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

January 2, 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 11/10/2025 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**: *137* **Waking Staff**: *103*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *11/10/2025*

Inspection Dates and Department Representative

11/10/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *81*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *19* **Residents Served**: *17*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *81*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *56* **Have Physical Disability**: *0*

Inspections / Reviews

11/10/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/22/2025*

12/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/02/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/06/2026*

Inspections / Reviews *(continued)*

01/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/02/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at approximately 6:00 pm, resident [redacted] fell in the Garden House hallway while returning to their room from dinner. This incident was most closely observed by staff person A, who immediately reported that resident [redacted] had pushed down resident [redacted] However, this allegation of abuse was not reported by the home until [redacted] at 11:30 pm.

Plan of Correction ***Accept [redacted] - 12/22/2025)***

Resident reported several times that [redacted] "fell over [redacted] own feet." Statements from all staff on scene corroborate that Resident [redacted] did not have [redacted] walker present at the time of fall. The walker needed to be retrieved by staff, from [redacted] room, status post fall.

A comprehensive investigation of all staff on SDCU at the time of the fall, did not substantiate staff person A's claim. In fact, other witnesses watched Resident [redacted] leave [redacted] doorway and attempt to assist the resident off the floor, fulfilling [redacted] previous life service role working with the public. Staff person A failed to write a statement regarding [redacted] immediate verbalization regarding the potential of resident [redacted] pushing resident [redacted] while walking to the scene of the fall, as requested by the Memory Care Director. [redacted] statement alleging a push by resident [redacted] was made prior to resident [redacted] explaining at least two times that [redacted] indeed tripped over [redacted] feet. Staff member A's failure to mention the claim again while on scene, or after the resident explained the fall and failure to provide a statement led all staff present who reported to the scene along with staff person A to believe that staff persons A's assumptive verbalization was not based on fact or reality. In fact, no other staff members present note hearing residents [redacted] supposed comments of "damn right, I pushed them and I told them to stop touching my stuff" as alleged in 42b of this report. The claim of a "push" did not reservice again until staff member A was overheard coaching resident [redacted] regarding "what to do if someone pushes [redacted] on 10/23/25 in the dining room at dinner. Statements were obtained and the claim was reported at that time.

The Pinnacle conducted staff training regarding allegations of abuse and reporting protocols in April, July, September and November of 2025. The Pinnacle has been reporting allegations of abuse to Protective Services and The Bureau of Human Services Licensing. A comprehensive Abuse Log is being maintained to identify trends and interventions. Training on abuse and incident reporting will be enacted again as part of The Pinnacle's all day inservice training initiative in December of 2025.

Beginning in the calendar year 2026, abuse identification and reporting will be conducted upon hire and annually for all staff.

A formal grievance process has been enacted as a means of tracking concerns and complaints for all residents. A Grievance log is maintained to allow for easy identification of trends and issues for early intervention and root cause analysis. Grievance training occurred in July and November of 2025. Grievance forms are available at The Wellness Station and Front Desk for residents, visitors and families.

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

Implemented [redacted] - 01/02/2026)

42b - Abuse

2. 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 6:00 pm, resident [redacted] was in the Garden House hallway, walking from the dining room to their apartment after dinner, when resident [redacted] pushed resident [redacted] to the floor. Resident [redacted] then stood over resident [redacted] holding resident [redacted] arm as if to help pull the resident up off the floor, but was also interfering as staff attempted to attend to resident [redacted] on the floor. When staff asked if resident [redacted] pushed resident [redacted] resident [redacted] responded by stating "damn right, I pushed [them]." and "I told [them] to stop touching my stuff." Immediately after the fall, resident [redacted] initially told staff that they tripped over their own feet, causing them to fall, however, once staff brough resident [redacted] back to their room, resident [redacted] then reported that resident [redacted] had actually pushed them. Resident [redacted] assessment and support plan dated [redacted] indicates that resident [redacted] has exhibited disruptive behaviors requiring additional attention and can be verbally aggressive, but there is no indication that resident [redacted] has a need related to physical aggression. The plan to support resident 2's needs related to behavioral expressions listed only as observe an report to nursing, with no indication of any other additional attention or supervision.

The home did not perform an assessment of resident [redacted] following the fall on [redacted], resident 2's assessment and support plan was updated on [redacted] following the incident.

Plan of Correction ***Accept ([redacted] - 12/22/2025)***

Resident reported several times that [redacted] "fell over [redacted] own feet." Statements from all staff on scene corroborate that Resident [redacted] did not have [redacted] walker present at the time of fall. The walker needed to be retrieved by staff, from [redacted] room, status post fall.

A comprehensive investigation of all staff on SDCU at the time of the fall, did not substantiate staff person A's claim. In fact, other witnesses watched Resident [redacted] leave [redacted] doorway and attempt to assist the resident off the floor, fulfilling [redacted] previous life service role working with the public. Staff person A failed to write a statement regarding [redacted] immediate verbalization regarding the potential of resident [redacted] pushing resident [redacted] while walking to the scene of the fall, as requested by the Memory Care Director. [redacted] statement alleging a push by resident [redacted] was made prior to resident [redacted] explaining at least two times that [redacted] indeed tripped over [redacted] feet. Staff member A's failure to mention the claim again while on scene, or after the resident explained the fall and failure to provide a statement led all staff present who reported to the scene along with staff person A to believe that staff persons A's assumptive verbalization was not based on fact or reality. In fact, no other staff members present note hearing residents [redacted]s supposed comments of "damn right, I pushed them and I told them to stop touching my stuff" as alleged in 42b of this report. The claim of a "push" did not reservice again until staff member A was overheard coaching resident [redacted] regarding "what to do if someone pushes [redacted] on [redacted] in the dining room at dinner. Statements were obtained and the claim was reported at that time.

On [redacted] Staff Member A also claimed that [redacted] and another staff member, brought resident [redacted] back to [redacted] room and at that time resident [redacted] reported that resident [redacted] had pushed [redacted] However, staff person A's peer indicates that [redacted] did not accompany Resident [redacted] to [redacted] room after the fall [redacted] went to the dining room. This same peer also reported that resident [redacted] "never reported resident [redacted] for being violent to [redacted] any other time, not even later that night."

42b - Abuse (continued)

Resident [redacted]s [redacted] support plan did not indicate issues related to physical aggression as this alleged incident of physical aggression occurred on [redacted]. Residents support plans will now address need and interventions related to physical expressions. As indicated in this citation, the support plan for resident [redacted] was updated status post this incident.

The Memory Care Director completed an assessment of resident [redacted] immediately after the incident on [redacted]. Proof of this assessment is documented in the Memory Care Director's statement of the [redacted] incident, as provided to The Department during their visit on [redacted] Additional documentation for this immediate assessment, as mentioned in the Memory Care Director's initial statement, was also requested and provided via email from the electronic health record on [redacted] to The Department.

The Pinnacle conducted staff training regarding allegations of abuse and reporting protocols in April, July, September and November of 2025. The Pinnacle has been reporting allegations of abuse to Protective Services and The Bureau of Human Services Licensing. A comprehensive Abuse Log is being maintained to identify trends and interventions.

Training on abuse and incident reporting will be enacted again as part of The Pinnacle's all day Inservice training initiative in December of 2025.

Beginning in the calendar year 2026, abuse identification and reporting will be conducted upon hire and annually for all staff.

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

Implemented ([redacted] - 01/02/2026)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person A was hired [redacted]. However, this staff person did not complete training on emergency medical plan.

Plan of Correction ***Accept ([redacted] 12/22/2025)***

The new management team started mid-June of 2025. The new Business Office Manager started on August 12th, 2025 and was trained to this standard on date of hire.

All new employee files were audited by the Regional Director of Operations for adherence to this standard and noncompliant files were identified.

All staff completed an all-day training in August 2025 per the regulatory requirements of 2600.65 as they pertain to annual training standards. Another all-day training course is planned before December 31st, 2025 to focus on repeating all regulatory 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 onboaring requirements that have been missed by previous

65b Rights/Abuse 40 Hours (continued)

administration's efforts.

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

Implemented [redacted] - 01/02/2026)

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 [redacted] at 9:48 am, there was a trail of circular brown stains on the carpet in the Garden House hallway of resident rooms, on the side of the unit that is on the left when entering.

Plan of Correction ***Accept [redacted] 12/22/2025)***

This issue was not identified as part of the Exit Summary conducted with The Department on 11/10/25. However, there is no current trail of circular brown stains on the carpet in SDCU.

Housekeeping will extract all common area carpets in SDCU by December 31st, 2025 as an additional preventative initiative, even though the referenced stains no longer exist at this time.

All staff were trained in the use of TELS Maintenance system in September of 2025, as a means of reporting any Maintenance or Housekeeping issues throughout the building in a timely manner. This training will be repeated, prior to December 31st, 2025, to enable The Pinnacle to be proactive in addressing surface and cleanliness issues versus reactive.

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

Implemented [redacted] - 01/02/2026)

141b1 - Annual Medical Evaluation

5. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] s most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept [redacted] - 12/22/2025)***

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

New DME's are being obtained for all residents by December 30th, 2025 for individuals admitted prior to July 1st, 2025 to address all of the prior period issues with outstanding or incomplete DME's. Resident [redacted] will be included in this initiative.

141b1 - Annual Medical Evaluation (continued)

Each document requiring revisions will be permanently 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 on the same document or regulation.

New residents admitted will be compliant with this regulatory standard and the Wellness Director, or Designee, will audit all new admissions and annual documentation per these regulatory guidelines for timely completion of Medical Evaluations.

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

Implemented [redacted] - 01/02/2026)

227g -Support Plan Signatures

6. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] participated in the development of their support plan on [redacted]. However, the resident did not sign the support plan, and there was no indication that the resident was unable or refused to sign.

Resident [redacted] participated in the development of their support plan on [redacted] However, the resident did not sign the support plan, and there was no indication that the resident was unable or refused to sign.

Plan of Correction ***Accept ([redacted] - 12/22/2025)***

Resident [redacted] Point Click Care Assessment and Support Plan were completed on [redacted]

The Pinnacle houses the resident assessment and Support Plans together as a comprehensive document. SDCU resident [redacted] signed the front of the assessment versus the actual Support Plan when the new document was completed. Resident was not unable to sign, nor did [redacted] refuse to sign the document [redacted] just provided [redacted] signature on an alternative page. Proof of this was submitted at time of survey and the surveyor scanned this to himself as part of the survey process.

Should this occur again with a confused resident, Pinnacle staff will write on the Support Plan in the signature section, that the resident provided signature, see front page of the assessment. The Executive Director will train the Wellness Coordinator and Wellness Director to this expectation by [redacted] to always prove compliance with the expectation of residents signing the Support Plan.

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

Implemented [redacted] - 01/02/2026)

252 - Record Content

7. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

On [redacted] resident[redacted] record did not include the resident's eye color, hair color, or distinguishing marks.

Plan of Correction ***Accept ([redacted] - 12/22/2025)***

The Pinnacle has collected this vital distinguishing information for every Personal Care resident.

The Pinnacle has worked with our IT Department and Point Click Care to ensure that this information will be reflected on the face sheet for every Personal Care resident.

The Wellness Director, or Designee, will input all of this information for all residents in Personal Care by December 31st, 2025 and print new face sheets for each chart.

This vital descriptive information will be obtained at point of admission for all new residents and will be reflected on all face sheets from time of admission henceforth.

The Wellness Director, or Designee, will audit three charts per month for the next thirty days to ensure compliance.

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

Implemented ([redacted] 01/02/2026)