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

January 5, 2026

[redacted]
MSA PLYMOUTH MEETING OPERATING, LLC
[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 09/23/2025, 09/24/2025 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**: *03/24/2026*

**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**: *162* **Waking Staff**: *122*

## Inspection Information

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

**Reason**: *Complaint, Incident* **Exit Conference Date**: *09/24/2025*

## Inspection Dates and Department Representative

*09/23/2025 - On-Site*: [redacted]

*09/24/2025 - On-Site*: [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *138* **Residents Served**: *107*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents**: *4*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *107*

**Diagnosed with Mental Illness**: *5* **Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *55* **Have Physical Disability**: *1*

## Inspections / Reviews

**09/23/2025 Partial**

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/15/2025*

## Inspections / Reviews *(continued)*

**11/21/2025 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *12/30/2025*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/31/2025*

**01/05/2026 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *12/30/2025*

**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 10:14 AM, a laptop computer screen was open with resident information on-screen on top of the 2nd floor medication cart. The laptop was unlocked, unattended, and accessible.*

*Repeat Violation: [redacted] et al., [redacted] et al.*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The Executive Director, or Designee, will host training for all staff on confidentiality per the regulatory guidelines by November 30th, 2025.*

*The Executive Director instituted documented daily rounds, during the work week, from June 10th, 2025, continuing for sixty days. These rounds will begin again, by the Executive Director or Designee, from November 1, 2025, until November 30th, 2025.*

*All Department Managers were re-educated on the confidentiality of the medication cart on August 28th, 2025, to assure that all Department Managers are reinforcing and supporting this regulatory expectation during Manager on Duty weekends and walks throughout The Pinnacle.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 23b - Instrumental Activities of Daily Living Assistance

**2. Requirements**

2600.
23.b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

**Description of Violation**

*The assessment and support plan for resident #[redacted], dated [redacted] and [redacted] indicates the resident requires assistance to and from meals and activities. On [redacted] following breakfast, the resident did not receive this assistance as required.*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The service failure, as referenced, stemmed from a call bell response issue which is being addressed via additional equipment, a system update and daily monitoring of call bell response times as referenced in this POC under regulation 2600.60a.*

*The Wellness Director conducted an all staff inservice on August 21st, 2025 regarding the Pre-Admission Screen,*

## 23b - Instrumental Activities of Daily Living Assistance (continued)

*Assessment, RASP and Med Eval and how these documents provide a basis to help each department to provide care for the residents of The Pinnacle.*

*Current Support Plans are accessible to all nursing department staff in a binder labeled by floor. These binders are stored in the Second Floor Medication Room. The SDCU binder is in the SDCU neighborhood.*

*The Pinnacle has installed a Point of Care system that will make all current support plans accessible via computer as part of nursing staff members' daily assignments. This system is due to "go live" for implementation by January 1st, 2026. An additional training on the use of the Support Plan, RASP, Pre-Screen, Med Eval and all other regulatory documents will be conducted prior to December 31st, 2025, to stress the importance of using these documents as a guide for care improvement.*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented [redacted] - 01/05/2026)***

## 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**

*On [redacted], at approximately 9:00 AM, it was discovered that resident [redacted] pushed resident [redacted] against a wall. Residents [redacted] and [redacted] are [redacted]. They both moved to the home in August 2025 from a care facility out of state. The progress notes from the previous facility indicate there was an incident of abuse and aggression toward staff at that facility in July 2025. The progress notes are part of the resident's record. The home did not take steps to ensure resident [redacted] safety.*

*Repeat Violation: [redacted] et al., [redacted] et al., [redacted]*

**Plan of Correction** ***Accept ([redacted] - 11/21/2025)***

*Staff reported the incident between residents [redacted] and #[redacted] immediately and they were separated to guarantee both residents' safety. Staff will continue reporting all forms of suspected abuse without delay.*

*The referenced residents no longer share a room at The Pinnacle and will not be permitted to return to a shared accommodation while both parties reside at The Pinnacle.*

*The Executive Director, or Designee, will retrain the Wellness Director, Wellness Coordinator and Wellness Nurses by November 30th, 2025, regarding the importance of conducting a comprehensive assessment and a review of all transfer documents prior to or at the point of admission of new residents.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 54a - Direct Care Staff

**4. Requirements**

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

**Description of Violation**

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

*Repeat Violation:* [redacted]

**Plan of Correction** ***Accept*** [redacted] ***- 11/21/2025)***

*Staff Member A is no longer employed at The Pinnacle.*

*The Executive Director, or Designee, will train the Business Office Manager on the expectations of the regulations as they pertain to implications of this standard by November 20th, 2025.*

*The Business Office Manager, or Designee, will complete a documented comprehensive audit of all employee files by November 30th, 2025.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented*** [redacted] ***- 01/05/2026)***

## 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 has a "Resident Call System" policy that indicates "Staff shall respond to the Resident call system as quickly as practical." According to the response times listed below, needed services could not be provided due to lack of available direct care staffing in the home.*

- *Resident* [redacted] *waited 3 hours (hr.) and 0 minutes (min.) on* [redacted] *at 9:06 AM and 1 hr. 22 min. on* [redacted] *at 1:02 PM,*
- *Resident* [redacted] *waited 3 hr. 28 min. on* [redacted] *at 2:42 PM and 4 hr. 1 min. on* [redacted] *at 10:21 AM,*
- *Resident* [redacted] *waited 1 hr. 34 min. on* [redacted] *at 10:08 AM and 3 hr. 13 min. on* [redacted] *at 11:38 AM,*
- *Resident* [redacted] *waited 3 hr. 48 min. on* [redacted] *at 3:31 AM and 15 hr. 31 min. on* [redacted] *at 7:30 AM,*
- *Resident* [redacted] *waited 3 hr. 9 min. on* [redacted] *at 7:24 AM and 58 min. on* [redacted] *at 1:38 PM.*

*Repeat Violation:* [redacted] *et al.*

**Plan of Correction** ***Accept*** [redacted] ***- 11/21/2025)***

*The Pinnacle completed an all-staff training on the Call Bell Policy prior to June 30th, 2025, and again before September 30th, 2025, to embrace the importance of timely responsiveness in meeting the resident's needs.*

## *60a - Staff/Support Plan (continued)*

*New equipment was purchased to address identified failures in call bell response this includes pagers, walkie talkies and pendants.*

*The previous response hierarchy in which Care Staff were informed of call bells by the Medication Technician has been replaced and enhanced to include all Medication Technicians and Care Staff having pagers for immediate awareness of resident need.*

*The Pinnacle has identified that the current call bell systems software is delayed and antiquated, and the system needs a full upgrade. This upgrade has been approved for capital expense, and the vendor has been contacted to schedule a technician.*

*Call bell response times are reviewed and posted for all staff in the staff lounge daily to keep resident service at the forefront of our process improvement efforts.*

*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:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 65b - Rights/Abuse 40 Hours

**6. 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 A completed their 40th scheduled work hour by February 2025. 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.*

*Repeat Violation:* [redacted]

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The new Business Office Manager started on August 12th, 2025 and was trained to this standard on August 12th, 2025.*

*All new employee files will be audited by The Business Office Manager, or Designee, by December 15th, 2025, for compliance with this standard.*

## *65b - Rights/Abuse 40 Hours (continued)*

*All staff completed an all-day training in August 2025 per the regulatory requirements of 2600.65 as they pertain to annual training requirements. Another all-day training course will be planned before December 31st, 2025, to focus on all new hire training requirements for anyone that missed past onboarding training, as many of the new hire requirements and annual requirements are in close alignment. This will be considered our compliance initiative for all the 2023, 2024 and early 2025 onboarding requirements that have been missed by previous administrations efforts.*

*The Business Office Manager, or Designee, will audit all new hires monthly as part of the Quality Assurance process to be sure that we are compliant with all new hire standards as imposed by the Regulatory Process.*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented [redacted] - 01/05/2026)***

## 65f - Training Topics

**7. 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.
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 B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.*

*Repeat Violation: [redacted] et al.*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*Staff person B is no longer employed at The Pinnacle.*

*The Business Office Manager will be retrained on Chapter 2600.65f guidelines by the Executive Director by November 30th, 2025.*

*All staff completed an all-day training in August 2025 per the regulatory requirements of 2600.65 as they pertain to annual training requirements. Another all-day training course will be planned before December 31st, 2025, to focus on all new hire training requirements for anyone that missed past onboarding training, as many of the new hire requirements and annual requirements are in close alignment.*

## *65f - Training Topics (continued)*

*A complete audit of all training files will be completed to comprehensively review any missing training courses. The all-day training scheduled by December 31st, 2025, will be added to the file for all staff to cover missing onboarding or annual training from the past.*

*The Relias training system continues to be used to augment in person training and support regulatory compliance.*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented ( - 01/05/2026)***

## 82c - Locking Poisonous Materials

**8. 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**

*Several items were found unlocked, unattended, and accessible to residents of the memory care unit (Garden House) because the door to the medication station was broken and could not be closed and locked. The Garden House residents are not capable of recognizing and using poisons safely. These items included:*

- *Gel Rite Hand Sanitizer, with a manufacture's label indicating " In case of ingestion, contact a physician or poison control center right away".*
- *Derma Wound Cleanser with a manufacturer's label indicating "if swallowed, please contact poison control."*

*Repeat Violation: et al.*

**Plan of Correction** ***Accept - 11/21/2025)***

*The door to medication station was repaired on 9/23/25 when found by the surveyors. The survey team was made aware of the repair during their visit on 9/24/25.*

*All staff were trained by September 30th, 2025, in the use of the online work order system, TELS, to request need of repair in a resident's room or throughout the community to avoid potentially hazardous situations.*

*Housekeepers are required to audit the residents' rooms weekly for outstanding items in need of repair or maintenance attention. Managers on Duty are required to complete common area audits every weekend and report items in need of repair in the community at large.*

*All "poisonous items were removed from the unlocked area upon identification and returned to the locked area on 9/24/25 after the door was repaired.*

*All staff were trained on Identifying and Securing Poisonous Materials in June of 2025 and magnetic secured locks were added to all resident bathrooms in SDCU to avoid potentially hazardous situations.*

*The timely completion of work orders entered into the TELS system is monitored by the Facilities Director, Executive Director and Regional support positions.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

## 82c Locking Poisonous Materials *(continued)*

***Implemented [redacted] 01/05/2026)***

## 95 Furniture and Equipment

**9. Requirements**

2600.
95. Furniture and Equipment Furniture and equipment must be in good repair, clean and free of hazards.

**Description of Violation**

*The door jamb to the medication station in Garden House was damaged and the door was unable to close and/or lock.*

**Plan of Correction** ***Accept ([redacted] - 11/21/2025)***

*The door to medication station was repaired on 9/23/25 when found by the surveyors. The survey team was made aware of the repair during their visit on 9/24/25.*

*All staff were trained by September 30th, 2025, in the use of the online work order system, TELS, to complete requests for work order requests for items in need of repair in a resident's room or throughout the community to avoid potentially hazardous situations.*

*Housekeepers are required to audit the residents' rooms weekly for outstanding items in need of repair or maintenance attention. Managers on Duty are required to complete common area audits every weekend and report items in need of repair in the community at large.*

*The timely completion of work orders entered into the TELS system is monitored by the Facilities Director, Executive Director and Regional support positions.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 105f Labeling/Return of Clothes

**10. 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**

*The home does not have a system to safeguard resident laundry from loss. Several piles of unattended, unlabeled clothes were observed in the 3rd floor laundry room.*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*All Staff have been trained on regulatory laundry protocols by November 7th, 2025.*

*The Pinnacle used a whiteboard system for laundry management on each floor/laundry room. The Pinnacle will be upgrading this system using magnetized laminated room numbers stored by floor on magnetic boards. Housekeeping and Laundry staff members will be educated by the Wellness Director, or Designee, to place the room number magnet for the resident's room on top of the basket of laundry when it enters the laundry room. When items are placed into the washer the magnet will be moved onto the washing machine and rotated to the dryer.*

## *105f - Labeling/Return of Clothes (continued)*

*The magnet will be replaced on the primary whiteboard at the end of the wash and folding cycle for use the next time. Items will be immediately returned to the resident after folding, regardless of shift, this is a process change, as returning of laundry has been shift dependent. If the resident is asleep, items will be placed in the residents sanitized basket outside of the resident's door, enabling the staff member to take the laundry into the resident and put it away during the next care interaction ie: answer of a call bell, medication disbursement or shift care.*

*The Wellness Director, or Designee, will complete a weekly audit of each laundry room to ensure the system is being effectively utilized for 60 days.*

*The Executive Director, or Designee, will meet with the Personal Care residents monthly at Personal Care Resident Roundtable/Council Meeting to specifically question the success of laundry processes and document results for the next 90 days.*

*Residents will also be reminded of the Grievance Process at the upcoming November Roundtable meeting, to ensure immediate resolutions to any issues, especially as related to laundry in this instance. Staff will be retrained to the Grievance and Concern Process in November 2025 to reinforce timely resolution to all concerns.*

*Results of this Plan of Correction and Grievances will be reviewed as part of the Quality Assurance process, per Meridian Senior Living guidelines for the next 90 days.*

**Licensee's Proposed Overall Completion Date:** *11/28/2025*

***Implemented [redacted] - 01/05/2026)***

## 105g - Lint Removal and Duct Cleaning

**11. 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 [redacted], there was a significant accumulation of lint in the lint trap of both of the dryers in the 3rd floor laundry room. There were no clothes in the dryers at the time.*

*Repeat Violation.[redacted] et al.*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The filters were immediately cleaned once identified.*

*A lint removal log was previously implemented for the 11 to 7 shift, who are responsible for the bulk of laundry service at The Pinnacle. This log has been extended to include signatures by all three nursing shifts for checking the lint traps in the laundry room.*

*The Housekeeping staff are also responsible for checking the laundry room daily to ensure that the lint filters are clean and sanitary to prevent potential fires.*

## *105g - Lint Removal and Duct Cleaning (continued)*

*All staff have been retrained on the regulatory requirements surrounding laundry service and lint cleaning. This all-staff training was completed by November 1st, 2025, to stress the importance of all team members checking the lint traps as they pass or enter the laundry rooms to prevent potentially hazardous conditions.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 121a - Unobstructed Egress

**12. 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 [redacted] at approximately 9:35 AM, it was noted that the door leading to the patio in Garden House is marked "Not an Exit". However, the patio does have a hidden exit door with an "Exit" sign hanging on the door. There is no handle on the "inside" of the door, facing the patio, but there is a handle and a lock on the "outside" of the door meaning it could be locked from the outside.*

*Repeat Violation: [redacted] et al.*

**Plan of Correction** ***Accept ([redacted] 11/21/2025)***

*The Pinnacle has removed all signs noting that the Garden House patio is not an exit.*

*The Pinnacle will install Exit signage clearly delineating the patio as a point of exit from the community.*

*The schematics in Garden House will also be updated to demonstrate this as one of the four points of exit from Garden House, since the magnetic locking system automatically disengages when the fire alarm is engaged, per regulatory policy.*

*The hidden patio exit door does not require a handle on the interior to open when disengaged. The door simply needs to be pushed. The handle on the outside of the door is required for use when the magnetic lock is disengaged, as it is the only means of opening the door from the exterior since the door swings outward.*

*The referenced "lock" is inaccurately identified in this citation, as the attached picture demonstrates. It is not a lock it is the mechanism for magnetic disengagement which is operable by using the internal patio keypad or fire system.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 133.2 - Exit Signs Direction

**13. Requirements**

2600.

## 133.2 - Exit Signs Direction *(continued)*

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

**Description of Violation**

*The patio door in Garden House, does not have a direct visual line to the nearest exit. In fact, this door is marked "Not an Exit". There are no signs marking the line of travel to the exits. On [redacted] the home served 107 residents.*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The Pinnacle has removed all signs noting that the Garden House patio is not an exit.*

*The Pinnacle will install Exit signage clearly delineating the patio as a point of exit from the community.*

*The schematics in Garden House will also be updated to demonstrate this as one of the four points of exit from Garden House, since the magnetic locking system automatically disengages when the fire alarm is engaged, per regulatory policy.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] - 01/05/2026)***

## 141a 1-10 Medical Evaluation Information

**14. Requirements**

2600.

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 [redacted] medical evaluation, dated [redacted] does not include allergy information.*

*Repeat Violation:* [redacted]

**Plan of Correction** ***Accept [redacted] 11/21/2025)***

*A comprehensive audit of all residents' medical evaluations was completed in August 2025 by the Wellness Director.*

*Each document requiring revisions 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 order to also prevent future citations for matters that predate the current staff members in the community, new DME's will be obtained for all residents by December 30th, 2025, for individuals admitted prior to July 1st, 2025,*

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

*when the new Wellness Director and Interim Executive Director started.*

*New residents admitted will be compliant with this regulatory requirement and the Wellness Director, or Designee, will audit all new admission and annual documentation per these regulatory guidelines for timely conferences with the families and residents.*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented ([redacted] - 01/05/2026)***

## 223a - Description of Service

**15. Requirements**

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

**Description of Violation**

*The home's current written description of services and activities at the home does not include the scope and general description of the services and activities that the home provides.*

**Plan of Correction** ***Accept ([redacted] - 11/21/2025)***

*The referenced policy has been submitted to the Meridian home office for review and compliance with Pennsylvania Chapter 2600 regulatory standards.*

*The new policy will include the scope and general description of the services and activities that the home provides.*

*All Department Managers and Sales Staff will be trained on the new policy for awareness and compliance to protect residents from seeking admission to The Pinnacle if this Personal Care Home is not able to meet their needs or serve them in a safe environment and to clarify the potential denial of admission or issuing discharges.*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented [redacted] - 01/05/2026)***

## 223b - Service Procedures

**16. Requirements**

2600.
223.b. The home shall develop written procedures for the delivery and management of services from admission to discharge.

**Description of Violation**

*The "Resident Handbook" indicates that the resident apartments are "equipped with a call service that is monitored 24 hours a day, seven days a week". Due to the multiple list of long wait times listed on the call bell report, some of which are listed in violation 60a, the home is not delivering this service as listed.*

## 223b - Service Procedures *(continued)*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The Pinnacle completed call bell policy training in June and September of 2025 to embrace and promote the timely responsiveness to resident's needs.*

*The Pinnacle purchased additional equipment (pagers, walkies and pendants) to address mechanism failure. The use of the equipment has also been expanded beyond just Medication Technicians carrying a pager and alerting the care team to pages. Beginning November 10th, 2025, the Care Staff also now carry pagers to expedite response time.*

*Call bell response times are reviewed and posted daily in the staff lounge to focus the entire team on improving response efforts.*

*Additionally, The Pinnacle has identified that the current call bell systems software is delayed and antiquated, and the system needs a full upgrade. This upgrade has been approved for capital expense, and the vendor has been contacted to schedule a technician.*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented [redacted] - 01/05/2026)***

## 227a - Support Plan 30 Days

**17. Requirements**

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

**Description of Violation**

*Resident [redacted] was admitted on [redacted] however, the resident's initial support plan was not completed until [redacted].*

*Repeat Violation: [redacted].*

**Plan of Correction** ***Accept [redacted] - 11/21/2025)***

*The Wellness Director completed a comprehensive audit of all resident support plans/assessments in August of 2025.*

*The resident's physical, cognitive and holistic needs were considered and resident support plans were updated accordingly. Each document requiring a revision was identified with a caveat statement concerning the Plan of Correction as the reason for the audit.*

*The Pinnacle continues to receive citations on documentation reflecting periods prior to the start of the Interim Executive Director or current Wellness Director. Therefore, a new support plan will be initiated for all residents by December 31st, 2025, as part of this initiative. This will be completed whether the resident is due for review or missing items are identified.*

*New residents admitted since this violation will be compliant with this regulatory requirement. New admissions will be audited by the Wellness Director, or Designee, for date of completion and full compliance for the next 90 days.*

## 227a Support Plan 30 Days *(continued)*

**Licensee's Proposed Overall Completion Date:** *12/31/2025*

***Implemented [redacted] - 01/05/2026)***

## 251c - Standardized Forms

**18. Requirements**

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

**Description of Violation**

*Resident #[redacted] DME, dated [redacted] was not completed on the Department's current standardized form.*

*Resident [redacted] DME, dated [redacted] was not completed on the Department's current standardized form.*

**Plan of Correction** ***Accept[redacted] - 11/21/2025)***

*The Interim Executive Director retrained the Wellness Director and Wellness Coordinator on the use of the new DME forms. All of the previous forms have been destroyed.*

*Resident [redacted] and Resident [redacted] DME's will be completed anew, by their current physicians, on the new forms. A caveat statement shall be noted in the resident's electronic health record and on the new DME referencing the Plan of Correction as the reason for initiation of the new DME to avoid altering the due date for further assessments.*

*All future DME's will be completed using the new form supplied by The Department. The Wellness Director, or Designee, will be responsible for reviewing the new admission paperwork for use of the standardized form.*

**Licensee's Proposed Overall Completion Date:** *12/01/2025*

***Implemented [redacted] 01/05/2026)***