pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ROYAL PCH**
LEGAL ENTITY

To operate **ROYAL PCH**
NAME OF FACILITY OR AGENCY

Located at **1339 WHEATSHEAF LANE, ABINGTON, PA 19001**
(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 **5**
(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 **December 17, 2025** until **June 17, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **153261**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 17, 2025

[redacted]
Royal PCH, LLC
1339 Wheatsheaf Lane
Abington, Pennsylvania 19001

RE: Royal Personal Care Home
License #: 153261

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on September 11, 2025 and October 23, 2025 of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because the home is new and not yet serving four or more residents.

In accordance with 55 Pa.Code § 2600.11(b) (relating to procedural requirements for licensure or approval of personal care homes, a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

During the inspection, citations on the enclosed Licensing Inspection Summary were found. All citations specified on the Licensing Inspection Summary must be corrected by the dates specified on the Licensing Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Your PROVISIONAL license is enclosed, based on substantial but not complete compliance with 55 Pa.Code Ch. 2600.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *Royal PCH* **License #**: *15326* **License Expiration**:

Address: *1339 WHEATSHEAF LANE , Abington, PA 19001*

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

Administrator

Name: [redacted]

Legal Entity

Name: *Royal PCH*

Address: *1339 WHEATSHEAF LANE , Abington, PA, 19001*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date**: *11/15/2023* **Issued By**: *Township of Abington*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *2* **Waking Staff**: *2*

Inspection Information

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

Reason: *New* **Exit Conference Date**: *09/11/2025*

Inspection Dates and Department Representative

09/11/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served**: *1*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *1*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

09/11/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/10/2025*

Inspections / Reviews *(continued)*

10/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/10/2025*

10/09/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/20/2025*

12/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

62 - Contact List

1. 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 A, the [redacted]r, does not maintain a list of staff persons.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Creation of Staff Contact List:
A comprehensive and current list of all staff persons, including substitute personnel and volunteers, has been created.
This list includes names, addresses, and telephone numbers for each individual.
Ongoing Maintenance:
The staff contact list will be reviewed and updated monthly, or immediately upon any staffing changes, to ensure accuracy and compliance.
Administrator Responsibility:
The administrator is responsible for maintaining and updating the staff contact list and will ensure it is readily accessible for review at all times.
Documentation:
The staff contact list will be stored in a secure but accessible location within the administrative office and will be available for inspection upon request.
Prevention of Recurrence:
The administrator has been retrained on the regulatory requirement to maintain an up-to-date staff contact list.
A reminder has been set in the administrator's calendar to review and update the list monthly.
Internal audits will be conducted quarterly to verify compliance.
Date of Full Compliance:
The staff contact list was created and implemented as of 09/11/25. Ongoing monitoring will ensure continued compliance.
Date of staff training: 09/12/25
Date of quarterly audit: 9/12/25

Licensee's Proposed Overall Completion Date: *10/08/2025*

Not Implemented [redacted] - 11/10/2025)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

There is an unattached garage present on the property that the home is currently using to store building material and tools, however the area was unlocked and accessible on 9/11/25. The garage was significantly cluttered with power tools, electric table saw, a wheelbarrow, empty water containers and buckets, cardboard, used materials such as dry wall, gutters, windows, cut lumber, vinyl fencing and garden edge pieces, gas cans, box springs and a mattress . There was no space to walk in or through the garage due to the amount of items piled and strewn across the floor of the

85a - Sanitary Conditions (continued)

garage creating an unsanitary, hazardous area.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Restricted Access:
Neither staff nor residents are permitted in the garage under any circumstances. Access is strictly limited to the Administrator and the Vice President. (owners)
The garage is now kept locked at all times when not in use by authorized personnel.

Ongoing Maintenance:
The Administrator or Vice President will conduct monthly inspections to ensure the garage remains locked.
A maintenance log will be kept to document inspections and any corrective actions taken.
Prevention of Recurrence:
Only the Administrator and Vice President have keys and access to the garage.
The garage will remain locked at all times except when in use by authorized personnel.
Regular inspections and documentation will ensure continued compliance with safety standards.
Date of Full Compliance: 10/03/25
The garage was brought into compliance as of 10/03/25. Ongoing monitoring will ensure continued adherence.
Date garage was cleaned: 10/03/25
Date dumpster will pick up remaining materials, and full compliance will be met: 10/13/25
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented [redacted] - 11/10/2025)

88a - Surfaces

3. 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

The glass shower door is missing in room 3. The metal hinges of the door stick out causing a hazard.

Plan of Correction ***Directed [redacted] - 10/09/2025)***

Corrective Actions Taken:

Immediate Hazard Removal:
The metal hinges and any remaining hardware from the shower door in room 3 have been removed to eliminate the hazard as of 10/01/25.
The glass shower door was not installed at the resident's request for that particular room.
Resident-Centered Approach:
The decision not to install the shower door was made in accordance with the resident's preference for room 3.
Future Prevention:
Going forward, hinges and hardware will not be installed until the shower door is ready to be put up or until installation is confirmed with the resident purchasing or occupying the suite.
All rooms will be inspected to ensure no similar hazards exist.

88a - Surfaces (continued)

Prevention of Recurrence:
Staff have been retrained to ensure that no hardware or hinges are installed unless the shower door is being immediately installed or the resident has confirmed their preference.
Maintenance protocols have been updated to require a final inspection of all surfaces and hardware before a room is considered ready for occupancy.
DATE OF TRAINING: 10/01/25
Frequency of inspection: Annually

Proposed Overall Completion Date: 10/08/2025

Directed POC-[redacted] - 10/9/25
Resident rooms and common areas shall be inspected by the administrator or designee at least monthly to ensure there are no hazards or surfaces that need repair. If an area is identified as needing repair, the repair shall occur within 10 calendar days of the observed hazard identification. Documentation of completed trainings, and completed initial and ongoing audits shall be kept and made available for Department review upon request.

Directed Completion Date: *10/08/2025*

Implemented ([redacted] - 11/10/2025)

89b - Hot Water Temperature

4. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 9/11/2025 at 10:42 AM the hot water temperature in room 34 measured 123.2 degrees Fahrenheit.

At 11:01 AM, the hot water temperature in room 3 measured 123.6 degrees Fahrenheit and at 1:13 PM it was 110.6 degrees Fahrenheit after the thermostat was adjusted by the home. as directed by an agent of the Department.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Thermostat Adjustment (Completed on 9/11/2025):
Upon notification, the thermostat was immediately adjusted on 9/11/2025 as directed by the Department agent.
Follow-up temperature checks confirmed that the hot water temperature in room 3 was reduced to 110.6°F, within the required range.
System-Wide Temperature Checks:
All resident-accessible areas were checked to ensure hot water temperatures did not exceed 120°F.
Any necessary adjustments were made to maintain compliance throughout the facility.
Purchase of Thermometers:
Thermometers were purchased for the home to ensure accurate and regular monitoring of hot water temperatures in all resident-accessible areas.
Documentation:
All temperature readings and corrective actions were documented and are available for review.

89b - Hot Water Temperature (continued)

Prevention of Recurrence:
Maintenance staff have been retrained on the regulatory requirement that hot water temperatures in resident-accessible areas may not exceed 120°F.
A schedule has been implemented for weekly hot water temperature checks in all resident-accessible areas using the newly purchased thermometers.
Any temperature readings above 120°F will be addressed immediately, and corrective actions will be documented.
DATE OF CHECK: 9/12/25
STAFF TRAINING: 9/12/25

Licensee's Proposed Overall Completion Date: *10/08/2025*

Not Implemented [redacted] - 11/10/2025)

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 closet between the kitchen and dining area does not include a breathing shield.

Additionally, the items for the first aid kit were not stored together in a portable container that could be easily transported in the event of an injury.

Plan of Correction ***Accept[redacted] - 10/08/2025)***

Corrective Actions Taken:
Breathing Shield Added (Completed on October 3, 2025):
A breathing shield was immediately purchased and added to the first aid kit to ensure compliance with requirements.
Portable First Aid Kit Assembled (Completed on October 3, 2025):
All required first aid items, including nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, and tweezers, were gathered and placed together in a new portable red cross bag
The portable first aid kit is now stored in the closet between the kitchen and dining area and is easily accessible and transportable in the event of an emergency.
Documentation:
The contents of the first aid kit have been inventoried and documented. The kit will be checked monthly to ensure all required items are present and in good condition.
Prevention of Recurrence:
Staff have been retrained on the regulatory requirements for first aid kits and the importance of maintaining all required items together in a portable container.
A monthly checklist has been implemented to verify the presence and condition of all first aid kit items.
Date of Full Compliance:
October 3, 2025
Responsible Person:
[redacted]

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

96a - First Aid Kit *(continued)*

Implemented [redacted] - 11/10/2025)

100a - Exterior - Free of Hazards

6. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 9/11/2025 at 10:07 AM, on the left side of the home, there was a grate missing on the window well behind an air conditioning unit creating a large square hole measuring approximately 2 feet by 3 feet and about 2 feet deep.

Plan of Correction ***Accept[redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Hazard Removal (Completed on September 11, 2025):
A temporary barrier was placed around the exposed window well immediately upon discovery to prevent access and eliminate the immediate hazard.
The grate was installed over the window well on September 11, 2025, restoring the area to a safe condition.
Inspection of Exterior Grounds:
A full inspection of the building's exterior and grounds was conducted to identify and address any other potential hazards.
Documentation:
The corrective actions and installation of the new grate have been documented and are available for review.
Prevention of Recurrence:
Maintenance staff have been retrained on the importance of regular inspections of the building exterior and grounds to ensure all areas remain in good repair and free of hazards.
Exterior inspections will be conducted monthly, and any hazards will be addressed immediately.
A maintenance log has been implemented to document inspections and corrective actions.
Date of Full Compliance:
September 11, 2025
Start date of monthly audit: 09/11/25
Monthly training Date: 9/12/25
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented [redacted] - 11/10/2025)

103f - Refrigerator/Freezer Temps

7. Requirements

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

Description of Violation

There was no thermometer in the refrigerator in the kitchen.
There was no thermometer in the freezer in the kitchen.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Installation of Thermometers (Completed on October 3, 2025):
Thermometers were purchased and installed in both the refrigerator and freezer in the kitchen on September 14, 2025, to ensure compliance with temperature monitoring requirements.
Temperature Monitoring:
Staff have been instructed to check and record refrigerator and freezer temperatures daily to ensure food is stored at safe temperatures (refrigerator at or below 40°F, freezer at or below 0°F).
Documentation:
Temperature logs have been implemented and will be maintained for review during inspections.
Prevention of Recurrence:
Staff have been retrained on the regulatory requirements for food storage temperatures and the necessity of having thermometers in all refrigerators and freezers.
The presence and functionality of thermometers will be checked during monthly kitchen inspections.
Date of Full Compliance:
September 29, 2025
Date of training: 9/14/25
Date audit began: 9/29/25
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented [redacted]S - 11/10/2025)

107d - Procedure Emergency Management Agency Submission

8. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been sent to local emergency management agency.

Plan of Correction ***Accept ([redacted] - 10/08/2025)***

Corrective Actions Taken:
Immediate Submission (Completed on September 12, 2025):
The home's current written emergency procedures were reviewed, updated as needed, and submitted to the local emergency management agency on September 19, 2025.
Documentation:
Confirmation of submission has been obtained and is kept on file for review during inspections.
Prevention of Recurrence:
The administrator has been retrained on the regulatory requirement to submit written emergency procedures annually.
An annual reminder has been set in the administrator's calendar to review, update, and submit emergency procedures to the local emergency management agency each year.
A compliance checklist has been updated to include this annual submission requirement.

107d - Procedure Emergency Management Agency Submission (continued)

Date of Full Compliance:
September 19 2025
Responsible Person:
[redacted]

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

Implemented [redacted] - 11/10/2025)

121a - Unobstructed Egress

9. 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 9/11/2025 at 9:55 AM, A large cinder block blocked egress from the home's basement emergency egress.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Removal of Obstruction (Completed on September 11, 2025):
The large cinder block was immediately removed from the basement emergency egress on September 11, 2025, restoring full, unobstructed access.
Inspection of All Egress Routes:
All stairways, hallways, doorways, passageways, and egress routes throughout the home were inspected to ensure they are unlocked and unobstructed.
Documentation:
The corrective action and inspection results have been documented and are available for review.
Prevention of Recurrence:
Staff have been retrained on the importance of keeping all egress routes unlocked and free of obstructions at all times.
Egress routes will be checked daily as part of routine safety rounds, and any obstructions will be addressed immediately.
A monthly safety checklist has been implemented to ensure ongoing compliance.
Date of Full Compliance:
September 11, 2025
date of training: 9/12
Date monthly check began: 9/29
Responsible Person:
[redacted]*l*

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented ([redacted] - 11/10/2025)

123b - Emergency Procedures Posted

10. Requirements

2600.

123b - Emergency Procedures Posted *(continued)*

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Posting of Emergency Procedures (Completed on September 19, 2025):
Copies of the home's current emergency procedures were posted on September 19, 2025, in conspicuous and public locations, including the main entrance, dining area, and staff office.
An additional copy is kept in the administrative office for reference and inspection.
Documentation:
The locations of posted emergency procedures have been documented and will be checked during routine inspections.
Prevention of Recurrence:
Staff have been retrained on the regulatory requirement to keep emergency procedures posted at all times in public and conspicuous places.
A monthly checklist has been implemented to verify that emergency procedures remain posted and up to date.
Date of Full Compliance:
October 3, 2025
date of training: 9/12
Date monthly check began: 9/29
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented [redacted] - 11/10/2025)

125a - Combustible Storage

11. Requirements

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

Description of Violation

A very dirty air filter and a was stored next to the HVAC system, and a package of paperwork was stored on top of the HVAC system in the second-floor closet.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Removal of Combustible Materials (Completed on September 11 2025):
The dirty air filter and package of paperwork were immediately removed from the area around and on top of the HVAC system on September 11 2025.
The area was cleaned and inspected to ensure no other combustible or flammable materials were present near the HVAC system or hot water heater.
Proper Storage Implemented:
All combustible and flammable materials are now stored in designated areas away from any heat sources or hot water heaters.

125a - Combustible Storage (continued)

Documentation:
The corrective actions and inspection results have been documented and are available for review.
Prevention of Recurrence:
Staff have been retrained on the regulatory requirement that combustible and flammable materials may not be stored near heat sources or hot water heaters.
Monthly inspections of all HVAC and hot water heater areas have been implemented to ensure ongoing compliance.
A maintenance checklist has been updated to include verification of proper storage of combustible materials.
Date of Full Compliance:
September 11, 2025
date of training: 9/12
Date monthly check began: 9/29
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Not Implemented [redacted] - 11/10/2025)

132a - Monthly Fire Drill

12. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill has not been held at the home.

Plan of Correction ***Accept ([redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Fire Drill Conducted (Completed on September 16, 2025):
An unannounced fire drill was conducted at the home on October 3, 2025, to ensure compliance with the requirement.
Fire Drill Schedule Implemented:
A schedule has been established to ensure that an unannounced fire drill is held at least once every month going forward.
Documentation:
All fire drills will be documented, including the date, time, and participants, and records will be maintained for inspection.
Prevention of Recurrence:
Staff have been retrained on the regulatory requirement for monthly unannounced fire drills.
A calendar reminder and compliance checklist have been implemented to ensure drills are conducted and documented each month.
Date of Full Compliance:
October 3, 2025
Date of training 9/12
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

132a - Monthly Fire Drill *(continued)*

Implemented [redacted] - 11/10/2025)

162c - Menus Posted

14. Requirements

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

Description of Violation

The home's menu for the week of 9/7/2025-9/13/2025 was posted. However, the menu for next week was not posted.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Posting of Weekly Menu (Completed on September 11, 2025):
The menu for the upcoming week was prepared and posted in a conspicuous and public place in the home on September 11, 2025, in accordance with regulatory requirements.
Menu Preparation and Posting Schedule:
A schedule has been implemented to ensure that menus are prepared and posted at least one week in advance, every week.
Documentation:
Copies of all weekly menus and posting dates will be maintained for review during inspections.
Prevention of Recurrence:
Staff responsible for menu planning and posting have been retrained on the requirement to prepare and post menus one week in advance in a public and conspicuous place.
A calendar reminder and compliance checklist have been implemented to ensure ongoing compliance with menu posting requirements.
Date of Full Compliance:
September 11, 2025
Date of training: 09/12/25
Date of use of checklist 9/12/25
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented [redacted] - 11/10/2025)

183b - Meds and Syringes Locked

15. 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 9/11/2025 at 10:29 AM, Melatonin 5 mg gummies, Fiberwell sugar free gummies and Senokot laxative gummies were unlocked, unattended, and accessible on the dining table in room one

183b - Meds and Syringes Locked (continued)

. Nystatin topical powder was also found unlocked and unattended in the bathroom of this unit.

At 10:48 unlocked medications including folic acid were found unlocked, unattended, and accessible in the 3rd floor bathroom.

Plan of Correction ***Accept [redacted] - 10/09/2025)***

Corrective Actions Taken:
Immediate Securing of Medications (Completed on September 11, 2025):
All prescription and over-the-counter medications, as well as topical powders and supplements, were immediately removed from accessible areas and secured in locked containers or medication storage areas on September 11, 2025.
Inspection of All Resident Areas:
A thorough inspection of all resident rooms and common areas was conducted to ensure that no medications or syringes were left unlocked or unattended.
Documentation:
The corrective actions and inspection results have been documented and are available for review.
Prevention of Recurrence:
All staff have been retrained on the regulatory requirement that all prescription medications, OTC medications, CAM, and syringes must be kept in a locked area or container at all times, including those in resident rooms.
Daily medication checks have been implemented to ensure compliance.
A compliance checklist has been updated to include verification of proper medication storage during routine rounds.
The frequency of checks is monthly
Date of Full Compliance:
September 11, 2025
date of training: 9/12
Date monthly check began: 9/29
Responsible Person:
[redacted]

Licensee's Proposed Overall Completion Date: *10/08/2025*

Not Implemented [redacted]S - 11/10/2025)

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

Facility Information

Name: *Royal PCH* **License #**: *15326* **License Expiration**:

Address: *1339 WHEATSHEAF LANE , Abington, PA 19001*

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

Administrator

Name: [redacted]

Legal Entity

Name: *Royal PCH*

Address: *1339 WHEATSHEAF LANE , Abington, PA, 19001*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date**: *11/15/2023* **Issued By**: *Township of Abington*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *2* **Waking Staff**: *2*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *10/23/2025*

Inspection Dates and Department Representative

10/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served**: *1*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *1*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

10/23/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/14/2025*

Inspections / Reviews *(continued)*

11/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/21/2025*

11/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/28/2025*

12/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

82c - Locking Poisonous Materials

1. 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

The home currently has one resident residing in the home. Resident # 1, has been assessed as incapable of recognizing and using poisons safely. On 10/23/25, the following was observed:

Smart Care Hand Sanitizer, with a manufacture's label indicating "if swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents near the window in the kitchen closest to the dining room.

Giant Brand Dishwasher Gel Detergent, with a manufacture's label indicating "if swallowed contact a physician or Poison Control Center immediately", was unlocked, unattended, and accessible to residents near the window in the cabinet under the kitchen sink.

Sensodyne Pronamel, with a manufacture's label indicating "if more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in Resident # 1's bathroom.

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

Plan of Correction:
The administrator immediately conducted a full sweep of the facility to identify and secure all poisonous materials. All such items are now stored in locked cabinets, inaccessible to residents.
Staff have been retrained on the policy for storing poisonous materials and will check daily to ensure compliance.
Documentation of daily checks will be maintained
. Completion date: 10/23/25
Staff Training Date: 10/31/25
Date Checks begin: 10/31/25

Licensee's Proposed Overall Completion Date: *11/20/2025*

Not Implemented [redacted] - 12/05/2025)

89b - Hot Water Temperature

2. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 10/23/25 at 10:36 A.M., the hot water temperature at the bathroom of bedroom 2 measured 125.4 degrees Fahrenheit.

On 10/23/25 at 10:44 A.M., the hot water temperature at the bathroom of bedroom 4 measured 127.9 degrees Fahrenheit.

89b - Hot Water Temperature *(continued)*

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

Thermostats on water heaters have been adjusted to ensure water temperature does not exceed 120°F.
Maintenance staff will check and record water temperatures weekly.
Staff have been retrained on the importance of monitoring water temperature for resident safety. Daily checks by the VP will also be conducted and recorded for added measures.
Completion Date: 10/23/2025 and ongoing.

Staff Training Date: 10/31/25

Date Checks begin: 10/24/25

Licensee's Proposed Overall Completion Date: *11/20/2025*

Not Implemented ([redacted] - 12/05/2025)

105g - Lint Removal and Duct Cleaning

3. 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 10/23/25, there was an approximate 1 inch accumulation of lint in the lint trap of the right dryer. There were no clothes in the dryer at the time.

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

The lint trap was cleaned immediately by the staff.
Staff have been retrained to clean the lint trap after every use and to document each cleaning as per regulation. A cleaning chart checklist is maintained in the laundry room for documentation. A weekly inspection of dryer vent ducts will be performed and logged by the administrator as well as the care staff.
Completion Date: 10/23/2025 and ongoing.
Staff Training Date: 10/31/25
Date Checks begin: 10/31/25

Licensee's Proposed Overall Completion Date: *11/20/2025*

Not Implemented ([redacted] - 12/05/2025)

125a - Combustible Storage

4. Requirements

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

Description of Violation

On 10/23/25 a plastic bag containing the paper manufacturer's instructions for the HVAC system was observed on top of the HVAC system in the basement.

125a - Combustible Storage *(continued)*

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

The plastic bag and all combustible materials were removed from the HVAC area immediately.
The Staff have been retrained by the admin. on the proper storage of combustible materials.
Monthly checks of all heat sources and water heaters will be conducted to ensure compliance. The checklist has been updated to reflect the weekly maintenance checklist by the administrator
Completion Date: 10/23/2025 and ongoing.

Staff Training Date: 10/31/25
Date Checks begin: 10/31/25

Licensee's Proposed Overall Completion Date: *11/20/2025*

Not Implemented [redacted] 12/05/2025)

132d - Evacuation

5. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 9/4/25 at 11:00 A.M., residents evacuated to a public thoroughfare or public area. The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills: 9/24/25 and 10/15/25. Both dates indicate that it took 3 min to evacuate the building.

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

Staff have been retrained on evacuation procedures to ensure a timely and safe evacuation by the home's administrator.
Additional fire drills have been conducted, and all recent drills have been completed within the required time frame as per regulations.
Documentation of all fire drills, including times and staff participation, is being maintained.
A certified fire safety expert will be contacted to assess and specify a maximum safe evacuation time in writing, as required by regulation.
Documentation of drills and the expert's assessment will be maintained for compliance.
Completion Date: 11/17/2025
Staff Training Date: 10/31/25
Dates of additional drills:
Date a fire safety expert to assess safe evacuation: Next available date 11/26 as per the fire department.

Licensee's Proposed Overall Completion Date: *11/20/2025*

Not Implemented [redacted] - 12/05/2025)

183b - Meds and Syringes Locked

6. Requirements

2600.

183b - Meds and Syringes Locked *(continued)*

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 10/23/25 at 11:30 A.M., two gray medication boxes were unlocked, unattended, and accessible in the medication closet. The medications included in the gray medication boxes were:

1. Trazadone 50 mg
2. Senokot Laxatives
3. Melatonin 5mg
4. Memantine 10 mg

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

All medication boxes are now kept locked at all times.
A double lock system has been implemented for all areas where medications and syringes are stored, ensuring two separate locking mechanisms must be opened to access medications.
Staff have been retrained on medication storage policies and the new double lock procedure.
Daily checks of medication storage areas will be documented to ensure both locks are engaged at all times.
Completion Date: 10/23/2025 and ongoing.
Supporting Documentation:
Staff training logs, daily/weekly/monthly checklists, maintenance logs, and compliance.
Ongoing checks will be performed by the administrator

Completion Date: 11/17/2025

Staff Training Date: 10/31/25

Licensee's Proposed Overall Completion Date: *11/20/2025*

Not Implemented ([redacted] - 12/05/2025)