

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

October 15, 2025

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

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/28/2025, 07/29/2025, 08/15/2025, 07/28/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE PINNACLE AT PLYMOUTH MEETING **License #:** 15023 **License Expiration:** 06/23/2025

Address: 215 PLYMOUTH ROAD, PLYMOUTH MEETING, PA 19462

County: MONTGOMERY **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: MSA PLYMOUTH MEETING OPERATING, LLC

Address: [REDACTED]

Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

| | | |
|------------------|-------------------------|-------------------------------------|
| 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:** 167 **Waking Staff:** 125

Inspection Information

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

Reason: Complaint, Incident **Exit Conference Date:** 07/29/2025

Inspection Dates and Department Representative

07/28/2025 - On-Site: [REDACTED]

07/29/2025 - On-Site: [REDACTED]

08/15/2025 - Off-Site: [REDACTED]

07/28/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 138 **Residents Served:** 100

Secured Dementia Care Unit

In Home: Yes **Area:** Garden House **Capacity:** 19 **Residents Served:** 15

Hospice

Current Residents: 9

Number of Residents Who:

| | |
|--|--|
| Receive Supplemental Security Income: 0 | Are 60 Years of Age or Older: 100 |
| Diagnosed with Mental Illness: 44 | Diagnosed with Intellectual Disability: 0 |
| Have Mobility Need: 67 | Have Physical Disability: 0 |

Inspections / Reviews

07/28/2025 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/06/2025

09/09/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/09/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 09/12/2025

09/11/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/09/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 10/10/2025

10/15/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/09/2025

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 [REDACTED], at 11:08 AM, a controlled substance accountability log containing resident medical information was unlocked, unattended, and accessible on top of the 4th floor medication cart.

Plan of Correction

Accept ([REDACTED] - 09/09/2025)

Identified items were immediately secured and the agency nurse was coached regarding the importance of confidentiality.

The Executive Director has been conducting documented daily rounds, during the work week, to ensure compliance with computer etiquette and confidentiality. These rounds began on June 10th, 2025, and continued for 60 days to reinforce the expectations of this regulatory requirement. Feedback and coaching were immediately provided to staff as issues were identified.

All Managers were trained on August 28th, 2025, on the importance of confidentiality of materials related to residents and the medication cart to assure that all Department Heads are reinforcing and supporting these regulatory expectations during all rounds of The Community daily.

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

Implemented ([REDACTED] - 10/15/2025)

23a Activities of Daily Living Assistance

2. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [REDACTED], for resident [REDACTED] indicates the resident requires assistance with peri-care and disposing of used incontinent products every shift. On [REDACTED], the resident did not receive this assistance as required during the 7 AM to 3 PM shift.

Plan of Correction

Accept ([REDACTED] 09/09/2025)

The Pinnacle self-reported this issue and suspended the staff member involved in this matter. The employee was eventually terminated pending the outcome of the investigation.

An All-Staff training inservice was conducted on August 21st, 2025, to review the importance of the Support Plan and all regulatory mandated paperwork in supporting care.

The Wellness Director, or Designee, will develop a Support Plan reference binder for all Medication Technicians and

23a - Activities of Daily Living Assistance (continued)

Care Staff to review and reflect on their assigned residents care needs.

The new Wellness Director and Clinical Team will reassess all residents, who haven't been reviewed in the past sixty days, by October 1st, 2025 to determine an accurate current level of care need for each resident at The Pinnacle.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented () - 10/15/2025)

51 - Criminal Background Check

3. Requirements

2600.

- 51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, who was hired on () had a background check that was completed on () over 1 year prior to being hired.

Plan of Correction

Accept () - 09/11/2025)

Staff Person A was not hired by the home on 7/23/25. Staff Person A was hired and is employed by a subcontracted staffing agency and her first day of work at The Pinnacle was 7/23/25. She was hired more than a year prior to the shift at The Pinnacle. Staff person A is in good standing with the staffing agency, and her background check is compliant to work in the community.

Personal Care Homes complete background checks prior to hire and do not complete additional checks during an employee's tenure, unless situations warrant, per the regulatory requirements.

The Pinnacle will contact the staffing agency and inform them that we will not be able to utilize any nurses unless the agency completes an additional background check within a year of the shift they are attempting to fill.

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented () - 10/15/2025)

62 - Contact List

4. Requirements

2600.

- 62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person B, the administrator, maintains a list of staff persons that does not include substitute and contracted agency staff persons.

Plan of Correction

Accept () - 09/11/2025)

The Pinnacle accessed the staffing agency portal to obtain all documentation required for the surveyors. These documents are reviewed prior to an agency staff member working at The Community to verify credentials and

62 Contact List (continued)

training compliance to The Pinnacle's emergency protocols.

The Pinnacle created a binder on September 1st, 2025, and is printing all relevant documents for substitute personnel. This binder will include the name, address and telephone number for agency staff members and the agency itself to avoid any delays in accessing this information.

The Wellness Director, or Designee, will review this binder monthly to assure that all team members scheduled are in the binder.

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented [REDACTED] - 10/15/2025)

65a - FS Orientation 1st Day**5. 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 [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.

Repeat violations: [REDACTED]

Plan of Correction

Accept [REDACTED] - 09/11/2025)

Staff person A, an employee of the staffing agency, completed the required training on emergency preparedness and fire safety, as the documents are reviewed and signed off in the agency's portal prior to assignment at The Pinnacle, per approval regarding a prior citation with The Department. However, the staff member did not complete this same training when arriving on site at The Pinnacle, causing the regulatory citation.

Agency staff members will continue to complete this training on the portal, as previously approved with POC 4/29/25. Additional documented training will also be provided when for each agency staff member at The Pinnacle when arriving, via the same form signed prior to coming to The Community.

The Wellness Coordinator, or Designee, will be responsible for completing the training outlined in this regulatory

65a FS Orientation 1st Day (continued)

guideline. This training will be held in the aforementioned agency binder.

The Wellness Director, or Designee, will review this binder monthly to assure that all team members scheduled are in the binder and their training paperwork is compliant.

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented [REDACTED] 10/15/2025)

95 - Furniture and Equipment

6. Requirements

2600.

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

Description of Violation

On [REDACTED] at 10:14 AM, the home did not have sufficient hot and cold water in the shower of room [REDACTED]. The shower head was broken and leaking water heavily from the sides which cause a complete lack of pressure from the shower head itself.

Plan of Correction

Accept [REDACTED] - 09/09/2025)

The Pinnacle was not aware of this issue. However, as soon as The Pinnacle became aware, the shower head was replaced.

The Facilities Director, or Designee, will conduct retraining for All Staff by September 30th, 2025 regarding the use of the TELS system to note compromised furniture or equipment in The Community. This inservice will also include training specifically for the Housekeeping Staff in auditing the room during weekly cleaning and reporting issues via TELS.

The Facilities Director, or Designees, will be responsible for the daily review of the TELS work order system and prioritizing the execution of the tasks to maintain regulatory compliance.

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

Implemented [REDACTED] - 10/15/2025)

105f - Labeling/Return of Clothes

7. Requirements

2600.

105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

On [REDACTED] at 3:44 PM the home received a complaint reporting that resident [REDACTED] towels had been missing for 3 days. On [REDACTED] Staff person C stated in an e mail that the lost towels were located in a laundry area on a different floor and were not returned to the resident in time.

105f Labeling/Return of Clothes (continued)

Plan of Correction

Accept () - 09/11/2025)

Residents' items were returned but not within the regulatory timeframe of twenty four hours. Root cause analysis of the matter identified that the residents' items were taken to another floor to be laundered secondary to the lacking need for two functioning washing machines on each floor.

Regional Director of Operations has instructed the Maintenance Department to order additional machines to replace items that are not functioning and add additional machines to bring the count to two for each floor to avoid the need to transport items to alternate floors to launder them. Operable machines will be on site by 9/30/25.

All staff responsible for laundering of resident's items will be trained to the twenty four hour return requirement by September 30th, 2025.

Facilities Maintenance Department will ensure that the machinery is maintained and in proper working order.

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

Implemented () - 10/15/2025)

182c - Medication Administration

8. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On [redacted] at 10:45 AM, the home did not witness resident 2 ingest [redacted] medication. Resident [redacted] requires this assistance to take [redacted], and [redacted]. Staff person C handed resident [redacted] medication, applesauce, a cup of water, and a fork then left the room, without observing the resident ingest the medication.

Plan of Correction

Accept () 09/09/2025)

Surveyor and Resident [redacted] were present in Staff Person C's office conducting an interview when Staff Person C entered to offer medication.

All Medication Technicians will be inserviced, by the Wellness Director, or Designee, by September 30th, 2025 regarding the need to physically watch all residents ingest medication, even if another Medication Technician, Nurse, Surveyor or Administrative Personnel is present with the resident.

Residents will be reminded during Septembers Resident Council Meeting regarding the safety need for staff to watch the ingestion of medications.

182c - Medication Administration (continued)

Wellness Director, or Designee, will watch five medication passes via the Practicum observer form during the month of October to be sure that this guideline is embraced.

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented [REDACTED] - 10/15/2025)

187b - Date/Time of Medication Admin.

9. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On [REDACTED] at 10:45 AM, resident [REDACTED] was handed a pill cup with a [REDACTED] tablet, and a [REDACTED]. Staff person A documented this medication as administered at 9 AM but did not witness the resident ingest the medication.

Plan of Correction

Accept [REDACTED] - 09/09/2025)

Surveyor and Resident [REDACTED] were present in Staff Person C's office conducting an interview when Staff Person C entered to offer medication.

All Medication Technicians will be inserviced, by the Wellness Director, or Designee, by September 30th, 2025, regarding the need to physically watch all residents ingest medication, even if another Medication Technician, Nurse, Surveyor or Administrative Personnel is present with the resident.

Residents will be reminded during Septembers Resident Council Meeting regarding the safety need for staff to watch the ingestion of medications.

Wellness Director, or Designee, will watch five medication passes via the Practicum observer form during the month of October to be sure that this guideline is embraced and that timely administration parameters are followed.

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented [REDACTED] - 10/15/2025)

227g -Support Plan Signatures

10. Requirements

2600.

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

Description of Violation

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

Repeat violations: [REDACTED]

227g Support Plan Signatures (continued)**Plan of Correction****Accept** [REDACTED] - 09/09/2025)

The Wellness Director, or Designee, completed a comprehensive audit of all Support Plans and assessments by August 11th, 2025. Non compliant support plans are being addressed via resident and family conferences and signatures on new documents will be sought as significant changes or biannual review timeframes, per Meridian standard, dictate.

Each document requiring a revision has been identified via a caveat statement concerning the Plan of Correction as the reason for the noncompliant dating or information to prevent further citations on what the home has already identified, such as this citation.

New residents' admissions since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Director, or Designee, for date and completion compliance to prevent this noncompliant trend from continuing.

Results of compliance audits will be discussed as part of the Plan of Correction during Quality Assurance Meetings for 90 days per Meridian Senior Livings expectations.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented [REDACTED] - 10/15/2025)