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

April 23, 2026

SBLP UPPER DUBLIN OPCO LLC

RE: THE 501 AT MATTISON ESTATE
501 MATTISON AVENUE
AMBLER, PA, 19002
LICENSE/COC#: 14926

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/12/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE 501 AT MATTISON ESTATE* **License #**: *14926* **License Expiration**: *10/13/2026*

Address: *501 MATTISON AVENUE, AMBLER, PA 19002*

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

Administrator

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

Legal Entity

Name: *SBLP UPPER DUBLIN OPCO LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *08/03/2022* **Issued By**: *Upper Dublin Township*
Type: *I-2* **Date**: *08/03/2022* **Issued By**: *Upper Dublin Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *147* **Waking Staff**: *110*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *02/12/2026*

Inspection Dates and Department Representative

02/12/2026 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *118* **Residents Served**: *102*

Special Care Unit

In Residence: *Yes* **Area**: *3rd floor* **Capacity**: *42* **Residents Served**: *40*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *102*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *45* **Have Physical Disability**: *0*

Inspections / Reviews

02/12/2026 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/16/2026*

Inspections / Reviews *(continued)*

03/18/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *04/22/2026*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *03/23/2026*

03/23/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *04/22/2026*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *04/22/2026*

04/23/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *04/22/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

42b Abuse/Neglect

1. Requirements

2800.
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 Resident eloped from the residence's Secure Care Unit (SCU). Resident was admitted to the residence's SCU on . Resident has a diagnosis of , uses hearing aids, ambulates with a walker and can be unsteady at times. Resident assessment and support plan dated 1/27/2026 shows that the resident requires some supervision in the home and cannot leave the home unattended. The support plan also indicates that the resident uses a WanderGuard. The SCU is equipped with delayed egress emergency exit doors with push bars that will disengage the magnetic locking system if the push bar is held down for 15 seconds. When the push bar is engaged and the door opens, an alarm sounds at the door and sends a notification to the homes iPad system that staff have and carry around with them. The doors in the Secure Care Unit are also equipped with a WanderGuard system intended to prevent the magnetic lock from disengaging when a wrist tag is near the sensors, however, it is unclear if the WanderGuard system is designed to prevent the lock from disengaging with the push bar is activated for the delayed egress.

On resident was last seen by staff person A around 8:30pm. Resident was lying in bed with hearing aids removed, after receiving their scheduled medications. At approximately 9:00pm, staff person A, who was assisting a different resident in a nearby room, heard an alarm sounding at stairwell #7 door. Staff person A was not immediately able to attend to the door alarm because they were completing care with another resident and could not step away. After completing care with the other resident, staff person A went to the door where the alarm was sounding, did a quick visual check of the stair well and deactivated the alarm. The stairwell appeared empty, but at this time, Staff person A noticed that resident door was opened and found that resident was no longer present in their room. Staff person A screamed out "Anyone seen [resident]?" and staff in the unit began searching the 3rd floor but was unable to locate

According to the WanderGuard system report, resident used the push bar to open the door and exited to stairwell #7 at 8:57 PM, setting off a low sounding audible alarm at the door and notifications were sent to the home's aerial iPad system. At this time, there were 2 other staff working on the unit, who were both attending to other residents, and neither heard the alarm going off at the door due to their respective locations in the SCU. Both staff reported that they did see the door alert on the iPad but were unable to immediately respond due to actively providing care for other residents. The WanderGuard system indicated that Staff person A deactivated the door alarm after about 3 minutes and 48 seconds after it was initially activated.

At 9:17 PM the residence's exterior security camera, which focuses on the main entrance door and outside area, captured a video of resident crossing in front of the residence's main entrance and then resident moved out of view while continuing to walk towards the other side of the building.

At an unknown time, resident was then sighted by a concerned citizen in a nearby neighborhood who contacted 911. At approximately 9:30 PM an ambulance arrived at the front entrance of the residence with resident inside. Staff person B had just walked out of stairwell #7 as part of the search for the missing resident and was met by the ambulance crew and was able to positively identify the resident as living in the SCU. The resident was bleeding from the face and arm but was alert and knew name. Resident was then transported to hospital for evaluation after sustaining injury from an apparent fall, while walking around outside the residence.

42b Abuse/Neglect (continued)

On [redacted] there were piles of snow which had been shoveled/plowed to the sides of the sidewalks and roads. It last snowed 7 inches on 1/25/2026. The high temperature of day on 2/4/26 was 34 degrees Fahrenheit and a low of 27 degrees Fahrenheit. Resident [redacted] was observed to be wearing only a long sleeved shirt, pajama pants and shoes when [redacted] left the residence. Resident was not walking with their walker. The resident was found by the ambulance crew at an unknown location close to the residence in an area that is dark, and only partially lit by nearby homes or streetlamps.

On [redacted] resident [redacted] returned to the residence's secure care unit after sustaining the following injuries: right [redacted] and [redacted]

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

All wellness staff were in serviced on 2/5/26 on company elopement policies and procedures. All wellness staff were in serviced on 2/5/26 regarding the importance of responding immediately to SDCU door alarms and always carrying their tablets. Additional door alarms have been installed on all first floor stairwell exit doors leading from the memory care unit.
All wellness new hires will receive in service training on company elopement policy and procedures and responding to door alarms. An elopement drill was conducted on 3/11/26, then monthly x 2 months, then twice per year moving forward.
The HWD or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented ([redacted] - 04/23/2026)

54a Direct care staff quals

2. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.
4. Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident’s final support plan under § 2800.227(e) (relating to development of the final support plan).

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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

Staff A was immediately removed from the schedule. A waiver was submitted to DHS for review and was approved on 3/11/26.
All Wellness staff files have been audited on 3/5/2026 to ensure documentation of a high school diploma, GED, or active registry status on the Pennsylvania Nurse Aide Registry are on file.
Moving forward, the HR Director or designee will ensure that all staff have the required education credentials, or

54a Direct care staff quals (continued)

that a waiver is submitted and approved prior to the start of employment.
The HR Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/23/2026)

65j Annual training content

3. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons A and B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year [redacted] to [redacted]

Plan of Correction ***Accept[redacted] 03/23/2026)***

Maintenance Director was re-educated by the ALM on 2/12/26 regarding the necessity of completing annual fire training with a fire safety expert. The annual fire training has been scheduled for 3/27/26.
All employee files were audited for fire safety training, initial and annual on 3/20/26. The HR Director will then audit 10% of files monthly x 3 months to ensure ongoing compliance
Moving forward, the Maintenance Director or designee will be responsible for scheduling the annual training with a fire safety expert or by a staff person trained by a fire safety expert. The Maintenance Director will also be responsible for ensuring ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/23/2026)

82a Poisons original containers

4. Requirements

2800.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On [redacted] at 9:19 AM, two unlabeled cleaning squirt bottles, each containing a small amount of unidentified liquid, were observed on an unattended housekeeping cart outside room 309.

82a Poisons original containers *(continued)*

Plan of Correction ***Accept [redacted] - 03/23/2026)***

Re-training was held on 2/12/26 explaining the above regulation to all housekeepers. Housekeepers were instructed that when working in the Special Care/Dementia Care Unit (SDCU), they must have all cleaning chemical bottles labeled and in their original container.
The Lead Housekeeper or Maintenance Director will train each new housekeeper, before they begin working in the SDCU, on the proper storage of all unsafe chemicals.
An audit will be performed on all housekeeping carts weekly x 6 weeks to ensure ongoing compliance.
Additional training will be provided annually during housekeeping meetings.
The Maintenance Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/23/2026)

82c Locked poisons

5. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] at 9:19 AM, two unlabeled cleaning squirt bottles, each containing a small amount of unidentified liquid, were observed on an unattended housekeeping cart outside room 309. Not all residents of the home, including resident [redacted] have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

Re-training was held on 2/12/26 explaining the above regulation to all housekeepers. Housekeepers were instructed that when working in the Special Care/Dementia Care Unit (SDCU), they must keep carts locked when the cart is not in their direct sight. They were also instructed that they may take the cart into an apartment with them while working.
The Lead Housekeeper or Maintenance Director will train each new housekeeper, before they begin working in the SDCU, on the proper storage of all poisonous materials.
All staff will be reeducated on the regulation on 3/27/26. There will be an audit of the secure neighborhood weekly x4, then monthly x2 to ensure ongoing compliance.

Additional training will be provided annually during housekeeping meetings.
The Maintenance Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] 04/23/2026)

100b Removal snow/obstructions

6. Requirements

2800.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On [redacted], at 9:36 AM, there was an approximate 3 to 5 inch high by 1.5 foot wide accumulation of snow/ice impeding the sidewalk pathway from emergency exit door at stairwell 8.

At 9:39 AM the entire length of sidewalk/pathway outside of emergency exit stairwells 9 and 10 were not cleared and covered entirely in about 2 inches of snow.

The last significant snow fall for the area occurred at the end of January 2026.

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

Maintenance staff immediately shoveled all remaining snow from the sidewalks and around the emergency exits on 2/12/26.
On 2/13/26, the Maintenance Director trained maintenance staff to ensure that during future snowstorms, staff will pre-salt walkways and shovel snow during and after the storm to maintain safe access to all entrances and emergency exits.
The Maintenance Director or designee will be responsible for ensuring ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/23/2026)

131f Fire extinguisher inspection

7. Requirements

2800.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

There was no date of the inspection on the fire extinguisher located near elevator 3 on the 3rd floor.

There was no date of the inspection on the fire extinguisher located in near room [redacted]

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

The fire extinguisher was inspected, re-tagged, and dated on 2/14/26. All fire extinguishers were inspected by the Maintenance Supervisor on 2/14/ 26 to ensure they were properly dated and in good working condition.
Moving forward, the Maintenance Director or designee will conduct weekly checks of all fire extinguishers for four weeks and then twice per month for two months. The Maintenance Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/23/2026)

231c1 Preadmit screening

8. Requirements

2800.
231.c.1. Special care unit for residents with Alzheimer's disease or dementia.

i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.
ii. A geriatric assessment team is a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident and assists in developing a support plan by working with the resident's physician, designated person and the resident's family to coordinate the resident's care.

Description of Violation

Resident [redacted] was admitted to the special care unit on [redacted] However, resident [redacted] written cognitive preadmission screening was completed on [redacted].

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

• All SDCU charts were audited on 3/11/26 by HWD to verify that prescreening were completed within 72 hours of admission.
• HWD will provide retraining to the Memory Care Director on the requirements of Regulation 2800.231(c)(1) to ensure prescreening is completed within the required timeframe.
• Beginning 4/1/26, HWD or designee will conduct monthly random chart audits of 10% of the resident census in SDCU for three months to ensure continued compliance.
• HWD will be responsible for monitoring and ensuring ongoing compliance with Regulation 2800.231(c)(1).

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/23/2026)