

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

August 11, 2025

[REDACTED], COO
EAGLEVIEW LANDING LP
[REDACTED]
[REDACTED]

RE: EAGLEVIEW LANDING
650 STOCKTON DRIVE
EXTON, PA, 19341
LICENSE/COC#: 14698

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/11/2025, 06/12/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *EAGLEVIEW LANDING* License #: *14698* License Expiration: *09/13/2025*
Address: *650 STOCKTON DRIVE, EXTON, PA 19341*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *EAGLEVIEW LANDING LP*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *03/27/2019* Issued By: *Uwchlan Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *95* Waking Staff: *71*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *06/12/2025*

Inspection Dates and Department Representative

06/11/2025 - On-Site: [REDACTED]
06/12/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
License Capacity: *121* Residents Served: *69*
Secured Dementia Care Unit
In Home: *Yes* Area: *Garden House* Capacity: *45* Residents Served: *25*
Hospice
Current Residents: *7*
Number of Residents Who:
Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *69*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *26* Have Physical Disability: *0*

Inspections / Reviews

06/11/2025 - Full
Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/13/2025*

07/15/2025 - POC Submission
Submitted By: [REDACTED] Date Submitted: *08/08/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/08/2025*

Inspections / Reviews *(continued)*

08/11/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/08/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

17 - Record Confidentiality

1. 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 6/11/2025, The Resident Task book for Memory care unit residents was unlocked, unattended, and accessible on top of the memory care medication cart.

Plan of Correction

Accept (█ - 07/15/2025)

Action: On June 11th, 2025, during inspection, the Director of Nursing removed the binder from the cart and placed it in the med room that is secured by key fob access only.

Training: Direct Care staff will be educated by the Director of Nursing on regulation 2600.17 by 7/30/25.

Documentation will be kept.

Ongoing: The Director of Nursing, Assistant Director of Nursing or manager on duty will round in Memory Care beginning on 7/14/25 daily for 4 weeks and weekly for 2 weeks and randomly thereafter starting 9/1/25 to ensure compliance is maintained. An Audit tool with the findings will be reviewed during monthly Quality Assurance meetings with documentation kept beginning July 25, 2025.

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

Implemented (█ - 08/11/2025)

65a - FS Orientation 1st Day

2. 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.

Description of Violation

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

65a - FS Orientation 1st Day (continued)

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

Plan of Correction

Accept ([REDACTED] - 07/15/2025)

Action: As of 7/3/2025 Agency Staff person A and B will not return to work until training has been completed and documented.

Training: Executive Director to educate the Director of Nursing and Assistant Director of Nursing on regulation 65 a. by 7/30/25 and documentation will be kept.

Ongoing: An audit was completed by the administrative assistant on all agency staff who have worked in the home in the past 30 days on 6/25/25 and a new training binder was started. The Director of Nursing or Executive Director will monitor that any Agency staff members coming into the home has the first day training prior to working the first shift beginning 7/3/25. Training binder will be reviewed monthly at Quality Assurance meetings for compliance beginning 7/25/25.

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

Implemented ([REDACTED] - 08/11/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.

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

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

Description of Violation

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

Plan of Correction

Accept ([REDACTED] - 07/15/2025)

Action: As of 7/3/2025 Agency Staff person B will not be scheduled to work in the home until training has been completed and documented.

Training: Executive Director to educate the Director of Nursing and Assistant Director of Nursing on regulation 65 b. by 7/30/25. Documentation will be kept

Ongoing: An audit was completed by the administrative assistant on all agency staff who have worked in the home

65b - Rights/Abuse 40 Hours (continued)

in the past 30 days on 6/25/25 and a new training binder was started. Beginning 7/3/25, the Executive Director or Director of Nursing will monitor to ensure that each agency staff will have the required training within the first 40 hours worked. Training binder will be reviewed monthly at Quality Assurance meetings for compliance beginning 7/25/25 and documentation will be kept.

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

Implemented (█) - 08/11/2025

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 6/11/2025, at 10:12 am, there was a brown substance frozen on the bottom of the freezer in the first-floor memory care unit.

Plan of Correction

Accept (█) - 07/15/2025

Action: The brown substance was removed by the housekeeper on 6/11/25 following the inspection findings.
Training: The Executive Director will educate the housekeeping staff on regulation 85 e. by 7/30/25 with documentation kept.
Ongoing: Housekeeping and/or direct care staff will monitor refrigerators and freezers in common areas starting 7/15/25 weekly and will clean as needed with documentation kept and reviewed during Quality assurance meeting. Documentation of Quality Assurance meetings will be kept. This area will be monitored monthly by the housekeeping supervisor beginning 7/25/25

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

Implemented (█) - 08/11/2025

103f - Refrigerator/Freezer Temps

5. Requirements

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

Description of Violation

On 6/11/2025, at 10:30 am, there was no thermometer in the two second floor bistro refrigerators.

Plan of Correction

Accept (█) - 07/15/2025

Action: Maintenance Director placed thermometers in the two second floor bistro refrigerators on 6/11/25 upon inspection finding.
Training: The Executive will educate the maintenance staff on regulation 103 f by 7/30/25 with documentation kept.
Ongoing: Thermometer checks have been added to TELS electronic compliance system for monthly checks by the maintenance director to ensure placement remains beginning 7/15/2025. Documentation will be kept in TELS and will be reviewed monthly during Quality Assurance meetings starting 7/25/25. The Executive Director will monitor this area and report findings to the Maintenance Director starting 7/15/25.

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

103f - Refrigerator/Freezer Temps (*continued*)*Implemented (█ - 08/11/2025)*

103i - Outdated Food

6. Requirements

2600.

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

Description of Violation

On 6/11/2025, at 10:12 am, there were two unlabeled, undated chick-fil-a containers, one with fruit and one with yogurt in the second-floor memory care unit refrigerator.

On 6/11/2025, at 10:12 am, there was an unlabeled, undated water bottle filled with a white liquid that appeared to be milk, located in the second-floor memory care unit refrigerator.

Plan of Correction*Accept (█ - 07/15/2025)*

Action: All food without proper label and date was immediately removed from the refrigerator and discarded by the director of dining on 6/11/25 following inspection.

Training: All direct care staff and dining staff will be trained by the Executive Director and the Dining Director on regulation 103i by 7/30/2025. Documentation will be kept.

Ongoing: Executive director or member of leadership team will complete daily audits x 2 weeks, weekly audits x 4 weeks starting 7/15/25 and monthly thereafter to ensure compliance. Documentation will be kept and will be reviewed monthly during Quality Assurance meetings beginning 7/25/25. The Executive Director will monitor this area and document the findings.

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

Implemented (█ - 08/11/2025)

107d - Procedure Emergency Management Agency Submission

7. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the office of emergency management. The home could not provide any documentation.

Plan of Correction*Accept (█ - 07/15/2025)*

Action: Executive Director sent the Emergency Procedures Plan to the county on 6/25/25, which was denied. A meeting was set up with the Emergency Management Representative following the denial to ensure the necessary changes are made to be compliant. The meeting is scheduled for 7/8/25.

Training: The Executive Director, Regional Director of Operations and Maintenance Regional Director were

107d - Procedure Emergency Management Agency Submission (continued)

educated by the Chester County emergency management representative [REDACTED] on 7/8/25 on the necessary documents required to have an approved OEM via a Teams meeting call.

Ongoing: The Emergency management agency provided a template to the Executive Director and Regional Director of Maintenance to develop a proper plan. The Executive Director has a scheduled call with the Regional Director of Maintenance on 7/16/25 to finalize the plan. The Executive Director will maintain annual communication with the County Emergency Management Agency to ensure annual compliance remains once the plan is officially approved. The Executive Director will submit new plan to the Chester County Emergency Management agency by 7/30/25 and will be reviewed with the leadership team upon approval. Written emergency procedures will be reviewed, updated, and submitted annually to the local emergency management agency. The OEM notification letter will be kept. Any updated information will be reviewed at monthly the Quality Assurance meeting, then education with the staff by their department manager with documentation kept.

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

Implemented ([REDACTED]) - 08/11/2025

132e - Fire Drill Sleeping Hours

8. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 10/29/2024 at 5:06 am. The previous fire drills are not being conducted during sleeping hours.

Plan of Correction

Accept ([REDACTED]) - 07/15/2025

Action: Executive Director contacted Fire and Life Safety Solutions company on 6/12/25 following inspection and planned for the 6/17/25 fire drill to be done at 3:00 am. This was successfully completed and documented on the fire drill log.

Training: Executive Director will educate the Maintenance Director on regulation 132 e. to include at least one fire drill during hours of sleep between 11pm - 7 am every 6 months by 7/30/25. Documentation will be kept.

Ongoing: The Executive Director will monitor the fire drill log monthly starting 6/12/25, and it will be reviewed at monthly Quality Assurance meetings beginning 7/25/25. Documentation will be kept.

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

Implemented ([REDACTED]) - 08/11/2025

181d - Storing Medication

9. Requirements

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 1 self-administers medications and stores medications in [REDACTED] room. On 6/12/2025, at 11:26 am, there were several unlocked, unattended medications to include Lorazepam .5 mg tablet in resident 1's bedroom. The bedroom door was not locked.

181d - Storing Medication (continued)

Plan of Correction

Accept (█ - 07/15/2025)

Action: The Executive Director locked the apartment door when exiting Resident #1's room with inspector present.

Training: The Director of Nursing and med tech staff will be educated by the Executive Director on regulation 181d by 7/30/2025, and documentation will be kept. Resident #1 will be educated that █ apartment door must always be locked to secure medications when █ exits the apartment. Education by the Director of Nursing will be completed by 7/30/25. Documentation of resident education will be documented in █ record.

Ongoing: Starting 7/15/2025 the Director of Nursing will complete an audit monthly to ensure medications are properly stored and secured for all residents who self-administer medications and documentation will be kept and be reviewed during monthly Quality Assurance meetings beginning 7/25/25.

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

Implemented (█ - 08/11/2025)

181f - Record of Medication

10. Requirements

2600.

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

Description of Violation

On 6/12/2025, resident 1's record did not include a current list of medications. The list in the resident's record did not include Saline Spray, Hydrochlorothiazide 12.5 mg, Tylenol, CVS Stool Softener, Voltaran, and Vicks VapoRub.

On 6/12/2025, resident 1 was missing medications that were listed on their medication record to include Icy Hot Original pain-relieving cream, and Vitamin C tab 1000 mg.

Plan of Correction

Accept (█ - 07/15/2025)

Action: The Executive Director notified Resident #1's Provider of this violation on 7/11/25 and requested that a medication review be completed to have a current list of medication on the resident's record and medication in the resident's room to self-administer. The Director of Nursing will follow up with the Provider by 7/15/25 to ensure the medication review is done and prescribed orders are received.

Training: The Regional Director of Clinical Services will educate the Executive Director, Director of Nursing and Assistant Director of Nursing on regulation 181f by 7/15/2025 and documentation kept.

Ongoing: The Director of Nursing or Assistant Director of Nursing will complete an audit from 7/15/2025 to 7/25/25 on self-medicating residents for compliance with medication self-administration. Residents who self-administer their medications will be assessed each month by the Director of Nursing and/or the Assistant Director of Nursing beginning 7/26/25. The Director of Nursing will maintain the audit documentation.

This area will be reviewed at the monthly Quality Assurance meetings beginning 7/25/25. The Executive Director will monitor this area quarterly starting 8/1/25 and communicate the findings to the Director of Nursing.

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

Implemented (█ - 08/11/2025)

183e - Storing Medications

11. 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 6/11/2025, resident 2 is prescribed lorazepam medication to use as needed. The blister pack has a puncture in it for pill #6.

On 6/11/2025, resident 3 is prescribed tramadol medication to use as needed. The blister pack has a puncture in it for pill #13.

On 6/11/2025, resident 4 is prescribed lorazepam medication as a straight order. The blister pack has a puncture in it for pill #5.

Plan of Correction

Accept ([REDACTED] - 07/15/2025)

Action: Resident # 2, 3, 4's medications with puncture holes in the blister packs were destroyed by Med tech and Nurse on 6/11/25 following inspection. The pharmacy was notified, and residents will not be charged for the replacement medication.

Training: The Director of Nursing will educate the medication staff on regulation 183 e. by 7/30/25 with documentation kept.

Ongoing: Beginning 7/15/25 medication cart audits will be conducted by the medication staff and/or Assistant Director of nursing and/or Director of Nursing weekly ongoing and will be reviewed and monitored by the Executive Director with documentation kept. This area will be reviewed monthly at Quality Assurance meetings beginning 7/25/25.

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

Implemented ([REDACTED] - 08/11/2025)

187a - Medication Record

12. 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).

187a - Medication Record (continued)

13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 5 is prescribed a sliding scale of insulin lispro inject subcutaneously as directed per sliding scale three times a day as follows: 100= 0 units, 200-250= 2 units, 251-300 units= 4 units, 300-350= 6 units, 350-400 units= 8 units, greater than 401 contact MD. On the following days and times the units of insulin administered were not documented:

6/1/25 and 6/2/25 @ 12:00 pm and 4:00 pm

6/3/25, 6/4/25, 6/5/25, and 6/6/25 @8:00 am, 12:00 pm, and 4:00 pm

6/7/25 @ 8:00 am and 12:00 pm

6/8/25 @ 12:00 pm

6/9/25 @ 8:00 am and 4:00 pm

6/10/25 @ 12:00 pm amd 4:00 pm

6/11/25 @ 8:00 am and 4:00 pm

Resident 6 is prescribed Novolog inject subcutaneously as directed per sliding scale three times daily before meals as follows: 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units and greater than 400 Call and MD. On the following days and times the units of insulin administered were not documented:

6/1/25, 6/3/25, 6/4/25, 6/7/25 and 6/8/25 @ 12:00 pm and 4:00 pm

6/2/25 and 6/9/25 @ 8:00 am and 4:00 pm

6/5/25 @ 8:00 am, 12:00 pm, and 4:00 pm

6/6/25, 6/10/25, and 6/11/25 @ 4:00 pm

Plan of Correction**Accept (█ - 07/15/2025)**

Action: Resident #5's medication order on the medication administration record was corrected to include documented sliding scale blood sugar documentation on 6/12/25 by the Director of Nursing following inspection.

Training: The Director of Nursing will educate the medication staff on regulation 187d by 7/30/2025 with documentation kept.

Ongoing: Beginning 6/16/2025 the Director of Nursing/Assistant Director Nursing, or medication technician, will review all sliding scale orders to ensure proper entry into the medication administration record upon receiving pharmacy entered order prior to approving the order. This area will be reviewed and documented at monthly QA meetings beginning 7/25/25. The Executive Director will monitor this area monthly by auditing sliding scale orders beginning 7/25/25.

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

Implemented (█ - 08/11/2025)