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

May 15, 2026

[redacted]
EAGLEVIEW LANDING LP
[redacted]

RE: EAGLEVIEW LANDING
650 STOCKTON DRIVE
EXTON, PA, 19341
LICENSE/COC#: 14698

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/28/2026 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *EAGLEVIEW LANDING* **License #**: *14698* **License Expiration**: *09/13/2026*

Address: *650 STOCKTON DRIVE, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *EAGLEVIEW LANDING LP*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/27/2019* **Issued By**: *Uwchlan Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *102* **Waking Staff**: *77*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *01/28/2026*

Inspection Dates and Department Representative

01/28/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *121* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *27* **Residents Served**: *21*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

01/28/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/06/2026*

03/16/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/20/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/18/2026*

Inspections / Reviews *(continued)*

05/15/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/20/2026*

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

16c Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at approximately 10:00 AM, there was an incident of alleged verbal abuse of a resident by a staff person. The home did not report this incident to the department until [redacted] at 12:05 PM.

Plan of Correction ***Accept [redacted] - 03/16/2026)***

It is important to safeguard the health and well-being of our residents by ensuring that all Reportable Incidents are reported to DHS within the required timeframe.
IMMEDIATE: On 1/30/26, the Executive Director provided re-education on Reportable Incidents to the Director of Nursing, the Assistant Director of Nursing, and the Memory Care Coordinator.
TRAINING: On 2/11/26, a mandatory staff meeting was held during which all staff received training on regulation 2600.16 abuse, reporting requirements, and reportable incidents by the Executive Director, PCHA.
ONGOING In addition, a new process was created and implemented to ensure compliance. All incidents are now reviewed and reported during the morning stand-up meeting. Reportable incidents are identified at that time, and the Executive Director oversees the process to ensure that the nursing team completes the investigation, fills out the incident report form, and submits the report to DHS via email within the required 24-hour timeframe. The Executive Director will review all reportable incidents monthly at QAPI meetings beginning 3/11/26.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

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 10:00 AM, Resident [redacted] had taken a pillow belonging to another resident. Staff Person A took the pillow back from Resident [redacted] and put it in a place where Resident [redacted] would not be able to reach it. Resident [redacted] got angry with Staff Person A and made statements toward them such as "You're a patheti[redacted], and "You're worthless". Staff Person A walked away from Resident [redacted] however Resident [redacted] continued to follow Staff Person A and yell a[redacted] Staff Person B attempted to intervene and de-escalate Resident [redacted] telling the resident "That's enough, Resident [redacted], you need to stop".

Resident [redacted] redirected their anger towards Staff Person B, telling the staff person "you're worthless", and "you're a [redacted]". Staff Person B and Resident [redacted] then became involved in a face-to-face, angry and aggressive verbal altercation. During this interaction, Staff Person B yelled inappropriate and derogatory statements towards Resident [redacted] including but not limited to: "If I'm a [redacted], your [redacted] a [redacted]", "That's why your family sent you here", and "That's why your teeth are falling out", the latter statement referencing the resident's dentures.

42b - Abuse (continued)

Repeat violation: [redacted] *et al*

Plan of Correction ***Accept*** [redacted] ***- 03/16/2026)***

It is important to ensure that all residents are treated with dignity and respect at all times.
IMMEDIATE: The staff member involved in this incident was suspended during an investigation and terminated on 1/6/26.
TRAINING: On 2/11/26, all staff were re-educated on abuse prevention (2600.15), appropriate redirection techniques, and reportable incidents (2600.16) by the Executive Director, PCHA. On 3/19/26, all staff will receive additional training on Resident Rights (2600.42) and redirection to reinforce expectations for respectful and appropriate interactions with residents by the Director of Nursing.
ONGOING: All incidents and resident behaviors are reviewed monthly during the QAPI meeting to ensure proper protocols were followed, appropriate redirection techniques were utilized, and that behaviors and interventions are properly documented, starting 3/11/26.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] ***- 05/15/2026)***

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

On [redacted]*, staff from an outside hauling company were walking through the home unattended by home staff; the home did not have completed criminal background checks for the hauling company personnel.*

Repeat violation: [redacted] *et al,* [redacted]

Plan of Correction ***Accept*** [redacted] ***- 03/16/2026)***

It is important to ensure the safety of our residents, staff, and visitors by verifying that all contractors working within the community have the required criminal background checks on file.
IMMEDIATE: On 1/29/26, the Executive Director and Administrative Assistant completed an audit to ensure criminal background checks from repeat vendors were on file. Criminal background checks were requested and obtained for all vendors who may provide services within the community as needed.
TRAINING: On 2/2/26, the Executive Director provided education to the Concierge, Administrative Assistant, and Maintenance Assistant regarding DHS criminal background check regulations and requirements for contractors working within the community.
ONGOING: The leadership team reviews all vendors scheduled to be in the building during the morning stand-up meeting to ensure all required documentation, including criminal background checks, is on file prior to services being provided. In addition, the Executive Director will review services provided by vendors monthly during the QAPI

51 Criminal Background Check (continued)

meeting, beginning 3/11/26 to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

65a - FS Orientation 1st Day

4. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person C, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, or, telephone use and notification of emergency services.

Repeat violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 03/16/2026)***

It is important to ensure that all staff receive the required training during orientation prior to working on the floor.
IMMEDIATE: The staff person with missing training, was re educated on fire safety by the maintenance assistant on 1/29/26. A new orientation program was created and implemented by the Executive Director to ensure all required trainings are completed.
TRAINING: On 2/18/26, the Leadership Team was trained on the new orientation program and the expectations for ensuring all required orientation components are completed by the Executive Director. All new hires are required to complete the orientation program prior to beginning their on the floor training.
ONGOING: The Executive Director reviews all orientation checklists and signs off once the required training has been completed. Orientation documentation and compliance will be reviewed monthly during the QAPI meetings beginning 3/11/26, to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

65a - FS Orientation 1st Day *(continued)*

82c - Locking Poisonous Materials

5. 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

On [redacted], at 9:47AM, the following items were unlocked, unattended and accessible to residents in room [redacted]

- *Colgate Toothpaste, 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".*
- *Arm & Hammer Deodorant, with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center right away".*
- *CareOne Antiseptic Mouthwash, with a manufacture's label indicating "If more than used for rinsing is accidentally swallowed, get medical help or contact a Poison Control Center right away".*

Not all residents of the home, including Resident [redacted] have been assessed capable of recognizing and using poisons safely.

Repeat violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 03/16/2026)***

It is important to protect the health and well-being of our Memory Care residents by ensuring they do not have access to poisonous materials.
IMMEDIATE: The Memory Care Coordinator immediately did room checks to ensure all toiletries were locked away in each resident room/bathroom. Verbal reminders were given at shift change on the importance of locking up all poisonous materials.
TRAINING: On 1/30/26, the Executive Director provided re-education to the Director of Nursing, Assistant Director of Nursing, and Memory Care Coordinator regarding the proper storage and security of poisonous materials. On 2/11/26, all staff were educated on poisonous materials and safe storage practices during the mandatory staff meeting by the Executive Director, PCHA.
On 2/2/26, the Executive Director conducted an audit to ensure that all poisonous materials were properly secured in the designated locked cabinet.
ONGOING: Moving forward, the Memory Care Coordinator or Assistant Director of Nursing will conduct weekly audits during the month of February, biweekly audits during the month of March, and monthly audits thereafter to ensure continued compliance.
All audit results will be reviewed with the Memory Care Coordinator upon completion and discussed monthly during the QAPI meeting, beginning 3/11/26 to monitor for ongoing compliance, beginning 3/11/26.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

121a - Unobstructed Egress

6. Requirements

121a - Unobstructed Egress *(continued)*

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 9:26AM, snow blocked egress from the home's Personal Care Dining Room and Common Seating Area directly next to the Dining Room.

Plan of Correction ***Accept [redacted] - 03/16/2026)***

IMMEDIATE: On 1/28/26, the snow removal company was contacted and immediately removed the snow and cleared the exit pathway in the courtyard that day. This area has since been added to the snow removal contract to ensure it is included in future snow removal services.
The Executive Director was onsite during the February snowstorm and ensured that the courtyard exit pathway remained clear of snow.
TRAINING: The Director of Maintenance, who began employment with the community on 2/9/26, was educated by the Executive Director on snow removal requirements and expectations.
ONGOING: The Director of Maintenance will oversee snow removal for the entire property going forward to ensure all required areas, including emergency exit pathways, remain clear and accessible.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

185a - Implement Storage Procedures

7. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] is prescribed [redacted], take 2 tablets = [redacted] by mouth every 4 hours as needed.
On [redacted] this medication was not available in the home.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 03/16/2026)***

IMMEDIATE: The medication was obtained from pharmacy.
TRAINING: On 1/30/26, the Executive Director provided re-education to the Director of Nursing and the Assistant Director of Nursing regarding proper protocols for medication administration and medication storage.
On 1/30/26, a medication cart audit was completed for both the Memory Care and Personal Care neighborhoods to ensure that all medications were properly stored in the medication carts and readily available for residents as prescribed.
The Director of Nursing conducted an additional medication cart audit on 2/27/26 to ensure continued compliance.
ONGOING: Moving forward, medication cart audits will be conducted monthly by the Lead Certified Medication Technician and reviewed by the Director of Nursing and/or Assistant Director of Nursing.
These audits will also be reviewed monthly during the QAPI meeting beginning 3/11/26 to monitor for ongoing compliance.

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] 05/15/2026)

187b - Date/Time of Medication Admin.

8. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [redacted] is prescribed [redacted], take 1 tablet at bedtime. Resident [redacted]s January, 2026 medication administration record does not include the initials of the staff person who administered [redacted] [redacted] on [redacted] at 8:00 PM.

Repeat violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 03/16/2026)***

IMMEDIATE: On 1/29/26, the Executive Director provided re-education to the Director of Nursing and the Assistant Director of Nursing regarding proper protocols for medication administration and documentation.
TRAINING: On 1/30/26, The Director of Nursing re-educated the lead med tech on completion of medication cart audits. On 1/30/26, a medication cart audit was completed for both the Memory Care and Personal Care neighborhoods by the Director of Nursing and lead med tech to ensure that all medications properly signed off and administration was documented.
ONGOING: The Director of Nursing conducted an additional medication audit on 2/27/26 to ensure continued compliance. Moving forward, medication audits will be conducted monthly by the Lead Certified Medication Technician and reviewed by the Director of Nursing and/or Assistant Director of Nursing.
These audits will also be reviewed monthly during the QAPI meeting beginning 3/11/26 to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

227g -Support Plan Signatures

9. 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]s support plan, dated [redacted], was not signed by the Assessor, the Resident and/or the Resident's Designated Person.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 03/16/2026)***

IMMEDIATE: On 1/29/26 and 1/30/26, the Director of Nursing conducted RASP audits to ensure all resident care plans were completed and in compliance with applicable DHS requirements.
TRAINING: On 1/30/26, the Executive Director provided re-education to the Director of Nursing, Assistant Director

227g -Support Plan Signatures (continued)

of Nursing, and Memory Care Coordinator regarding the proper completion of Resident Assessment and Support Plans (RASPs) in accordance with DHS regulations.
ONGOING: Moving forward, the Executive Director will conduct random monthly RASP audits to ensure continued compliance with RASP completion requirements. The results of these audits will be reviewed monthly with the Leadership Team during QAPI meetings beginning 3/11/26 to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] 05/15/2026)

234a - Admission Support Plan

10. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident[redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted]

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 03/16/2026)***

IMMEDIATE: On 1/29/26 and 1/30/26, the Director of Nursing conducted RASP audits to ensure all resident care plans were completed and in compliance with applicable DHS requirements.
TRAINING: On 1/30/26, the Executive Director provided re-education to the Director of Nursing, Assistant Director of Nursing, and Memory Care Coordinator regarding the proper completion of Resident Assessment and Support Plans (RASPs) in accordance with DHS regulations.
ONGOING: Moving forward, the Executive Director will conduct random monthly RASP audits to ensure continued compliance with RASP completion requirements. The results of these audits will be reviewed monthly with the Leadership Team during QAPI meetings beginning 3/11/26 to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)

234e - Involvement/Participation

11. Requirements

2600.
234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

Resident[redacted]'s support plan was revised on [redacted]. Neither the resident nor the resident's designated person were involved in the revision.

Plan of Correction ***Accept [redacted] - 03/16/2026)***

It is important for the residents to participate in their care plan and any revisions made to their plan of care.

234e Involvement/Participation (continued)

IMMEDIATE: On 1/29/26 and 1/30/26, the Director of Nursing conducted RASP audits to ensure all resident care plans were completed and in compliance with applicable DHS requirements.
TRAINING: On 1/30/26, the Executive Director provided re education to the Director of Nursing, Assistant Director of Nursing, and Memory Care Coordinator regarding the proper completion of Resident Assessment and Support Plans (RASPs) in accordance with DHS regulations.
ONGOING: Moving forward, the Executive Director will conduct random monthly RASP audits to ensure continued compliance with RASP completion requirements. The results of these audits will be reviewed monthly with the Leadership Team during QAPI meetings beginning 3/11/26 to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 05/15/2026)