified Dementia Practitioner, will also train all staff in behavioral de-escalation techniques and interventions to redirect and prevent catastrophic resident reactions, on or before July 30th, 2025.

In addition, the Wellness Director will be conducting monthly inservices on Dementia and Dementia practices. This training will begin on or before 7/1/25 and continue through 9/1/25 until all staff have received the identified training modules.

Training hours focusing specifically on dementia will total 10 hours for the 2025 calendar year exceeding the 6-hour annual expectation.

Relias will continue to be used to augment the expectations of the annual training program.

236 - Staff Training (continued)

Training documents will be reviewed as part of the Quality Assurance process and regulatory expectations until the end of this calendar year.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] 08/20/2025)

251e - Records Availability

41. Requirements

2600.
251.e. Resident records shall be made available to the resident and the resident's designated person during normal working hours.

Description of Violation

On [redacted]/2025 at 11:00 AM, Resident 1's [redacted] requested information from the resident's record. However, Staff Person N refused to provide records.

Plan of Correction ***Accept [redacted] - 07/07/2025)***

Staff with access to the medical record will be inserviced on Meridian Senior Livings policy regarding accessibility to the resident record on or before July 15th, 2025 by The Interim Executive Director, or Designee.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented ([redacted] - 08/20/2025)

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:** *06/23/2025*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *MSA PLYMOUTH MEETING OPERATING, LLC*

Addre [redacted]

Phone

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *119* **Waking Staff:** *89*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *06/25/2025*

Inspection Dates and Department Representative

06/24/2025 - On-Site: [redacted]

06/25/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served:** *84*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care* **Capacity:** *19* **Residents Served:** *15*

Hospice

Current Residents: *7*

Number of Residents Who:

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

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

Have Mobility Need: *35* **Have Physical Disability:** *0*

Inspections / Reviews

06/24/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/15/2025*

09/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2025*

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

On [redacted]25, resident #1 reported to the concierge that the resident was missing two envelopes containing $100.00 and $150.00 in cash. However, this allegation of possible financial abuse was was not reported to the local area agency on aging.

On [redacted]/25, resident #2's [redacted] notified staff person A via email of possible neglect by staff to resident #2. Staff persons B and C are seen on recorded video in resident #2's room. The staff person's are not assisting the resident in any way on the video but watch the resident move their wheelchair around the room while leaning very heavily to the left. When interviewed, resident #2 stated they refused requests for assistance in getting ready for bed. However, this allegation of abuse was not reported to the local area agency on aging.

On [redacted]/25, at 1:00 PM, staff person D was made aware of a report by resident #3 stating the resident felt mistreated and mocked by overnight staff. However, this allegation of verbal abuse was was not reported to the local area agency on aging.

On [redacted]25, at approximately 7:00 PM, resident #4 reported to staff person E, who was working the concierge desk, that a credit card was missing. However, this allegation of possible financial abuse was was not reported to the local area agency on aging.

Repeat Violation: 09/04/24

Plan of Correction ***Accept [redacted] 08/14/2025)***

The Pinnacle completed mandatory training regarding allegations of abuse and reporting protocols per Chapter 2600 and Older Protective Services regulatory guidelines with all staff Training on April 17th, 2025, and again in July of 2025. This same training will be enacted again as part of the annual inservice training requirement for all staff in August of 2025.

Training on preventing and reporting abuse will also be conducted in September and November of 2025. Beginning in calendar year 2026, abuse identification and reporting will be conducted upon hire and annually.

A formal grievance process has been enacted as a means of tracking concerns and complaints and is now a mechanism for tracking concerns as presented to Reception. All staff were trained in the Grievance process in July 2025. Grievance forms are available at The Wellness Station and Front Desk.

Compliance training will be reviewed for compliance during Quality Assurance meetings per Meridian Senior Living guidelines and regulatory expectations.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Not Implemented 09/05/2025-[redacted]

17 - Record Confidentiality

2. Requirements

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

Description of Violation

On 06/24/25, documentation with resident information was on top of an unattended medication cart. Additionally, a sticky note with a user ID and password was present on the cart. This information can be used to access the home's computer system and resident records.

Plan of Correction ***Accept [redacted] 08/14/2025)***

Identified items were immediately secured.

Wellness Director hosted an inservice on confidentiality and HIPAA requirements for Medication Technicians on June 30th, 2025.

The Executive Director initiated documented daily rounds, during the work week, to ensure compliance with computer etiquette and confidentiality beginning June 10th, 2025, and continuing for 60 days to reinforce the expectation of this regulatory requirement.

All Managers will be re-educated on the confidentiality of the medication cart by August 30th, 2025 to assure that all Department Heads are reinforcing and supporting this regulatory expectation as they traverse The Pinnacle.

Licensee's Proposed Overall Completion Date: *09/05/2025* Not Implemented 09/05/2025-[redacted]

42b - Abuse

3. 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

Resident #2 has a video camera in their room owned and operated by the resident's [redacted] On [redacted]/25, resident #2's [redacted] submitted a complaint to the home via email regarding a video showing the resident, leaning very heavily to the left side, in their wheelchair with two staff watching the resident. When interviewed, the resident stated the staff persons refused to assist the resident in getting ready for bed. The home's staff failed to provided care to the resident.

Repeat Violation: 10/16/24, et. al., 09/04/24.

Plan of Correction ***Accept [redacted] 08/14/2025)***

The Pinnacle completed mandatory training regarding allegations of abuse and reporting protocols per Chapter 2600 and Older Protective Services regulatory guidelines with all staff Training on April 17th, 2025, and again in July of 2025. This same training will be enacted again as part of the annual inservice training requirement for all staff in August of 2025.

Training on preventing and reporting abuse or neglect will also be conducted in September and November of 2025. Beginning in calendar year 2026, abuse identification and reporting will be conducted upon hire and annually.

42b - Abuse (continued)

The Wellness Director, or Designee, will complete an all team member training by August 30th, on the importance of the RASP/Support Plan.

The Executive Director, or Designee, interviewed a random sample of five residents for four weeks beginning 7/15/25 and will continue individual interviews of five residents monthly for the remainder of the month of August and September 2025 to explore the protection of resident rights and receiving care with dignity and respect, freedom of abuse and theft of property. Reports of these visits will be initiated by regulatory expectations to The Department, as required.

Reportables will be reviewed at Quality Assurance Meetings for trend identification and performance improvement for the next 90 days.

Not Implemented 09/05/2025-[redacted]

Licensee's Proposed Overall Completion Date: *09/05/2025*

42x - Safeguard

4. Requirements

2600.
42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

The home provides a secure drawer in each apartment for each resident to keep their personal possessions safe. However, the key to this drawer is the same for all the drawers in all the apartments. Additionally, the home does not track keys; who has one, who received a duplicate if a key had been lost, how many keys have been issued? Without proper safeguards and key control, the home has failed to provide a system for safeguarding the resident's money, personal possessions and belongings.

Plan of Correction ***Accept [redacted] 08/14/2025)***

The Pinnacle has identified a "CAM LOCK" that can be retrofitted into the existing locking system and uniquely keyed for each resident. The Community has ordered ten of these locks to be sure that they will work with the proper fit in the current space.

The new locks will be placed and, if appropriate, ordered and installed for the entire community by September 15th, 2025.

All residents and families will be notified of this initiative in the August monthly communication by The Regional Director of Operations, by August 30th, 2025.

Licensee's Proposed Overall Completion Date: *09/15/2025*

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's call bell policy states that "Staff shall respond to the call system as quickly as practical." The policy further

60a - Staff/Support Plan (continued)

states "If staff cannot respond timely, staff shall alert another staff member to respond and, as soon as practical, ensure that the resident has assistance." Based on a conversation with staff person D, the Regional Director of Operations, the "building standard" is 20 minutes.

The call bell records for resident #2 shows there are 17 instances between 06/01/25 and 06/24/25 where the resident had to wait longer than 20 minutes for a staff response. Per resident #2's support plan dated [redacted]/25, resident needs assistance with toileting, grooming, and personal hygiene. Specific examples are as follows:
06/04/25 from 10:26 AM to 4:07 PM (5 hours, 41 minutes)
06/20/25 from 10:17 AM to 10:58 AM (41 minutes)
06/23/25 from 8:58 PM to 11:00 PM (2 hours, 2 minutes)

The call bell records for resident #5 shows there are 2 instances between 06/09/25 and 06/11/25 where the resident had to wait longer than 20 minutes for a staff response. Per resident #5's support plan dated[redacted]/25, resident needs assistance with using the toilet, grooming and personal hygiene. Specific examples are as follows:
06/09/25 from 11:56 PM to 12:31 AM on 06/10/25 (34 minutes)
06/11/25 from 9:31 AM to 10:02 PM (31 minutes)

Plan of Correction ***Accept [redacted] - 08/14/2025)***

The Pinnacle completed an All Staff Training on the Call Bell Policy by June 30th, 2025. This same training will be completed for all staff again by September 30th, 2025 to embrace the importance of timely responsiveness in meeting resident's needs.

The new management team at The Community has learned via the referenced trainings and investigation of delays that several resident call pendants or staff response pagers required replacement secondary to equipment failure. New equipment has been purchased.

The Wellness Director has developed a response hierarchy that will be part of the retraining to be enacted by September 30th, 2025. This training will also include the need for timely reporting of equipment malfunctions or failure for replacement.

Call bell response times will be reviewed and posted daily in the staff lounge for all staff to focus on consistent response improvement.

Call bell responses will also be reviewed at monthly Quality Assurance meetings for metric analysis and trending per Meridian Senior Living guidelines.

Licensee's Proposed Overall Completion Date: *09/30/2025*

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The most recent DME for resident #1 is incomplete. The following areas are blank; "Date Resident Evaluated", "Date Form Completed", "Medical Professional Name:", "Medical Professional License #:", "Medical Professional Signature:"

141b1 - Annual Medical Evaluation (continued)

and "Date Signed:". The form does have an attached medication list dated 01/20/25.

Resident #4's most recent medical evaluation was completed on [redacted]/25. The resident's previous medical evaluation was completed on [redacted]/24.

Plan of Correction ***Accept [redacted]- 08/14/2025)***

The Wellness Director, or Designee will complete a comprehensive audit of all residents' medical evaluations by August 11th, 2025.

Each document requiring a revision will be identified and marked with a caveat statement or notation concerning the Plan of Correction as the reason for the noncompliant dating or missing information to prevent further citations. In situations where a medical evaluation is determined to need significant revisions secondary to a resident's significant change in condition, a new medical evaluation will be sought from the resident's physician and a new Support Plan will be initiated.

New residents admitted will be compliant with this regulatory requirement and will be audited for compliance at time of admission by the Wellness Director, or Designee.

Results of these audits will be reviewed at the monthly Quality Assurance Meeting per Meridian Senior Living policy and regulatory guidelines for the next 90 days.

Licensee's Proposed Overall Completion Date: *09/05/2025* *Not Implemented 09/05/2025- [redacted]*

187a - Medication Record

8. Requirements

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

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

Description of Violation

Resident #2 is prescribed Aspirin Chw 81 MG - take one tablet by mouth once daily, Carb/Levo Tab 25/100 MG - Take 1/2 tablet (12.5/50 MG) by mouth four times daily at 9AM-12PM-3PM-6PM and Certavite Tab Senior - take one

187a - Medication Record (continued)

tablet by mouth once daily. However, resident's June 2025 medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Accept [redacted] - 08/18/2025)***

The Wellness Director, or Designee, has reviewed the Missing Diagnosis report.

Medications without a supported diagnosis have been sent to the Nurse Practitioner or residents primary care physician for review to allow diagnoses to be updated in the system.

The Wellness Director has educated the Nurse Practitioner to include diagnoses in the body of new orders moving forward, thereby preventing this oversight in the future.

The Missing Diagnosis report will continue to be initiated monthly by the Wellness Director, or Designee, prior to Quality Assurance meeting to maintain compliance and enforcement of this standard.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Not Implemented 09/05/2025- [redacted]

224a - Preadmission Screen Form

11. 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 #2 was admitted to the home on [redacted]/24; however, the resident's preadmission screening form was completed on [redacted]24. The PreScreen Form also has a hand-written note on page 1 of the form that reads; "Admit Date [redacted]024 pre screen should have been w/in 30 day of [redacted]/24", which is the incorrect date of admission.

Repeat Violation: 08/01/24.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

The Wellness Director, or Designee, will complete a comprehensive audit of all Personal Care Preadmission Screening Forms on or before August 11th, 2025.

Each document requiring a revision will be identified with a caveat statement concerning the Plan of Correction as the reason for noncompliant dating identification or information to prevent further citations.

New residents admitted this violation will be compliant with this regulatory requirement and will be audited randomly by the Wellness Director, or Designee, for date compliance.

Results of this audit will be reviewed at Quality Assurance Meetings monthly for the next ninety days as part of the Plan of Correction review process by Meridian Senior Living guidelines.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Not Implemented 09/05/2025- [redacted]