pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MSA PLYMOUTH MEETING OPERATING, LLC**
LEGAL ENTITY

To operate **THE PINNACLE AT PLYMOUTH MEETING**
NAME OF FACILITY OR AGENCY

Located at **215 PLYMOUTH ROAD, PLYMOUTH MEETING, PA 19462**
(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 **138**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 19**

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 **March 24, 2026** until **March 24, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **150230**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

[redacted]
Regional Director of Operations
MSA Plymouth Meeting Operating, LLC
[redacted]
[redacted]

RE: The Pinnacle at Plymouth Meeting
215 Plymouth Road
Plymouth Meeting, Pennsylvania 19462
License #: 150230

Dear Ms. Beekman:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on February 2, 3, and 4, 2026, and April 16, 2026, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

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

June 11, 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 02/02/2026, 02/03/2026, 02/04/2026 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: *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**: *143* **Waking Staff**: *107*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *02/02/2026*

Inspection Dates and Department Representative

02/02/2026 - On-Site: [redacted]

02/03/2026 - On-Site:

02/04/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *93*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Momory Care Unit* **Capacity**: *19* **Residents Served**: *15*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *93*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *50* **Have Physical Disability**: *0*

Inspections / Reviews

02/02/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/08/2026*

Inspections / Reviews *(continued)*

03/19/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/06/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/24/2026*

03/25/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/06/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/06/2026*

06/11/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/06/2026*

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

28e - Death of a Resident

1. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Various residents, including Resident [redacted], passed away on [redacted]. Resident [redacted] personal belongings were removed from [redacted] room on [redacted]; however, the refund of the remainder of previously paid charges to the resident's estate was sent on [redacted].

Resident [redacted] passed away on [redacted]. Resident [redacted]s personal belongings were removed from [redacted] room on [redacted] however, the refund of the remainder of previously paid charges to the resident's estate was sent on

Plan of Correction ***Do Not Accept [redacted] - 03/18/2026)***

The Pinnacle has hired a new Business Office Manager.

The new Business Office Manager will be educated to the expectations of regulation 2600.28e on or before 03/20/26. The new Assistant Executive Director will also be trained to this regulatory expectation for comfort in serving as a back up to this task.

The Regional Director of Operations and Regional Operations Specialist have audited outstanding refunds and processed any with deficient compliance dates. Records of this audit will be kept in each file to avoid further citations for this same deficient practice.

Moving forward refunds will be requested within one week of resident discharge. Copies of refund requests and proof of remittance of owed funds within thirty (30) days of discharge will be kept in resident files.

The Business Office Manager will complete a weekly census audit for the next thirty days to establish a habit and maintain ongoing compliance with this standard. Deficient refunds will be corrected immediately and findings presented as part of the review of POC's during the QA process.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/18/2026*

Please indicate the title of the person responsible for training the Business Office Manager and the Assistant Executive Director.

Please include the start date of the audits to be performed by the BOM. Please indicate the date of the next QA meeting and the title of the person responsible for presenting the audit findings.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

The Pinnacle has hired a new Business Office Manager.

28e Death of a Resident (continued)

The new Business Office Manager will be educated by the Executive Director, or Designee, to the expectations of regulation 2600.28e on or before 03/20/26.

The new Assistant Executive Director will be trained by the Executive Director, or Designee, to this regulatory expectation for comfort in serving as a backup to this task by 3/20/26.

The Regional Director of Operations and Regional Operations Specialist have audited outstanding refunds and processed any with deficient compliance dates. Records of this audit will be kept in each file to avoid further citations for this same deficient practice.

Moving forward refunds will be requested within one week of resident discharge. Copies of refund requests and proof of remittance of owed funds within thirty (30) days of discharge will be kept in resident files.

Beginning the week of 4/1/2026, The Business Office Manager will complete a weekly census audit for thirty days to establish a habit and maintain ongoing compliance with this standard. The Business Office Manager will address any refunds found to be deficient refunds immediately upon finding an issue.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

28f Resident's Funds and 30 day Refund

2. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident [redacted] was discharged on [redacted] The home did not refund the remainder of previously paid charges to the residents until [redacted]

Resident [redacted] was discharged on [redacted]. The home did not refund the remainder of previously paid charges to the residents until [redacted]

Plan of Correction ***Do Not Accept [redacted] - 03/18/2026)***

The Pinnacle has hired a new Business Office Manager.

The new Business Office Manager will be educated to the expectations of regulation 2600.28f on or before 03/20/26. The new Assistant Executive Director will also be trained to this regulatory expectation for comfort in serving as a backup to this task.

28f - Resident's Funds and 30-day Refund (continued)

The Regional Director of Operations and Regional Operations Specialist have audited outstanding refunds and processed any with deficient compliance dates. Records of this audit will be kept in each file to avoid further citations for this same deficient practice.

Moving forward refunds will be requested within one week of resident discharge. Copies of refund requests and proof of remittance of owed funds within thirty (30) days of discharge will be kept in resident files.

The Business Office Manager will complete a weekly census audit for the next thirty days to establish a habit and maintain ongoing compliance with this standard. Deficient refunds will be corrected immediately and findings presented as part of the review of POC's during the QA process.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/18/2026*

Please indicate the title of the person responsible for training the Business Office Manager and the Assistant Executive Director.

Please include the start date of the audits to be performed by the BOM. Please indicate the date of the next QA meeting and the title of the person responsible for presenting the audit findings.

Plan of Correction ***Accept [redacted] - 03/24/2026)***

The Pinnacle has hired a new Business Office Manager.

The new Business Office Manager will be educated by the Executive Director, or Designee, to the expectations of regulation 2600.28e on or before 03/20/26.

The new Assistant Executive Director will be trained by the Executive Director, or Designee, to this regulatory expectation for comfort in serving as a backup to this task by 3/20/26.

The Regional Director of Operations and Regional Operations Specialist have audited outstanding refunds and processed any with deficient compliance dates. Records of this audit will be kept in each file to avoid further citations for this same deficient practice.

Moving forward refunds will be requested within one week of resident discharge. Copies of refund requests and proof of remittance of owed funds within thirty (30) days of discharge will be kept in resident files.

Beginning the week of 4/1/2026, The Business Office Manager will complete a weekly census audit for thirty days to establish a habit and maintain ongoing compliance with this standard. The Business Office Manager will address any refunds found to be deficient refunds immediately upon finding an issue.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

28f - Resident's Funds and 30-day Refund *(continued)*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

91 - Telephone Numbers

3. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in room [redacted] or [redacted]

Plan of Correction ***Do Not Accept ([redacted] - 03/18/2026)***

Magnets with the required phone numbers were immediately posted on the refrigerators in Room [redacted] and [redacted]

Regional Nurse completed a comprehensive audit of all rooms for compliance with this standard. Issues were immediately addressed as discovered.

Auditing of the phone number magnet is a part of the weekly cleaning schedule for Housekeeping and is being added to the marketing Move In and Move Out audit to maintain continued compliance.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/18/2026*

Please include the date of the initial room audit.

Please include the start date and duration of the ongoing room audits to be performed and designate a person in charge of this task. "Housekeeping" is too broad. Please include the title of the person responsible for the marketing move-in and move-out audits.

How will the home measure ongoing compliance?

Plan of Correction ***Accept [redacted] - 03/24/2026)***

Magnets with the required phone numbers were immediately posted on the refrigerators in Room [redacted] and [redacted]

Regional Nurse completed a comprehensive audit of all rooms for compliance with this standard during the month of February and early March 2026. Issues were immediately addressed as discovered.

Beginning the week of March 16th, 2026, the auditing of the phone number magnet is a part of the weekly cleaning schedule for individuals who have been hired into the role of Housekeeper at The Pinnacle.

The auditing of the placement of the mandated telephone number magnet be added to the Marketing Departments Move In and Move Out audit tool by the Assistant Executive Director by 3/31/26. The Assistant Executive Director, or Designee, will train the Marketing Directors to the standard of checking for the magnet during both phases of the room turnover process by March 31st, 2026, to maintain compliance with this regulation to maintain compliance

91 - Telephone Numbers (continued)

with this regulation through the room turnover process.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented ([redacted] - 06/11/2026)***

See attached.

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

Resident [redacted] in room [redacted] has two bedside lamps at each side of the bed, but neither of them can turned on.

Plan of Correction ***Do Not Accept [redacted] - 03/18/2026)***

Lightbulbs were immediately replaced in both lamps.

Regional Nurse completed a comprehensive audit of all rooms for compliance with this standard. Issues were immediately addressed as discovered.

Auditing of the bedside lighting source is a part of the weekly housekeeping audit and cleaning tool, but it does not specifically address testing the light source. The wording of the audit tool will be changed to note operable light source. Training will be provided to all housekeeping staff regarding this audit update.

SDCU Director will audit the SDCU rooms for the next thirty (30) days to ensure compliance with this standard.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/18/2026*

Please include the date of the initial audit.

Please include the date by which housekeeping staff will be trained, and the title of the person responsible for this task.

Please include the start date and duration for the weekly housekeeping audits, as well as the title of the specific person responsible for the completion of the audits.

Please include the start date and frequency of the audits to be performed by the SDCU director.

Plan of Correction ***Accept [redacted] - 03/24/2026)***

Lightbulbs were immediately replaced in both lamps.

Regional Nurse completed a comprehensive audit of all rooms for compliance with this standard during the month of February and early March 2026. Issues were immediately addressed as discovered.

Auditing of the bedside lighting source is a part of the weekly housekeeping audit and cleaning tool, but it does not

101j7 - Lighting/Operable Lamp (continued)

specifically address testing the light source. The wording of the audit tool will be changed by The Facilities Manager to note "operable light source by 3/10/26. The Facilities Maintenance Director will train all staff hired into the role of Housekeeper at The Pinnacle by 3/20/26 regarding this change. This form will be implemented the week of March 20th, 2026, for the Housekeepers to begin using the new form that notes "operable" as they complete their weekly cleaning.

SDCU Director began daily audits of the SDCU rooms on [redacted] workdays on 2/18/26 for compliance with this standard. These audits of the SDCU rooms will continue for the next thirty (30) days to ensure ongoing compliance with this standard.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented ([redacted] - 06/11/2026)***

See attached.

141a 1-10 Medical Evaluation Information

5. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted] medical evaluation did not include medication regimens, contraindicated medications or medication side effects.

Plan of Correction ***Do Not Accept ([redacted] - 03/18/2026)***

Resident [redacted] did not take any medications at the time the Medical Evaluation was completed. This explains why there was nothing listed on the medical evaluation.

As a proactive measure to avoid further citations against this regulatory standard, the Executive Director will train the new Wellness Director, the Marketing Team and the Nurses to the requirement that all areas of the Medical Evaluation must be completed, with no blanks. In instances where there is nothing to note staff will be instructed to record N/A as a means of avoiding the potential misinterpretation of blanks on the form.

141a 1 10 Medical Evaluation Information *(continued)*

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/18/2026*

The most recent medical evaluation for resident [redacted] dated 11/17/25 (a status change evaluation) shows 9 distinct medical diagnoses, to include coronary artery disease, diabetes, chronic kidney disease, low back pain, diabetic polyneuropathy, and Benign Prostatic Hyperplasia. Under the (8) Medications section of the form, there are two choices: " None, or "See Medication Addendum on Page 4", the latter being circled. The medication addendum states "see attached", implying the resident has medications (as expected with the listed diagnoses). Information obtained during the 3/3/26 inspections shows this resident does have medications.

Please revise your plan. The plan must include immediate steps the home took to correct the violation, specific, actionable steps to prevent violation recurrence and monitor ongoing compliance. Each step must include timeframes (start date, frequency, duration), and the title of the person responsible for each step.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

Resident [redacted] did not take any medications, regardless of [redacted] diagnoses, at the time the Change of Status Medical Evaluation was completed on 11/17/25. This explains why there was nothing listed on the medical evaluation. See Medication Addendum was incorrectly circled because there were NO medications prescribed by the resident's physician. Therefore, the Executive Director corrected the error by circling NONE.

The physician ordered Tylenol on 1/6/26 for a period until 1/12/26. The physician received an order on 1/9/26 to take Ibuprofen for seven days. On 1/28/26 the physician ordered Tylenol as a standing order. On 2/3/26 during the survey the surveyor noted an order for the standing Tylenol that was only initiated after the November medical evaluation was completed.

As a proactive measure to avoid further citations against this regulatory standard, the Executive Director will train the new Wellness Director, the Marketing Team and the Nurses to the requirement that all areas of the Medical Evaluation must be completed, with no blanks and in the instance of a resident not being on any medication, none will be the choice. In instances where there is nothing to note staff will be instructed to record N/A as a means of avoiding the potential misinterpretation of blanks on the form. This training will occur by 3/31/26.

The new Wellness Director, or Designee, will audit all Medical Evaluations for new residents beginning 4/1/2026 to ensure compliance with this standard immediately following [redacted] training. The Wellness Director, or Designee, will initial every new admission medical evaluation for the thirty days, to note this audit.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

183e - Storing Medications

6. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications *(continued)*

Description of Violation

On [redacted] there were two loose pills in the first drawer of the 4th floor medication cart.

Resident [redacted] is prescribed [redacted]. However, the foil on the back of pill #23 was torn and taped.

Resident [redacted] is prescribed [redacted]. However, the foil on the back of pills #3 and #4 was torn and taped.

Plan of Correction ***Do Not Accept [redacted] - 03/18/2026)***

Loose pills were destroyed and taped medications were addressed.

The new Wellness Director will be educated to the expectations of this regulatory guideline by 3/23/26.

All Medication Technicians and Nurses will be re-educated to the med cart audit process by March 30th, 2026, by the new Director of Wellness, or Designee. Carts will be audited weekly beginning April 1st, 2026, to ensure compliance with cart cleanliness and safe medication procedures regarding storing of medications. These audits will continue for 45 days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

Results of these audits and all Plans of Correction will be reviewed as part of the Quality Assurance process, per Meridian and BHSL guidelines.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Update: *03/18/2026*

Please indicate the date loose pills were destroyed, and define "taped medications were addressed" to be more specific about the actions that were taken.

Please indicate the title of the person responsible for training the wellness director.

Please more clearly define the training that the medication technicians and nurses will receive as auditing the carts identify violations that have already occurred but do not address preventative measure or immediate actions following identification of an instance of improper storage.

Please indicate the title of the person responsible for medication cart audits.

Please note that education on the med cart audit process itself may not be effective. It is not enough to be able to identify a violation after it has occurred. However, education on what the regulatory requirement and how to immediately identify medications that may be improperly stored, not discarded by a specific date, or kept within certain temperature parameters can prevent the violation from occurring, which is the main goal of the regulatory requirement.

183e - Storing Medications (continued)

Please indicate the start date, frequency, and duration that the wellness director or designee will review the audits.

Plan of Correction ***Accept [redacted] - 03/24/2026)***

Loose pills were removed from the cart and destroyed by the Wellness Director immediately following being made aware of this issue. Medications with taped foil were confirmed to be medications, as prescribed, and were administered.

The new Wellness Director will be educated, by The Executive Director, to the expectations of this regulatory guideline by 3/23/26.

All Medication Technicians and Nurses will be re-educated to the med cart audit process based on the parameters of this regulation and all of the parameters of 2600.193 a1-f and 2600.184 by March 30th, 2026, by the new Director of Wellness, or Designee to enable the staff to immediately identify and address medications that may be improperly stored, not discarded or kept outside of temperature parameters.

As an additional proactive measure, each medication cart will be audited by a Medication Tech or Nurse weekly for a period of thirty days beginning April 1st, 2026, to ensure compliance with cart cleanliness and safe medication procedures regarding storing of medications.

Results of the weekly audits that will begin the week of 4/1/26 will be reviewed by the Wellness Director, or Designee for thirty days to identify additional opportunities for education, intervention or order clarification.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented [redacted] 06/11/2026)***

See attached.

184b - Labeling OTC/CAM

7. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], [redacted], and [redacted] belonging to resident [redacted] were in the 4th floor medication cart and were not labeled with the resident's name.

Plan of Correction ***Do Not Accept [redacted] - 03/18/2026)***

Unlabeled medications were labeled by regulatory expectation.

The new Wellness Director will be educated to the expectations of this regulatory guideline by 3/23/26.

All Medication Technicians and Nurses will be re-educated to the med cart audit process by March 30th, 2026, by the new Director of Wellness, or Designee. Carts will be audited weekly beginning April 1st, 2026, to ensure

184b - Labeling OTC/CAM (continued)

compliance with cart cleanliness and safe medication procedures regarding storing of medications. These audits will continue for 45 days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

Results of these audits and all Plans of Correction will be reviewed as part of the Quality Assurance process, per Meridian and BHSL guidelines.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Update: *03/18/2026*

Please indicate the title of the person responsible for medication cart audits.

Please note that education on the med cart audit process itself may not be effective. It is not enough to be able to identify a violation after it has occurred. However, education on what the regulatory requirement and how to immediately identify an unlabeled medication as it comes in can prevent the violation from occurring, which is the main goal of the regulatory requirement.

Please indicate the start date, frequency, and duration that the wellness director or designee will review the audits.

Plan of Correction ***Accept [redacted] - 03/24/2026)***

Unlabeled medications were labeled by regulatory expectation.

The new Wellness Director will be educated, by The Executive Director, to the expectations of this regulatory guideline by 3/23/26.

All Medication Technicians and Nurses will be re-educated to the med cart audit process based on the parameters of this regulation and all of the parameters of 2600.193 a1-f and 2600.184 by March 30th, 2026, by the new Director of Wellness, or Designee to enable the staff to immediately identify and address medications that may be improperly stored, not discarded or kept outside of temperature parameters.

As an additional proactive measure, each medication cart will be audited by a Medication Tech or Nurse weekly for a period of thirty days beginning April 1st, 2026, to ensure compliance with cart cleanliness and safe medication procedures regarding storing of medications.

Results of the weekly audits that will begin the week of 4/1/26 will be reviewed by the Wellness Director, or Designee for thirty days to identify additional opportunities for education, intervention or order clarification.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented ([redacted] 06/11/2026)***

See attached.

185a - Implement Storage Procedures

8. 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] as needed. On [redacted], the medication was not available at home.

Resident [redacted] is prescribed [redacted] four times daily before meals. However, the time on the glucometer doesn't match with the actual time; it is 1 hour ahead.

Resident [redacted] is prescribed [redacted] glucose four times daily before meals. However, some of the readings on the glucometer do not match with the readings on the EMAR as follows:

- [redacted]

Plan of Correction ***Do Not Accept [redacted] - 03/19/2026)***

Resident [redacted] order for PRN Milk of Magnesium has been discontinued secondary to nonuse.

The new Wellness Director will be educated to the expectations of this regulatory guideline by 3/23/26.

All Medication Technicians and Nurses will be re-educated to the med cart audit process by March 30th, 2026, by the new Director of Wellness, or Designee. Carts will be audited weekly beginning the week of April 1st, 2026, to ensure compliance with cart cleanliness and safe medication procedures regarding storing of medications. These audits will continue for 45 days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

The new Director of Wellness will complete a comprehensive review of all four glucometers to ensure that each of the four residents requiring testing have a working, calibrated device by 3/24/26.

The 11-7 Med Tech, or Designee, will be educated by the new Wellness Director by March 30th, 2026, regarding obtaining the eMAR glucometer report daily to compare the recorded results physically against the glucometer reading daily beginning April 1st, 2026. These audits will continue for 45 days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

Results of these audits and all Plans of Correction will be reviewed as part of the Quality Assurance process, per Meridian and BHSL guidelines.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Update: *03/19/2026*

Please indicate the title of the person responsible for educating the new Wellness Director.

185a - Implement Storage Procedures (continued)

Please indicate the date of the next QA meeting and the title of the person responsible for reviewing the audit results.

Plan of Correction ***Accept [redacted] - 03/24/2026)***

Resident #9's order for PRN Milk of Magnesium has been discontinued secondary to nonuse.

The new Wellness Director will be educated to the expectations of this regulatory guideline by the Executive Director by 3/23/26.

All Medication Technicians and Nurses will be re-educated to the med cart audit process by March 30th, 2026, by the new Director of Wellness, or Designee. Carts will be audited weekly beginning the week of April 1st, 2026, to ensure compliance with cart cleanliness and safe medication procedures regarding storing of medications. These audits will continue for thirty (30) days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

The new Director of Wellness will complete a comprehensive review of all four glucometers to ensure that each of the four residents requiring testing have a working, calibrated device by 3/24/26.

The 11-7 Med Tech, or Designee, will be educated by the new Wellness Director by March 30th, 2026, regarding obtaining the eMAR glucometer report daily to compare the recorded results physically against the glucometer reading daily beginning April 1st, 2026. These audits will continue for 30 days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

187b - Date/Time of Medication Admin.

9. 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 one tablet by mouth twice daily at 8:00 a.m. and 2:00 p.m. However, on [redacted] and [redacted] at 2:00 p.m., the medication record does not include the initials of the staff person who administered the medication.

Resident [redacted] has an order for wound care on Tuesdays and Thursdays. Resident [redacted]s medication administration record does not include the initials of the staff person who completed wound care on [redacted] at 9:00 a.m.

Resident [redacted] has an order for [redacted] to be applied from knee to forefoot once daily in the morning and removed every night at bedtime. However, on [redacted], the medication record does not include the initials of the staff person who

187b Date/Time of Medication Admin. (continued)

removed the [redacted] at bedtime.

Plan of Correction ***Do Not Accept ([redacted] - 03/19/2026)***

The new Wellness Director will be educated to the expectations of this regulatory guideline and the use of the Medication Omission Report and 24 Hour Report by 3/23/26.

The Wellness Director, or Designee, will educate the Medication Technicians on or before March 30th, 2026, regarding the importance of reviewing the Medication Omission Report and the 24 Hour Report prior to the end of their shift.

Beginning April 1st, 2026, and continuing for the next 45 days, the 11 7 Med Tech, or Designee, will pull the Medication Omission Report and 24 Hour Report daily to ensure there are no outstanding omissions of medication administration documentation. Discrepancies will be highlighted and the Wellness Director, or Designee, will research, report and address any identified issues daily.

Results of these audits and all Plans of Correction will be reviewed as part of the Quality Assurance process, per Meridian and BHSL guidelines.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Update: *03/19/2026*

Please indicate the title of the person responsible for educating the new Wellness Director.

Please explain the use of the Medication Omission Report and the 24 hour report. When will these reports begin? How often will they be used and for what duration? Who is responsible for completing these reports? If this is used at the end of the shift, it may identify medications that were not marked as administered timely, but it may not prevent violation recurrence. Re-education to staff on the correct medication administration procedures and performing observations of administrations to measure understanding and compliance is a recommended step and has been found to be effective.

Please include the date of the next QA meeting and the title of the person responsible for reviewing audit results.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

The new Wellness Director will be educated to the expectations of this regulatory guideline, and the use of the Medication Omission Report and 24-Hour Report by 3/23/26 by The Executive Director, or Designee.

The Medication Omission report will be used to identify that all medications are signed for and given. The 24-hour report will demonstrate that medications were available, ie: it will show if someone writes an oddity like not available for any reason. These reports are generated from the system based on the daily medication pass.

The Wellness Director, or Designee, will educate the Medication Technicians on or before March 30th, 2026, regarding the importance of reviewing the Medication Omission Report and the 24-Hour Report prior to the end of their shift on a daily basis as a means for self-review.

187b - Date/Time of Medication Admin. (continued)

Beginning April 1st, 2026, and continuing for the next 30 days, the 11-7 Med Tech, or Designee, will pull the Medication Omission Report and 24-Hour Report daily to ensure there are no outstanding omissions of medication administration documentation. Discrepancies will be highlighted and the Wellness Director, or Designee, will research, report and address any identified issues daily.

The Wellness Director, or Designee, will watch one AccuCheck or medication pass per week for the next thirty days beginning April 1st, 2026, to assure directions of the prescriber are being followed.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

187d - Follow Prescriber's Orders

10. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted]. However, on [redacted] this medication was not available in the home.

Resident [redacted] is prescribed [redacted] and fingerstick blood glucose monitoring 3 times daily. Inject subcutaneously per sliding scale with meals; 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-500 = 12 units.

- [redacted]

Plan of Correction ***Do Not Accept [redacted] - 03/19/2026)***

The new Wellness Director will be educated to the expectations of this regulatory guideline and the use of the Medication Omission Report and the 24-Hour Report by 3/23/26.

The Wellness Director, or Designee, will educate the Medication Technicians on or before March 30th, 2026, regarding the importance of reviewing the Medication Omission Report and the 24-Hour Report prior to the end of their shift.

Beginning April 1st, 2026, and continuing for the next 45 days, the 11-7 Med Tech, or Designee, will pull the Medication Omission Report daily to ensure there are no outstanding omissions of medication administration

187d - Follow Prescriber's Orders (continued)

documentation. Discrepancies will be highlighted and the Wellness Director, or Designee, will research, report and address any identified issues daily.

The new Director of Wellness will complete a comprehensive review of all four glucometers to ensure that each of the four residents requiring testing have a working, calibrated device by 3/24/26.

The 11-7 Med Tech, or Designee, will be educated by the new Wellness Director by March 30th, 2026 regarding obtaining the eMAR glucometer report daily to compare the recorded results physically against the glucometer reading daily beginning April 1st, 2026. The glucometer readings will be compared to the sliding scale parameters to ensure adherence to the physician identified administration parameters. These audits will continue for 45 days. Results of these audits will be reviewed by the Wellness Director, or Designee, and deficiencies will be addressed immediately.

Results of these audits and all Plans of Correction will be reviewed as part of the Quality Assurance process, per Meridian and BHSL guidelines.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Update: *03/19/2026*

This top part of the plan, identical to the plan for 187d, is not appropriate for the violation that occurred. The outlined plan revolves around medication omission and glucometer calibration. This violation occurred because the resident was not administered the correct amount of medication per the physician's order.

It is highly recommended that staff receive training by a certified diabetes educator or licensed nurse as this is a serious violation that can have negative health outcomes. Audits performed may identify violations that have already occurred with negative resident results. Observations of administrations are recommended as well.

Please include the date of the next QA meeting and the title of the person responsible for presenting audit findings.

Plan of Correction ***Accept [redacted] - 03/24/2026)***

The new Wellness Director will be educated to the expectations of this regulatory guideline, and the use of the Medication Omission Report and 24-Hour Report by 3/23/26 by The Executive Director, or Designee.

The Medication Omission report will be used to identify that all medications are signed for and given. The 24-hour report will demonstrate that medications were available, ie: it will show if someone writes an oddity like not available for any reason. These reports are generated from the system based on the daily medication pass.

The Wellness Director, or Designee, will educate the Medication Technicians on or before March 30th, 2026, regarding the importance of reviewing the Medication Omission Report and the 24-Hour Report prior to the end of their shift on a daily basis as a means for self-review.

Beginning April 1st, 2026, and continuing for the next 30 days, the 11-7 Med Tech, or Designee, will pull the Medication Omission Report and 24-Hour Report daily to ensure there are no outstanding omissions of medication

187d Follow Prescriber's Orders (continued)

administration documentation. Discrepancies will be highlighted and the Wellness Director, or Designee, will research, report and address any identified issues daily.

The new Wellness Director who is a Registered Nurse, will complete a training with the Medication Technicians and licensed nurses on medication distribution and the use and administration of insulin and the implementation of a sliding scale in the Personal Care environment. This training will include what to do if the staff are confused or have questions regarding Accu Check results and how to properly follow the physicians order.

The Wellness Director, or Designee, will watch one Accu Check or medication pass per week for the next thirty days beginning April 1st, 2026, to assure directions of the prescriber are being followed.

Findings and trends from the audits will be presented as part of the review of the Plans of Correction at the Quality Assurance meetings, held monthly by the last Friday of each month.

Licensee's Proposed Overall Completion Date: *04/03/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

224a Preadmission Screen Form

11. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted] preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Do Not Accept [redacted] 03/19/2026)***

Resident [redacted] needs can be met by The Pinnacle. [redacted] has been a resident since 2024.

The Pinnacle continues to receive citations on Preadmission documents from 2023, 2024 and early 2025. A comprehensive audit of Preadmission Screens will be completed and a POC explanation noting an audit of the screen will be attached to the original screening tool to avoid further citation on documents, since the documents cannot be altered years after the assessment was completed. This will be completed by March 30th 2026.

The new Wellness Director and Wellness Coordinator will be trained on the regulatory expectations of 2600.224a on their date of hire to ensure that new resident assessments are compliant to regulatory expectations from the onset of their employment. New admissions will be dated and form completion compliant. The new Wellness Director, or Designee, will audit Preadmission Screen completion for the next 45 days for all Personal Care admissions.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/19/2026*

A physician/medical practitioner must make the determination that the resident's needs can be met in the PCH

224a - Preadmission Screen Form (continued)

setting. Please include that the physician/practitioner will re-evaluate the resident and either correct the form, or that the home will make plans to discharge based on the physician's recommendation. Please include the date by which this will occur and the title of the person responsible.

Please include the title of the person responsible for the initial audit.

Please include the title of the person responsible for training the new wellness director and wellness coordinator.

Please include the start date and frequency of the audit of preadmissions screenings to be conducted by the new Wellness Director/designee.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

Resident [redacted]s needs can be met by The Pinnacle. [redacted] has been an active and well-adjusted resident since 2024. The Wellness Coordinator who was employed at the time of the completion of the Pre Screen obviously made an error by checking the box indicating "NO" the resident's needs could not be met in Part III known as Determination. The Wellness Coordinator put a line through the "X" in the "NO" box but did not go back and check the "YES" box.

The Pre Screen is completed by the PCHA, The Designated Personal Care Home Staff Person or a Human Services Agency. However, in this instance, as indicated by The Department on 3/19/26 as part of the approval process for this Plan of Correction, The Pinnacle will have the Nurse Practitioner make the determination that Resident [redacted]s needs can be met in the PCH. The Nurse Practitioner will re-evaluate the resident and correct the Preadmission Screen Form by checking the "YES" box. The Nurse Practitioner will sign and date the original form as part of this Plan of Correction. Should the Nurse Practitioner determine that the residents' needs can no longer be met at The Pinnacle, the home will make plans to discharge the resident based on the physician's recommendation. This determination and form update will occur by the Nurse Practitioner by April 1st, 2026.

The Pinnacle continues to receive citations on Preadmission documents from 2023, 2024 and early 2025. A comprehensive audit of Preadmission Screens will be completed and a POC explanation noting an audit of the screen will be attached to the original screening tool to avoid further citation on documents from timeframes when the current staff was not employed at The Pinnacle. The current Pinnacle staff cannot alter documents in excess of two years old, as the residents' needs and baseline are very different at this time, in most cases. This audit will be completed by 4/1/26 by The Executive Director, or Designee.

The new Wellness Director and Wellness Coordinator will be trained on the regulatory expectations of 2600.224a within five days of their hire dates, by The Executive Director, to ensure that new resident assessments are compliant to the regulatory expectations from the onset of their employment.

The Wellness Director, or Wellness Coordinator, will audit any Prescreen that they do not personally complete for thirty days past their training date on this regulatory expectation to assure that dates and form information are complete. They will be required to initial the Prescreen noting their review for the thirty-day timeframe.

Licensee's Proposed Overall Completion Date: *04/05/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

252 - Record Content

12. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [redacted]s record do not include a photograph of the resident that is no more than 2 years old.

Resident [redacted]s and [redacted]s records do not include a record of incident reports for the individual residents.

Plan of Correction ***Do Not Accept [redacted] - 03/19/2026)***

All Personal Care residents will have their picture taken at time of admission and uploaded to The Pinnacle's electronic health record by the Lifestyle Director, or Designee.

Moving forward all residents residing at The Pinnacle will have their pictures updated annually between April 1st and April 30th. The date of upload is recorded in the electronic health record under the "edit photo" section.

Incident reports are kept in the incident report binder. All incident reports will be scanned into the resident's electronic health record under the Miscellaneous Tab and identified by date beginning April 1st, 2026, and moving forward.

252 - Record Content *(continued)*

Licensee's Proposed Overall Completion Date: *04/01/2026*

Update: *03/19/2026*

Has an audit of current records been performed?

Please include the title of the person responsible for the annual updates of photographs, and the methods by which this task will be tracked.

Please indicate the title of the person responsible for updating the incident binder, and the methods by which this will be tracked.

How will the home measure ongoing compliance?

Plan of Correction ***Accept [redacted] - 03/24/2026)***

All Personal Care residents will have their picture taken at time of admission and uploaded to The Pinnacle's electronic health record by the Lifestyle Director, or Designee.

Moving forward all residents residing at The Pinnacle will have their pictures updated annually between April 1st and April 30th by The Lifestyle Director exceeding the regulatory expectation of pictures being taken every two years. This includes all pictures being updated in April of 2026 by the Lifestyle Directors for all PC and SDCU residents versus completing an audit. The date of upload is recorded in the electronic health record under the "edit photo" section.

Incident reports are kept in the incident report binder which is provided to The Department immediately upon request. All incident reports will begin to be scanned into the resident's electronic health record under the Miscellaneous Tab and identified by date beginning April 1st, 2026, and moving forward by the person responsible for completing the report.

The Executive Director files the incident reports in the master Reportable binder that is kept in the Executive Director's office. The Executive Director will check the electronic health record prior to filing each report in the binder, as an assurance that the individual who has completed and sent the report to The Department also uploaded it to the electronic record beginning April 1st, 2026, and moving forward.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

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

June 11, 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 04/16/2026 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: *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**: *130* **Waking Staff**: *98*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *04/16/2026*

Inspection Dates and Department Representative

04/16/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *87*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st Floor* **Capacity**: *19* **Residents Served**: *14*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *87*

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

Have Mobility Need: *43* **Have Physical Disability**: *0*

Inspections / Reviews

04/16/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2026*

05/08/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/13/2026*

Inspections / Reviews *(continued)*

05/11/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/02/2026*

06/11/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

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

89a - Water Pressure

1. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On [redacted] at 9:15 A.M., the home did not have sufficient hot and cold water to resident bedroom [redacted]

Plan of Correction ***Accept [redacted] - 05/08/2026)***

As follow-up to the prior plan of correction regarding the untimely failure of the manufacturer seals in the hot water heaters, an event that could not have been foreshadowed but was immediately reported to The Department, the surveyor stated that the focus was on water access throughout the community.

The resident in Apartment Room [redacted] had hot and cold water at temperatures that met regulatory guidelines; however, the surveyor felt the water flow in the bathroom sink was not strong enough.

Immediately following the survey, The Facilities Director, removed the faucet screen restoring full flow to the spigot.

All staff will be retrained in the use of the online work order system, TELS, to complete requests for work orders for any issues or items identified to need repair in a resident's room or throughout the community. The Interim Executive Director, or Designee, expects to complete this training by May 31st, 2026.

Housekeepers are required to audit the resident's room weekly for functional repairs as they clean the room. The Facilities Director, or Designee, will complete a Housekeeping specific training on water temperatures and water flow to bring attention to this specific issue. This training is expected to be completed by May 31st, 2026, with the Maintenance and Housekeeping team members.

The timely completion of work orders entered in the TELS systems is monitored by the Facilities Director, Executive Director and Regional Support Positions.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

101j7 - Lighting/Operable Lamp

2. 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

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Do Not Accept [redacted] 05/08/2026)***

As mentioned at the time of survey, Resident [redacted] family started clearing the room of residents' personal items in preparation for the residents moving to a higher level of care.

101j7 Lighting/Operable Lamp (continued)

Staff placed a wall mount light next to the resident's bed for the remaining time that the resident resided at The Pinnacle. Resident [redacted] has discharged from The Pinnacle.

Auditing the bedside lighting source is a part of the weekly housekeeping cleaning protocol. Beginning the first week of May 2026 and continuing for the next thirty days/four weeks, the Housekeeping Supervisor, or Designee, will randomly audit three rooms per week for placement of a functioning light source by bedside in all Personal Care bedrooms. The absence of a lighting source will be immediately addressed, if found.

This, and all Plans of Correction will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Update: *05/08/2026*

The overall completion date is too far in the future.

Plan of Correction ***Accept [redacted] - 05/11/2026)***

As mentioned at the time of survey, Resident [redacted] family started clearing the room of residents' personal items in preparation for the residents moving to a higher level of care.

Staff placed a wall mount light next to the resident's bed for the remaining time that the resident resided at The Pinnacle. Resident [redacted] has discharged from The Pinnacle.

Auditing the bedside lighting source is a part of the weekly housekeeping cleaning protocol. Beginning the first week of May 2026 and continuing for the next thirty days/four weeks, the Housekeeping Supervisor, or Designee, will randomly audit three rooms per week for placement of a functioning light source by bedside in all Personal Care bedrooms. The absence of a lighting source will be immediately addressed, if found.

This, and all Plans of Correction will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Evidence of Completion ***Implemented [redacted] 06/11/2026)***

See attached.

141a - Medical Evaluation

3. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident. Resident [redacted] was admitted to the home [redacted] and their medical evaluation was completed [redacted].

141a - Medical Evaluation *(continued)*

Plan of Correction ***Do Not Accept [redacted] - 05/08/2026)***

Resident [redacted] DME was completed within the regulatory guidelines. However, [redacted] assessment was completed in December of 2025, outside of the assessment guidelines.

Resident [redacted] shall have a new medical evaluation completed to reflect a reassessment. Resident [redacted] does not see the visiting health provider, therefore, this reassessment will be expected to be completed by May 20th, 2026.

The Wellness Director, Nurses and Marketing Team will be trained specifically in the physical examination guidelines by the Interim Executive Director, or Designee. This training will be expected to be completed by May 31st, 2026.

All new residents and annual DME's will be audited by The Wellness Director, or Designee, for adherence to these regulatory standards. The Wellness Director, or Designee, will initial all new admission, significant change and annual DME's until June 30th, 2026, as proof of the ongoing auditing compliance to this regulation.

This, and all Plans of Correction, will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Update: *05/08/2026*

The overall completion date is listed as [redacted], however there is a step that is not expected to be completed until [redacted]. Please revisit the timeframe for completing that step.

Plan of Correction ***Directed [redacted] - 05/11/2026)***

Resident [redacted]s DME was completed within the regulatory guidelines. However, [redacted] assessment was completed in December of 2025, outside of the assessment guidelines.

Resident [redacted] shall have a new medical evaluation completed to reflect a reassessment. Resident [redacted] does not see the visiting health provider, therefore, this reassessment will be expected to be completed by May 20th, 2026.

The Wellness Director, Nurses and Marketing Team will be trained specifically in the physical examination guidelines by the Interim Executive Director, or Designee. This training will be expected to be completed by May 31st, 2026.

All new residents and annual DME's will be audited by The Wellness Director, or Designee, for adherence to these regulatory standards. The Wellness Director, or Designee, will initial all new admission, significant change and annual DME's until June 30th, 2026, as proof of the ongoing auditing compliance to this regulation.

This, and all Plans of Correction, will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Proposed Overall Completion Date: 06/30/2026

Directed Completion Date: *05/31/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

141a 1-10 Medical Evaluation Information

4. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted]s medical evaluation did not include their medical diagnoses.

Plan of Correction ***Do Not Accept [redacted] - 05/08/2026)***

Resident [redacted]s DME was completed within the regulatory guidelines. However, [redacted] assessment was completed in December of 2025, outside of the assessment guidelines.

Resident [redacted] shall have a new medical evaluation completed to reflect a reassessment. Resident [redacted] does not see the visiting health provider, therefore, this reassessment will be expected to be completed by May 20th, 2026.

The Wellness Director, Nurses and Marketing Team will be trained specifically in the expectation that .141a 2-10 be completed/included and signed as a part of the expectation for admission of a resident to The Pinnacle. This training will be expected to be completed by May 31st, 2026.

All new residents, annual and significant change DME's will be audited by The Wellness Director, or Designee, for adherence to these regulatory standards. The Wellness Director, or Designee, will initial all new admission, significant change and annual DME's until June 30th, 2026, as proof of the ongoing auditing compliance to this regulation.

This, and all Plans of Correction, will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Update: *05/08/2026*

The overall completion date is listed as [redacted], however there is a step that is not expected to be completed until [redacted]. Please revisit the timeframe for completing that step.

Plan of Correction ***Directed ([redacted] 05/11/2026)***

Resident [redacted]s DME was completed within the regulatory guidelines. However, [redacted] assessment was completed in December of 2025, outside of the assessment guidelines.

141a 1-10 Medical Evaluation Information (continued)

Resident [redacted] shall have a new medical evaluation completed to reflect a reassessment. Resident [redacted] does not see the visiting health provider, therefore, this reassessment will be expected to be completed by May 20th, 2026.

The Wellness Director, Nurses and Marketing Team will be trained specifically in the expectation that .141a 2-10 be completed/included and signed as a part of the expectation for admission of a resident to The Pinnacle. This training will be expected to be completed by May 31st, 2026.

All new residents, annual and significant change DME's will be audited by The Wellness Director, or Designee, for adherence to these regulatory standards. The Wellness Director, or Designee, will initial all new admission, significant change and annual DME's until June 30th, 2026, as proof of the ongoing auditing compliance to this regulation.

This, and all Plans of Correction, will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Proposed Overall Completion Date: 06/30/2026

Directed Completion Date: *05/31/2026*

Evidence of Completion ***Implemented [redacted] 06/11/2026)***

See attached.

162c - Menus Posted

5. 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 weeks of [redacted] to [redacted] were posted. However, the week of [redacted] to [redacted] was not posted.

Plan of Correction ***Accept [redacted] - 05/08/2026)***

The current week's menu was removed to make an adjustment to the dining offerings for the week, secondary to food delivery/order availability. The surveyor saw the Executive Chef rehang the current week while on site near the Second Floor Dining Room at the time of the physical survey walkthrough of The Pinnacle.

Shortly after the 4/16/26 survey, The Pinnacle promoted the Executive Chef into the position of Dining Services Director. The new Dining Services Director will be trained in this regulatory expectation by The Interim Executive Director. This training is expected to be completed by May 15th, 2026.

The new Dining Services Director will also be trained, by the Interim Executive Director, regarding the practice of keeping the weekly menus posted at all times. The weekly menu will include a caveat statement indicating the listed items are subject to change. Daily menus, which are posted for the upcoming days meals after dinner the prior day, will reflect any menu changes or alterations for the upcoming day or upcoming meal. The weekly menus, once

162c - Menus Posted (continued)

removed at the end of the week, will be updated permanently to match the daily revisions and kept for a period of one year, should a regulatory review be required. This will help prevent future occurrences of an unposted weekly menu, as a root cause analysis has determined that this is what occurred in the past two circumstances of unposted weekly menus. Evidence of this can be found in the surveyor's own observations, as mentioned above, ie: the upcoming two weeks of menus were already posted. This referenced training is also expected to be completed by May 15th, 2026.

The new Dining Services Director, or Designee, will audit the required postings for a period of sixty (60) days beginning April 1st, 2026, to ensure that the weekly menu and advanced menu remain posted conspicuously per the regulatory guidelines.

Dining Team members were trained in this regulatory expectation on April 20th, 2026.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Evidence of Completion ***Implemented [redacted] - 06/11/2026)***

See attached.

185a - Implement Storage Procedures

6. 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] as needed. On [redacted] this medication was not available in the home.

Resident [redacted] is prescribed [redacted] as needed. On [redacted] this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 05/08/2026)***

Resident [redacted] s [redacted] was reviewed with the Nurse Practitioner and discontinued.

Resident [redacted] s [redacted] reordered.

The new Wellness Director was trained to the expectations of this regulation on April 6th, 2026, by the Interim Executive Director.

The new Wellness Director, or Designee, will educate the Medication Technicians and Nurses regarding the implications of regulations 2600.185, most especially with regarding to prn/as needed medications.

Pinnacle med carts are currently being audited weekly either by The Pharmacy, a Nurse or a Medication Technician. The medication cart audit includes checking that the prn/as needed medications are present on the cart. These audits began on April 1st, 2026, and will continue for 45 days.

As an additional proactive measure, the Wellness Director or Designee will pull one resident's prn medications per week during a Practicum Observer observation audit with a staff person and assure that all prn medications are

185a - Implement Storage Procedures (continued)

present for that resident. This audit will begin during the week of 5/6/26 and continue for thirty days.

This, and all Plans of Correction, will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Evidence of Completion ***Implemented (06/11/2026)***

See attached.

231b - Medical Evaluation

7. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on ; however, the resident's medical evaluation was completed on and did not include that Resident requires dementia related care in a secured area.

Plan of Correction ***Accept - 05/08/2026)***

Although "transfer to SDCU" is clearly written on the DME, in the status change and immobile status section, as the reason for the new DME Resident s need for SDCU (the box at #14) is checked "no" in error.

Resident s Medical Evaluation under #14 was updated by the Nurse Practitioner to indicate that Resident requires dementia related care in a secure area.

The Wellness Director and Nurses will be trained in expectations of this regulatory guideline, 2600.231, by The Interim Executive Director. This training will be expected to be completed by May 31st, 2026.

All new, annual and significant changes DME's will be audited by The Wellness Director, or Designee, for adherence to these regulatory standards. The Wellness Director, or Designee, will initial all new admission, significant change and annual DME's until June 30th, 2026, as proof of the ongoing auditing compliance to this regulation.

This, and all Plans of Correction, will be reviewed as part of the monthly Quality Assurance Meeting, held monthly by the last Friday of the month.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Evidence of Completion ***Implemented 06/11/2026)***

See attached.