pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **A.M.P. LIVING COMMUNITIES**
LEGAL ENTITY

To operate **MORRIS-PACE WEST**
NAME OF FACILITY OR AGENCY

Located at **25 S 9TH STREET, LEBANON, PA 17042**
(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 **74** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 **November 13, 2025** until **November 13, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **340420**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: NOVEMBER 13, 2025

AMP Living Communites

RE: Morris-Pace West
25 S. 9th Street
Lebanon, Pennsylvania 17042
License #: 34042

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on August 5, 2025, August 6, 2025, and October 15, 2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summaries>

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

November 12, 2025

A.M.P. LIVING COMMUNITIES

RE: MORRIS-PACE WEST
25 S 9TH STREET
LEBANON, PA, 17042
LICENSE/COC#: 34042

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/05/2025, 08/06/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MORRIS-PACE WEST* **License #**: *34042* **License Expiration**: *10/11/2025*

Address: *25 S 9TH STREET, LEBANON, PA 17042*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

Name:

Legal Entity

Name: *A.M.P. LIVING COMMUNITIES*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1987* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *42* **Waking Staff**: *32*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *08/29/2025*

Inspection Dates and Department Representative

08/05/2025 - On-Site:

08/06/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *20* **Are 60 Years of Age or Older**: *29*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

08/05/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/15/2025*

Inspections / Reviews *(continued)*

09/24/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/26/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *10/01/2025*

11/12/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/26/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff member A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept - 09/18/2025)***

54a – Direct Care Staff
1. This regulation is important because direct care staff must have valid qualifications to provide safe and competent care to our residents.
2. During inspection, it was discovered that a staff member submitted a falsified high school diploma during onboarding. DHS verified the document was forged.
3. The staff member was immediately removed from direct care duties on 8/7/25 and suspended entirely until proper education documentation can be obtained on 8/20/25
4.all Employee files will be reviewed quarterly by the Administrator Assistant to ensure required educational documentation is verified and complete. Any discrepancies will be escalated to the Administrator immediately
5. All staff were educated/trained on qualifications required to be a direct care worker on 09/8/2025, provided by the Administrator (training roster attached)
6. I, as the Administrator, am responsible for preventing recurrence and ensuring only qualified staff provide direct care to my residents

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented - 11/12/2025)

82c - Locking Poisonous Materials

2. 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

There were three spray bottles observed in the second floor utility closet, labeled with a black marker; two bottles contained a green liquid and was labeled "all-purpose cleaner" and one bottle with a blue liquid labeled "Windex."

Plan of Correction ***Accept - 09/24/2025)***

2600.82(a) - Poisonous materials shall be stored in their original, labeled containers
1. This regulation is important because it minimizes the possibility that a resident or staff person will mistake a

82c - Locking Poisonous Materials (continued)

poisonous substance for a harmless substance
2. During inspection, spray bottles with handwritten labels containing cleaning solutions were found in a lock utility closet.
3. The bottles were immediately removed and replaced with manufacturer-labeled containers on 8/6/2025.
4. Effective 8/12/2025, only manufacturer-labeled chemicals approved for facility use are permitted, and all chemicals must remain locked in designated storage areas.
5. Staff received training on chemical safety on 09/08/2025, provided by the Administrator.(training roster attached)
6. Beginning 09/01/2025, chemical storage areas will be reviewed monthly as part of the Administrator Audit, with documentation maintained in our inspection binder
7. I, as the Administrator, am responsible, with support from the Administrator Assistant.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented █ - 11/12/2025)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 8/6/25, at 9:46 AM, in the home's main bathroom, the toilet in the 2nd bathroom stall was observed smeared with feces.

Plan of Correction ***Accept █ - 09/24/2025)***

85a – Sanitary Conditions
1. This regulation is important because unsanitary conditions, odors, or pest activity create health risks and affect residents living conditions.
2. During inspection, feces were observed on a toilet stall following a resident accident. Staff did not immediately restrict access until proper cleaning was completed
3. The housekeeper went to the restroom to immediately clean and disinfect on 8/6/25
4. Effective 8/15/2025, 1st floor restroom stalls are checked and documented at least twice per shift across all three shifts. Admin Assistant will review these logs weekly and documentation will be maintained in the inspection binder for DHS review
5. Staff received training on sanitation protocols on 09/8/2025, provided by the Administrator. (training roster attached)
6. I, as the Administrator, am responsible, with support from the Administrator Assistant to ensure sanitation is maintained and preventing recurrence.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented █ - 11/12/2025)

85a - Sanitary Conditions *(continued)*

88a - Surfaces

4. Requirements

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 8/7/25, the baseboard heater next to the toilet in the bathroom in room [redacted] was observed with a loose metal cover that is protruding from the wall presenting a hazard.

On 8/7/25, there were large areas of the wall observed with peeling paint and plaster in the shared shower / toilet room between resident bedrooms [redacted].

Plan of Correction ***Accept [redacted] 09/24/2025)***

88a – Surfaces
1. This regulation is important because all surfaces must be safe, clean, and in good repair to prevent hazards and maintain a sanitary environment.
2. During inspection, a loose heater cover was observed in Room [redacted] and peeling paint/plaster was observed in the shared bathroom between Rooms [redacted]
3. The heater cover was secured on 8/8/2025 and peeling surfaces were sanded and spackled on 8/14/2025. Photo evidence of repairs is attached.
4. beginning 9/1/25 hazards identified will be corrected within 24 hours and documented on the monthly Admin Audit form
5. Staff received training on environmental safety on 09/08/2025, provided by the Administrator.(training roster attached)
6. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring timely repairs and ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented [redacted] - 11/12/2025)

96a - First Aid Kit

5. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the medication room and in the second-floor closet does not include the thermometer and eye coverings. The first aid kit in the former medication office does not include tweezers, scissors, and a thermometer.

96a - First Aid Kit (continued)

Plan of Correction ***Accept ██ - 09/24/2025)***

96a – First Aid Kit
1. This regulation is important because complete first aid kits are required for emergency response and resident safety.
2. During inspection, first aid kit was missing required items including a thermometer, scissors, tweezers, and eye coverings. They were not all in one area.
3. The first aid kit designated for staff to use during emergency was restocked with the missing items and placed in the kitchen on 8/15/25.
4. on 8/15/25 , an inventory checklist was placed inside the kit. Monthly first aid kit review will be conducted by the Administrator assistant beginning 09/01/2025..
5. Staff received training on first aid log on 09/08/2025, provided by the Administrator.(training roster attached)
6. I, as the Administrator, am responsible, with support from the Administrator Assistant to ensure first aid kit is properly stocked

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented ██ - 11/12/2025)

105d - Change Bed Linens/Towels

6. Requirements

2600.
105.d. Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.

Description of Violation

On 8/7/25, bath towels in room 216, belonging to resident #1 were observed to be heavily stained.

Plan of Correction ***Accept (██ - 09/24/2025)***

105d – Bed Linens/Towels
1. This regulation is important because clean linens and towels are required to maintain resident hygiene and prevent infection.
2. During inspection, stained towels were observed in Room 216.
3. Towels were immediately replaced, and soiled items were laundered on 8/7/25. Photos of clean towels replacing soiled ones are attached.
4. Effective 9/8/25, housekeeping staff will change towels weekly during room cleaning and linen change. Staff will document weekly completions.The Administrator Assistant will verify monthly during room audits and documentation will be maintained in the inspection binder for DHS review. residents are also encouraged to trade soiled one at anytime.
5. Staff received training on hygiene and prevention of infection on 08/15/2025, provided by the Administrator. (training roster attached)
6. I, as the Administrator, am responsible for oversight.

105d - Change Bed Linens/Towels (continued)

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented ███ - 11/12/2025)

127a - Portable Space Heaters

7. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 8/5/25 at approximately10:00 AM, a portable space heater was observed in the basement of the home.

Plan of Correction ***Accept███ 09/24/2025)***

127a – Portable Space Heaters

1. This regulation is important because portable space heaters are prohibited due to fire hazards it may cause in the home.

2. During the inspection, a portable space heater was found stored in the basement locked closet.

3. The heater was removed and disposed in the trash on 8/5/2025.

4. On 9/1/2025 , signage was posted in storage areas prohibiting portable space heaters in the home.

5. Staff received training on fire safety in regards to space heaters on 09/08/2025, provided by the Administrator. (training roster attached)

6. Beginning 09/01/2025, the Administrator Assistant will perform monthly fire safety reviews that include inspection of all storage areas to confirm no space heaters are present. Documentation will be maintained on the Administrator monthly audit form for DHS review.

7. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring compliance with fire safety regulations.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented███ 11/12/2025)

132c - Fire Drill Records

8. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for drills conducted on the following dates do not include the correct number residents who were present in the home during the drill:

- *On 7/21/25 at 12:13 PM there were 36 residents present in the home; however, 43 residents were documented on the fire drill record as present in the home at the time of the fire drill.*

132c - Fire Drill Records (continued)

- *On 6/2/25 at 12:30 PM, there were 38 residents present in the home; however, 42 residents were documented on the dire drill record as present in the home at the time of the fire drill.*
- *On 5/26/25 at 11:00 AM, it could not be determined how many residents were present in the home; however, 42 residents were documented on the fire drill record as present in the home, with 40 residents evacuated during the fire drill.*
- *On 4/14/25 at 9:40 AM, there were 39 residents present in the home; however, 42 residents were documented on the fire drill record as present in the home at the time of the fire drill.*

Plan of Correction ***Accept [redacted] - 09/24/2025)***

132c – Fire Drill Records
1. This regulation is important because accurate fire drill records ensure effective emergency preparedness and documentation .
2. A fire drill was conducted 8/25/25 in which The drill was documented correctly based on the home census
3. Effective 8/11/2025 fire drill form will require verification of resident census and proper documentation by the Admin. i will be adding the form to tabula as my verification of the written log completed by Admin staff
4. On 08/11/2025, the Administrator provided training to the Administrator Assistant on fire drill documentation and emergency preparedness procedures
5. I, as the Administrator, am responsible for compliance and education of fire drill documentation.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented [redacted] - 11/12/2025)

141a 1-10 Medical Evaluation Information

9. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's medical evaluation dated [redacted]/25 does not include the following:

- *Special health or dietary needs of the resident.*
- *Body positioning and movement stimulation for residents, if appropriate.*
- *Health status, cognitive functioning.*
- *Mobility assessment updated annually or at the department's request.*

Resident #3's medical evaluation dated [redacted]/25 does not include the medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Plan of Correction ***Accept ([redacted] - 09/24/2025)***

141a – Medical Evaluation Information
1. This regulation is important because complete medical evaluations ensure residents receive appropriate care and services by our DC staff.
2. on 8/11/2025 all missing items on each medical evaluation were flagged and faxed to the residents' physicians for updated DME information.
3. On 08/15/2025, staff completed training on reviewing medical evaluations to ensure all required elements are present (see attached roster)
4. Monthly audits will verify medical evaluations are fully complete, not just present by the Administrator assistant beginning 08/11/2025. Deficiencies will be corrected within 48 hours of identification
5. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring medical evaluations of my residents are completed properly

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented ([redacted] - 11/12/2025)

142a - Secure Medical Care

10. Requirements

142a - Secure Medical Care *(continued)*

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

During the period of 5/28/25 to 7/9/25 resident #7 experienced toileting and bladder and management issues to include multiple incidents of bladder and bowel incontinence. Resident #7's assessment and support plan signed /25, stated the following from the home's perspective , "we will provide resident #7 with pull-ups until he can see doctor." According to the home's Administrator, depends undergarments/pullups are not provided by the home, and a prescription is needed from the doctor. The resident's assessment and support plan also states, "We (the home) will be calling resident #7's doctor to see if needs some type of medical help with this issue." The home failed to contact the resident's doctor regarding multiple incidents of bladder and bowel incontinence during this time period. This resulted in the resident not being examined to further determine if the resident required medical help to address his incontinent episodes, nor was a prescription of depend undergarments/pullups requested for the resident.

Plan of Correction ***Accept - 09/24/2025)***

142a – Secure Medical Care
1. This regulation is important because timely physician involvement is critical when a resident's health status changes.
2. The resident has been discharged because their needs could not be safely met
3. Effective 9/9/2025, a "Doctor contact" Form requires all staff to document outcomes, and updates to the resident's assessment and RASP. These forms will serve as documentation that the home secured medical care.
4. Beginning 09/09/2025, all completed Doctor Contact Forms are reviewed weekly by the Administrator. Documentation is maintained in the inspection binder for DHS review
5. Staff received training on contacting doctors using the form on 9/9/2025, provided by the Administrator. (training roster attached)
6. I, as the Administrator, am responsible for ensuring physician involvement and accurate documentation is being done by med techs.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented (- 11/12/2025)

144c1 - Smoking Area Guidelines

11. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 - Smoking Area Guidelines *(continued)*

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 8/5/25 at 9:53 AM, a cigarette butt was observed on the floor at the bottom of the stairwell in the doorway of the boiler room where the gas hot water heater and gas boilers are located.

On 8/5/25 and 8/6/25, residents #1 and resident #4 were observed smoking and vaping on multiple occasions on the side of the building in the alley. The home's designated smoking area is in the rear of the home on the back porch and the open-air area immediately adjacent to the back porch.

Plan of Correction ***Accept [redacted] - 09/24/2025)***

144c(1) – Smoking Safeguards
1. This regulation is important because proper smoking safeguards prevent fire hazards.
2. During inspection, a cigarette butt was found in the shop of the [redacted], and residents were observed smoking outside the designated smoking area.
3. The cigarette butt was removed, signage was posted, and residents #1 and #4 were counseled on smoking rules on 8/7/2025. They also signed a home rule warning notice on 9/9/2025.
4.Direct care staff will document daily observations of residents smoking in areas besides the designated smoking area (back deck) and whether receptacles are not being used properly. Documentation will be maintained in the home communication app for DHS review
5. Staff received training on smoking policies on 09/08/2025, provided by the Administrator. (training roster attached)
6. Monthly smoking safety reviews and designated smoking area observation will be conducted by the Administrator assistant beginning 09/01/2025.
7. I, as the Administrator, am responsible, with support from the Administrator Assistant for enforcing smoking policies.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented [redacted]/12/2025)

183b - Meds and Syringes Locked

12. 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 8/6/25, there was a tube of equate-brand Clotrimazole 1% cream observed unlocked, unattended and accessible

183b - Meds and Syringes Locked (continued)

in room 216. Residents #1 and #4 who reside in the room are not assessed to self-administer medications.

Plan of Correction ***Accept ██ - 09/24/2025)***

183b – Medications and Syringes Locked

1. This regulation is important because medications must be secured to prevent unauthorized use by residents of this home.

2. During inspection, an unsecured tube of Clotrimazole cream purchased by the resident was observed in Room ██

3. The item was removed and immediately secured in the medication room on 8/7/2025

4. The Administrator Assistant will verify during weekly room checks that all OTC medications are secured in the med room and not stored in resident rooms. Any unsecured items are immediately removed and logged.

5. Staff received training on medication storage on 08/15/2025, provided by the Administrator. (training roster attached)

6. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring compliance of OTC medications being secured during periodic walkthroughs of resident rooms.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented (██ - 11/12/2025)

183e - Storing Medications

13. 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 8/6/25 at 12:40 PM, there was a loose large white pill wedged between the controlled substance box and the wall of the right medication cart wall. In addition, there was as small red pill wedged between the controlled substance box and the wall of the left medication cart.

Plan of Correction ***Accept ██ - 09/24/2025)***

183e – Storing Medications

1. This regulation is important because medications must be stored in an organized and sanitary manner to ensure safe administration to our residents.

2. During inspection, the inspector used a flashlight and observed loose pills wedged between the narc drawer and the side of both medication carts.

3. Both carts were emptied, cleaned, and unknown pills disposed of immediately during the inspection on 8/6/2025

4. Effective 9/1/2025, medication carts are wiped down daily between shifts

5. Starting 8/18/25 deep cleaning of med carts per month will be done by admin assistant to ensure no loose pills are found.

6. Staff received training on medication cart organization on 08/15/2025, provided by the Administrator. (training roster attached)

7. I, as the Administrator, am responsible, with support from the Administrator Assistant for prevention of recurrence.

183e - Storing Medications (continued)

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented 11/12/2025)

184a - Resident's Meds Labeled

14. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #3 is prescribed acetaminophen 325mg take two tablets by mouth twice a day as needed for pain. The instructions on the pharmacy label are faded and difficult to read.

Plan of Correction ***Accept - 09/24/2025)***

184a – Medication Labels
1. This regulation is important because pharmacy labels must be legible to ensure accurate medication administration.
2. During inspection, Resident #3's acetaminophen label was faded and difficult to read.
3. The medication container was replaced with a legible label immediately on 8/5/2025.
3. Effective 8/11/25, weekly order reviews are conducted by admin team to find and fix any issues that may appear.
4. Staff received training on label verification on 08/15/2025, provided by the Administrator. (training roster attached). Additionally, Medication Cart Deep Cleaning audit will be utilize to verify all labels are compliant Beginning 08/11/2025.
6. Staff received training on label verification on 08/15/2025, provided by the Administrator. (training roster attached)
7. All medication techs are responsible for ensuring medications remain properly labeled and legible. The Administrator provides oversight to prevent recurrence.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented - 11/12/2025)

185a - Implement Storage Procedures

15. 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

Resident #5's blood sugar is prescribed to be checked 3 times daily. The resident's glucometer shows the following:

- *On 7/19/25 the glucometer shows a reading of 547 at 2:36 AM; the diabetic log sheet shows a date of 8/6/25*

185a - Implement Storage Procedures (continued)

and a reading of 547 at 7:00 AM.

- *On 7/18/25 the glucometer shows a reading of 554 at 3:27 PM; the diabetic log sheet shows a date of 8/5/25 and a reading of 544 at 7:00 PM.*
- *On 7/18/25 the glucometer shows a reading of 318 at 1:29 AM; the diabetic log sheet shows a date of 8/5/25 and a reading of 318 at 7:00 AM.*

Plan of Correction ***Accept █ - 09/24/2025)***

185a – Storage Procedures
1. This regulation is important because accurate glucometer readings and logs are critical for diabetic care management/documentation.
2. During inspection, Resident #5's glucometer readings did not align with the dates/times recorded in the diabetic log because the glucometer was not calibrated.
3. The glucometer was calibrated immediately during the inspection on 8/5/2025
4.Effective 08/11/2025, the Administrator Assistant conducts weekly glucometer calibration checks during medication cart audits. All new glucometers are calibrated upon admission before first use.
5. Staff received training on glucometer calibration on 08/15/2025, provided by the Administrator. (training roster attached)
6. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring accurate calibration, documentation, and review of glucometer results.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented █ - 11/12/2025)

187a - Medication Record

16. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #5 is prescribed Metformin 500mg, take 1 tablet by mouth every day. However, the diagnosis or purpose for the medication was not listed on the Medication Administration Record (MAR).

Plan of Correction ***Accept █ - 09/24/2025)***

187a – Medication Record
1. This regulation is important because medication administration records (MARs) must include the purpose of each medication to ensure safe and appropriate use.
2. During inspection, Resident #5's MAR for Metformin did not include the diagnosis or purpose.
3. The MAR was corrected immediately to include the proper diagnosis. The pharmacy was also emailed on 8/12/2025 to ensure that no medications are delivered to the home without a diagnosis or purpose clearly listed on

187a - Medication Record (continued)

the label.
4. On 8/15/25 a facility-wide MAR audit was conducted to ensure all medications included purposes. Beginning 08/18/2025, the Administrator Assistant conducts monthly MAR audits to verify completeness
5. Staff received training on MAR documentation on 08/15/2025, provided by the Administrator. (training roster attached)
6.I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring compliance and accuracy of medication records.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented █ - 11/12/2025)

187c - Refusal of Medication

17. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 7/1/25 through 8/6/25 at 7:00 AM, 5:00 PM and 8:00 PM, resident #2 refused to take scheduled doses of the following medications:

- *Midodrine 5mg tablet, take 1 tablet by mouth two times a day before meals for blood pressure.*
- *Mirtazapine 15mg tablets, take 1 tablet by mouth at bedtime for MDD.*
- *Vitamin B-12 500MCG, take 1 tablet by mouth daily for supplement.*
- *Vitron C 325mg take 1 tablet by mouth daily for supplement*

The home did not document the medication refusals in the resident's record on various dates including the following:

- *7/5/25*
- *7/7/25*
- *7/12/25*
- *7/21/25*
- *7/23/25 through 7/26/25*
- *7/28/25*
- *7/30/25*
- *7/31/25*
- *8/1/25*
- *8/2/25*
- *8/3/25*
- *8/4/25*
- *8/5/25*

187c - Refusal of Medication (continued)

Plan of Correction ***Accept[redacted] - 09/24/2025)***

187c – Medication Refusals

1. This regulation is important because refusals must be documented in resident chart and reported to ensure continuity of care.

2. During inspection, Resident #2's medication refusal log were not properly documented for each day[redacted] refused. The MAR documented the refusal, but the resident chart lacked the corresponding note

4. Effective 8/15/2025, med refusals must be entered into the resident's chart in tabula every time a resident refuse medication if not written on refusal log.

5. Resident #2 refusals was documented in their tabula chart for days staff did not document 8/4/2025, 7/28/2025, 7/26/2025, 7/25/25, 7/24/25, 7/23/25,7/5/25,7/7/25,7/12/25

6. Staff received training on refusal documentation on 08/15/2025, provided by the Administrator. (training roster attached)

7. weekly med cart audits will include refusal reviews by the Administrator assistant beginning 9/01/2025.

8. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring accurate refusal documentation.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented[redacted] - 11/12/2025)

224a - Preadmission Screen Form

18. 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's #3 and #6 preadmission screening forms dated[redacted]/25, do not include if the residents can safely use or avoid poisonous materials.

Resident #7's preadmission screening form does not include the date the form was completed.

Resident #8's preadmission screening form, dated[redacted]/25, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept[redacted] - 09/24/2025)***

224a – Preadmission Screening

1. This regulation is important because preadmission screenings ensure the home can safely meet the needs of new residents.

2. During inspection, several pre admission forms were missing completion dates or determinations.

3. Forms were corrected immediately to include missing information on 8/11/2025.

4. Administration team received training on admission documentation on 08/15/2025, provided by Administrator.

224a - Preadmission Screen Form (continued)

residents chart reviews of new residents will be conducted by the Administrator assistant beginning 08/18/2025.
5. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring compliance with admission documentation. I need to slow down to ensure the form is being completed properly.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented [redacted] - 11/12/2025)

225a - Assessment 15 Days

19. 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 #2's assessment dated [redacted]/25 does not include the residents' ability to self-administer medications as indicated on resident #2's medical evaluation dated [redacted]/25.

Resident #7's assessment signed by the administrator and the resident on [redacted]25 does not include the date the assessment was finalized.

Resident #8's assessment dated [redacted]/25 does not include the residents' ability to self-administer medications as indicated on resident #6's medical evaluation dated [redacted]/25.

Plan of Correction ***Accept [redacted] - 09/24/2025)***

225a – 15-Day Assessment
1. This regulation is important because initial assessments ensure appropriate supports are in place within 15 days of admission and for direct care workers to have knowledge on how to care for each individual resident of this home.
2. The assessments were updated and corrected on 8/11/2025
3. Beginning 08/15/2025, the Administrator Assistant conducts monthly audits of resident assessments and support plans, with emphasis on verifying completeness and accuracy (not just presence in the file). Deficiencies identified during audits are corrected immediately
4. Staff received training on resident assessment/support plan (RASP) documentation on 08/15/2025, provided by the Administrator. (training roster attached)
5. I, as the Administrator, am responsible, with support from the Administrator Assistant for ensuring assessments are filled out completely and timely.

225a - Assessment 15 Days (continued)

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented [redacted] - 11/12/2025)

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

November 12, 2025

A.M.P. LIVING COMMUNITIES

RE: MORRIS-PACE WEST
25 S 9TH STREET
LEBANON, PA, 17042
LICENSE/COC#: 34042

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/15/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MORRIS-PACE WEST* **License #**: *34042* **License Expiration**: *10/11/2025*

Address: *25 S 9TH STREET, LEBANON, PA 17042*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

Name:

Legal Entity

Name: *A.M.P. LIVING COMMUNITIES*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1987* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *10/15/2025*

Inspection Dates and Department Representative

10/15/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *20* **Are 60 Years of Age or Older**: *32*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

10/15/2025 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/02/2025*

10/28/2025 - POC Submission

Submitted By: **Date Submitted**: *11/03/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/04/2025*

Inspections / Reviews *(continued)*

11/12/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *11/03/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

82a - Poisonous Materials

1. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

A generic spray bottle labeled "simple green multi-purpose cleaner" was found in the basement maintenance room.

Plan of Correction ***Accept [redacted] - 10/28/2025)***

1. *This regulation is important because all poisonous materials must be kept in their original, labeled containers to prevent accidental misuse and ensure the safety of residents and staff.*
2. *During the inspection on 10/15/25, a generic spray bottle labeled "Simple Green Multi-Purpose Cleaner" was found in the basement maintenance room. The Administrator immediately removed and discarded the bottle in the trash to eliminate any potential risk.*
3. *In addition to our ongoing compliance plan, implemented on 9/1/2025 the Administrator will personally inspect the maintenance room every Monday and Friday starting 10/27/25 to ensure all cleaning and chemical supplies are stored in their original, labeled containers. Any unlabeled or improperly stored items will be discarded immediately, and staff responsible will receive corrective action and re-education.*
4. *On 10/24/25, all staff were re-educated on the importance of proper labeling, handling, and storage of all cleaning products. A signed training roster is maintained on file.*
5. *I, the Administrator, and the Maintenance Man are responsible for ensuring ongoing compliance with this regulation and for maintaining a safe, organized, and properly labeled maintenance area at all times.*

Licensee's Proposed Overall Completion Date: *10/27/2025*

Implemented [redacted] - 11/12/2025)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 10/15/25 at 12:30 PM, the bathroom floor in bedroom [redacted] was dirty and the bottom of the toilet was splattered with brown spots.

Plan of Correction ***Accept [redacted] - 10/28/2025)***

1. *This regulation is important because maintaining sanitary conditions helps ensure a clean, comfortable, and safe environment for all our residents.*
2. *During the inspection on 10/15/25, at 12:30 PM, the bathroom floor in Bedroom [redacted] was found to be dirty,*

85a - Sanitary Conditions (continued)

and the bottom of the toilet had brown residue. The resident explained that he prefers to clean [redacted] own bathroom and had declined staff assistance. I explained to the resident, in the presence of the inspector, that while i understand his independence, staff are still required to maintain sanitary conditions in all resident rooms per state regulation.

3. *On 10/15/25 , the med-tech supervisor immediately cleaned and sanitized the bathroom floor and toilet in Bedroom [redacted] to restore proper sanitary conditions.*
4. *The cleaning schedule implemented on 9/8/25 for all residents room is posted in the office and is initialed weekly by assigned staff to verify completion. All staff assigned to weekly room cleaning and linen changes will continue to follow the facility's cleaning schedule.*
5. *Beginning 10/24/25, staff will notify me or the Assistant Administrator if a resident refuses cleaning or linen service, so that we can address it right away and document resident re-education.*
6. *On 10/24/25, all staff were re-educated on maintaining sanitary conditions and proper daily bathroom cleaning procedures. A signed training roster is on file.*
7. *On 10/27/25, the resident was re-educated on the importance of allowing staff to clean [redacted] room and replace linens for health and safety reasons.*
8. *I, the Administrator, and the Direct care staff are responsible for preventing recurrence and ensuring that sanitary conditions are maintained throughout the facility*

Licensee's Proposed Overall Completion Date: *10/27/2025*

Implemented [redacted] 11/12/2025)

185a - Implement Storage Procedures

3. 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

Resident 1 is prescribed blood sugar tests before meals and bedtime as directed. The blood sugar reading stored in the resident's meter on 9/30/25 at 7:00 AM is 223; the reading documented on the medication administration record (MAR) is 233. The blood sugar reading stored in the resident's glucometer on 9/27/25 at 8:00 PM is 139; the reading documented on the MAR is 142.

Resident 2 is prescribed blood sugar checks 4 times daily. The blood sugar reading stored in the resident's glucometer on 10/14/25 at 8:00 PM is 303; the blood sugar reading documented on the MAR is 304.

Resident 3 is prescribed blood sugar checks 3 times a day. The resident has two glucometers. There are multiple readings documented on resident 3's MARs that are not stored in either of his glucometers including:

10/11 at 7:00 AM reading of 371
10/10 at 8:00 PM reading of 441
10/10 at 5:00 PM reading of 94
10/10 at 7:00 AM reading of 188
10/9 at 8:00 PM reading of 389

185a - Implement Storage Procedures (continued)

10/9 at 7:00 AM reading of 495
10/8 at 8:00 PM reading of 459
10/8 at 5:00 PM reading of 448
10/8 at 7:00 AM reading of 286
10/7 at 8:00 PM reading of 478
10/7 at 5:00 PM reading of 327
10/7 at 7:00 AM reading of 262
10/6 at 8:00 PM reading of 376
10/6 at 5:00 PM reading of 344

Plan of Correction ***Accept [redacted] - 10/28/2025)***

1. *This regulation is important because properly storing and handling glucometers helps keep our residents safe and ensures accurate readings for their diabetic care.*
2. *During the inspection on 10/15/25, there were differences found between the blood sugar readings stored in residents' glucometers and the readings documented on their Medication Administration Records (MARs) by mediation staff.*
3. *On 10/17/25, the home's handwritten diabetic log was updated to provide more spacing between entries after staff suggested that the previous layout was too close together, making it difficult to record residents' blood sugar readings accurately.*
4. *On 10/21/25, we ordered 48 new EasyTouch glucose meters ([redacted]) so that each current and future diabetic resident will have their own assigned meter of the same brand. This change will help staff document readings more accurately, avoid confusion between meters, and make it easier to keep devices properly calibrated.*
5. *On 10/24/25, all medication staff were retrained on how to properly use, store, and document glucose meter readings. A signed training roster is kept on file.*
6. *Starting 10/27/25, I the administrator will personally review at least four residents' diabetic logs every Monday to make sure that glucometer readings are properly documented in the residents MARs. These weekly audits will be kept on file to monitor consistency and accuracy.*
7. *I, the Administrator, and the medication staff are responsible for ensuring that accurate diabetic blood sugar logs are maintained at all times so that residents receive safe and reliable diabetic care.*

Licensee's Proposed Overall Completion Date: *10/27/2025*

Implemented [redacted] - 11/12/2025)