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

April 10, 2026

DOUGLASSVILLE AID II OPCO LLC

RE: AMITY PLACE
139 OLD SWEDE ROAD
DOUGLASSVILLE, PA, 19518
LICENSE/COC#: 22656

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/07/2026 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,

Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *AMITY PLACE* **License #**: *22656* **License Expiration**: *10/18/2026*

Address: *139 OLD SWEDE ROAD, DOUGLASSVILLE, PA 19518*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *DOUGLASSVILLE AID II OPCO LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/12/2009* **Issued By**: *Amity Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *49* **Waking Staff**: *37*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *01/07/2026*

Inspection Dates and Department Representative

01/07/2026 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *40*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *9* **Have Physical Disability**: *0*

Inspections / Reviews

01/07/2026 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/14/2026*

03/03/2026 - POC Submission

Submitted By: **Date Submitted**: *04/09/2026*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/10/2026*

Inspections / Reviews *(continued)*

03/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/01/2026*

04/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2026*

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

65f - Training Topics

1. 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

Staff person A hired, DOH [redacted] had no annual training in medication self-administration, meeting the needs of the residents as described in the preadmission screening form, assessment tool or medical evaluation and support plan, care for the residents with dementia and or cognitive impairments, infection control, personal care service needs, safe management techniques, in training year 2025.

Staff B, DOH [redacted], had no annual training in medication self-administration, meeting the needs of the residents as described in the preadmission screening form, assessment tool or medical evaluation and support plan, care for the residents with dementia and or cognitive impairments, infection control, personal care service needs, safe management techniques, in training year 2025.

Staff C, DOH [redacted], had no annual training in medication self-administration, meeting the needs of the residents as described in the preadmission screening form, assessment tool or medical evaluation and support plan, care for the residents with dementia and or cognitive impairments, infection control, personal care service needs, safe management techniques, in training year 2025.

Repeat violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 03/18/2026)***

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• Immediate Resolution: Re did annual training to meet regulations topics. July 8, 2026. Staff members recognized on January 7th were established as staff members needing yearly training. March 13, 2026 staff members were sent training needed for 2025 year.
• Training Plan: On January 8, 2026 A yearly training calendar is posted a prior year to keep all staff inform of mandatory training.
• Monitoring & Audit Plan: A monthly audit of staff training records will be conducted to identify upcoming due dates at least 60 days in advance. All ancillary departments (housekeeping, dietary, maintenance) will be added to the automatic reminder list for required annual training. Plan is every last Wednesday of each month of 2026 to hold required training to maintain a yearly compliance.

65f Training Topics (continued)

• Sustainability Plan: The Administrator and the BOM are responsible for monitoring annual training requirements and ensuring all staff including ancillary personnel complete required training on time.

Licensee's Proposed Overall Completion Date: *03/11/2026*

Implemented [redacted] 04/10/2026)

65g - Annual Training Content

2. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff members A, B, C hired on [redacted] did not receive their annual trainings in Fire safety by fire safety expert, Emergency Preparedness procedures, Residents' Rights, Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), Falls and accident prevention during training year of 2025.

Repeat violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 03/18/2026)***

65 Ancillary Staff Training
Violation: An ancillary staff member did not have documentation of required annual training for the current calendar year.
• Immediate Resolution: The ancillary staff member was immediately removed from duty until all required annual training topics were completed. This specific staff member is employed as a when needed employee. Moving forward from date of March 13, 2026. Staff members were assigned training for completion within seven calendar days.
• Training Plan: A yearly training calendar is posted a prior year to keep all staff inform of mandatory training. On January 8, 2026 A yearly training calendar is posted a prior year to keep all staff inform of mandatory training.
• Monitoring & Audit Plan: A monthly audit of staff training records will be conducted to identify upcoming due dates at least 60 days in advance. All ancillary departments (housekeeping, dietary, maintenance) will be added to the automatic reminder list for required annual training.
• Sustainability Plan: The Administrator and the BOM are responsible for monitoring annual training requirements and ensuring all staff including ancillary personnel complete required training on time.

Licensee's Proposed Overall Completion Date: *03/11/2026*

Implemented [redacted] - 04/10/2026)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Room# [redacted] utilizes a bedside mobility device. The device was able to be moved 6 inches to the left and right, horizontally to the bed.

Room [redacted] utilizes a bedside mobility device. The device was out 3 inches from the bed, and able to be moved back and forth away from the bed.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

81b – 2600.81(b) - Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.
Violation: Trash bag sitting under sink in common bathroom
• Immediate Resolution: The issue involving the identified resident(s) was corrected 01/07/26
• Training Plan: Wellness and management staff will monitor A standardized checklist was developed to ensure all required components under PA DHS 81(b) are met consistently. March 15, 2026 training plan will state what to look for when residents have devices.
• Monitoring & Audit Plan: Starting March 16, 2026 A second-level review by the Administrator and or Director of nursing will occur prior to finalization of applicable documentation. Current and future residents will have a sheet task sheet of safety monitoring. Starting March 16, 2026 Current residents with device will have an inspection sheet of their device and clearance.
• Sustainability Plan: Weekly audits will be conducted for 30 days.

Licensee's Proposed Overall Completion Date: *03/16/2026*

Implemented ([redacted] - 04/10/2026)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Room # [redacted] did not have a light source that could be reached from the bedside.

Plan of Correction ***Accept [redacted] 03/18/2026)***

Resident did not have a light source next to [redacted] bed
• Immediate Resolution: On January 8, 2026 Maintenance staff conducted a room-by-room inspection and repaired or replaced the inoperable bedside lamp(s) for the resident(s) identified during the inspection. The affected resident was provided with fully functional bedside lighting before the close of the same day.
• Training Plan: On March 17, 2026 A new Lighting Safety Checklist was added to monthly room inspections conducted by the Administrator, Maintenance, Housekeeping staff
• Monitoring & Audit Plan: The Administrator or designated staff will complete monthly audits of all resident

101j7 Lighting/Operable Lamp (continued)

rooms to confirm each bedside lamp/light is functioning.
• Sustainability Plan: Any found deficiencies will be corrected within 24 hours and reviewed with maintenance to ensure timely response. Starting the week of March 16, 2026 a room ready sheet will be available to use for current and future residents.

Licensee's Proposed Overall Completion Date: *03/17/2026*

Implemented ██ - 04/10/2026)

103e - Left Overs

5. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

In the activities room refrigerator, there was 1 open container of vanilla ice cream, 1 open container for chocolate and vanilla ice cream with no label or date on it. There were also 2 containers of open Leiby's ice cream that were undated.

In the kitchen walk in refrigerator, there were 5 pies with no label or date.

Plan of Correction ***Accept (██ - 03/18/2026)***

Violation: Cup of juice in bistro fridge and frozen chicken in walk in not labeled and dated (updated purchased refrigerator locks to be controlled by management team now) All left overs removed or monitor.
• Immediate Resolution: juice removed and chicken labeled and dated. Any items not properly labeled, dated, or stored were discarded immediately.
• Training Plan: On March 17, 2026 Kitchen staff were re educated verbally on proper procedures on the day of the inspection. Dining supervisor starting week of March 16, 2026 performed a full sanitation check to ensure compliance with food safety standards.
• Monitoring & Audit Plan: The Dining Supervisor or designee will conduct a daily refrigerator inspection to ensure: All leftovers are properly labeled and dated No items are kept past the allowable time.
• Sustainability Plan: Starting the week of March 16, 2026 A weekly audit log will be maintained and reviewed by the Dining room Director, Dining Supervisor and or Administrator.

Licensee's Proposed Overall Completion Date: *03/16/2026*

Implemented ██ - 04/10/2026)

130e - Hearing Impairment

6. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

130e - Hearing Impairment *(continued)*

Description of Violation

Resident ■ is unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that Resident ■ is alerted in the event of a fire.

Plan of Correction ***Accept (■ - 03/18/2026)***

• Immediate Resolution - On January 31, 2026 a purchase of Lifetone Bed Shaker for resident. The device was verified to be operational and functioning properly.
Training plan Wellness staff members and Management staff will be and have been trained on device. On February 12, 2026 staff were educated of device and how the device is monitored during audible alarm.
The Administrator or designee will conduct quarterly audits of:

Resident assessments indicating sensory impairment.

Installation logs of alerting devices.

Fire alarm system compatibility checks

Any identified concerns will be corrected immediately.

Licensee's Proposed Overall Completion Date: *03/11/2026*

Implemented (■ - 04/10/2026)

171b5 - First Aid Kit

7. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the home's bus used to transport residents does not include a breathing barrier or eye protection.

Plan of Correction ***Accept (■ - 03/18/2026)***

• Immediate Resolution: On 1/07/2026, the Administrator conducted an immediate audit of all first aid kits in the home. Any missing items (including but not limited to: sterile gauze pads, adhesive bandages, antiseptic, tape, scissors, tweezers, disposable gloves, CPR mouth barrier, etc.) were replaced and restocked. All kits were verified to be complete by Administrator the same day.
• Training Plan: To coach all necessary wellness staff members, ex. Med Techs, Supervisors, RCC, Director of the items that must be in a first aide kit at all times.
• Monitoring & Audit Plan: March 17, 2026 The Administrator or Resident Wellness Director will perform monthly audits of every first aid kit and will review the weekly logs to ensure compliance. Any missing items will be replaced immediately and addressed through staff coaching or retraining as necessary. Audit results will be reviewed during monthly safety meetings to ensure ongoing regulatory compliance.
• Sustainability Plan: The checklist will be attached to each kit and used during routine inspections. This checklist will start March 17, 2026 and last for six consecutive months to maintin compliance as well as provisional licensings.

Licensee's Proposed Overall Completion Date: *03/17/2026*

171b5 First Aid Kit *(continued)*

Implemented - 04/09/2026)

190a Completion Medication Course

8. Requirements

2600.
190.a. A staff person who has successfully completed a Department approved medications administration course that includes the passing of the Department's performance based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D passed the approved medication administration course on . Since then, 1 medication record review was completed, and 1 medication administration observation was completed, both

Staff person E passed the approved medication administration course on Since then, 1 medication record review was completed, and 1 medication administration observation was completed, both

Repeat violation: et al

Plan of Correction ***Accept 03/18/2026)***

Immediate Resolutions _ Any discrepancies were corrected immediately.
Training Plan - On October 25, 2025 A Medication Administration Observation Log has been developed and implemented.
A tracking spreadsheet/calendar system has been created to ensure all medication administration staff are observed no less than twice per calendar year. Observations will be scheduled at six-month intervals.
Monitoring & Plan - The Director of Nursing will maintain a master tracking tool identifying:

Staff name

Date of last observation

Date next observation is due

The Administrator will review compliance monthly during QA meetings.

Any staff not observed within the required timeframe will be scheduled immediately.

Results of audits will be documented in Quality Assurance minutes.

Licensee's Proposed Overall Completion Date: *03/11/2026*

Implemented - 04/10/2026)

190c Record of Training

9. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff person A's Medication Administration training course requalification form is marked as requalified, and signed by the student and trainer, however the [redacted] observation has not been completed yet.

Staff person F's Medication Administration training course requalification form is marked as requalified, and signed by the student and trainer, however the [redacted] observation has not been completed yet.

Plan of Correction ***Accept[redacted] - 03/18/2026)***

Immediate Resolutions _ Any discrepancies were corrected immediately.
Training Plan - The DON and ED on October 25, 2025 established A Medication Administration Observation Log has been developed and implemented.
A tracking spreadsheet/calendar system has been created to ensure all medication administration staff are observed no less than twice per calendar year. Observations will be scheduled at six-month intervals.
Monitoring & Plan - The Director of Nursing will maintain a master tracking tool identifying:
Staff name
Date of last observation
Date next observation is due
Effective March 17, 2026 The Administrator will review compliance monthly during QA meetings.
Any staff not observed within the required timeframe will be scheduled immediately.
Effective March 17, 2026 Results of audits will be documented in Quality Assurance minutes

Licensee's Proposed Overall Completion Date: *03/17/2026*

Implemented [redacted] 04/10/2026)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #[redacted] utilizes a bedside mobility device. The resident's assessment dated [redacted] does not indicate the resident utilizes a bedside mobility device.

Resident [redacted] assessment dated [redacted] indicates the resident is hard of hearing and uses hearing aids. The resident indicates they cannot hear the fire alarm without their hearing aids in, and they do not wear their hearing aids to bed at night. The assessment does not indicate this need or how the home is going to meet this need.

Resident [redacted] assessment dated [redacted] does not indicate the need for frequent monitoring when smoking cigarettes to prevent discarding cigarette in unsafe locations.

225c - Additional Assessment *(continued)*

Plan of Correction ***Accept (- 03/18/2026)***

• Immediate Resolution: On 01/07/26 the resident(s) identified as having a significant change in condition without a corresponding updated assessment were immediately reassessed using the Department-approved assessment form. The completed assessments were placed in the resident records, and care plans were updated to reflect current needs.
• Training Plan: Identifying signs of a significant change in resident condition The reporting process for changes in condition Regulatory requirements for completing additional assessment Attendance will be documented and stored in personnel files.
• Monitoring & Audit Plan: Starting March 17, 2026 The Administrator, RWD RCC will audit resident records weekly for 60 days, then monthly for 6 months, to ensure: All reported changes have been logged
• Sustainability Plan: Care plans are updated accordingly
Findings will be documented, and corrective actions taken as needed.

Licensee's Proposed Overall Completion Date: *03/18/2026*

Implemented - 04/10/2026)

227d - Support Plan Medical/Dental

11. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident s assessment date note the resident utilizes a bedside mobility device, the support plan does not indicate any risks associated with using the device, if the resident has the ability to use the device safely for the intended purpose or if the FDA guidelines require the device to be covered.

Resident assessment dated has been updated to indicate the resident has had 4 unwitnessed falls in October 2025, 4 unwitnessed falls in November 2025, and 4 unwitnessed falls in December 2025. There is no plan in place to ensure the resident's safety.

Plan of Correction ***Accept - 03/18/2026)***

The identified resident(s) support plan was immediately reviewed and updated to include:
Current diagnoses Medication list with dosage and frequency Allergies Physician orders Dietary requirements
Treatments and special medical instructions
The updated support plan was reviewed with the resident and/or resident representative.
On February 12, 2026 The support plan was signed and dated to reflect compliance.
administrative, nursing, and care staff responsible for developing and updating support plans were re-educated on
Required medical components of support plans
Timelines for updates after changes in condition
Effective March 18, 2026 Education included documentation standards and review procedures. by the administrator

227d Support Plan Medical/Dental (continued)

and DON will be reviewed with RCC and DON to comply with regulations to list what is required.
Conduct monthly random audits of 10% of resident support plans for 3 months.

Review findings in Quality Assurance meetings.

Any deficiencies identified will result in immediate correction and re education as needed.

Licensee's Proposed Overall Completion Date: *03/18/2026*

Implemented [redacted] - 04/10/2026)