

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

April 20, 2026

[REDACTED]
MCAP WILLOW GROVE OPERATOR LLC

[REDACTED]
ATTN LADONNA LEWIS
[REDACTED]

RE: COMMONWEALTH SENIOR LIVING
AT WILLOW GROVE
1120 YORK ROAD
WILLOW GROVE, PA, 19090
LICENSE/COC#: 13994

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/24/2026 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: COMMONWEALTH SENIOR LIVING AT WILLOW GROVE License #: 13994 License Expiration: 10/08/2026
Address: 1120 YORK ROAD, WILLOW GROVE, PA 19090
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: MCAP WILLOW GROVE OPERATOR LLC
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: Other Date: 02/15/1990 Issued By: Commonwealth L & I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 118 Waking Staff: 89

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Monitoring Exit Conference Date: 02/24/2026

Inspection Dates and Department Representative

02/24/2026 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

Table with 2 columns: Category and Value. Rows include General Information (License Capacity: 122, Residents Served: 75), Secured Dementia Care Unit (In Home: Yes, Area: Sweet Memories, Capacity: 52, Residents Served: 30), Hospice (Current Residents: 7), and Number of Residents Who (Receive Supplemental Security Income: 0, Are 60 Years of Age or Older: 75, Diagnosed with Mental Illness: 0, Diagnosed with Intellectual Disability: 0, Have Mobility Need: 43, Have Physical Disability: 0).

Inspections / Reviews

Table with 3 columns: Date/Type, Lead Inspector, Follow-Up Type, Follow-Up Date. Rows include 02/24/2026 Partial (Lead Inspector: [Redacted], Follow-Up Type: POC Submission, Follow-Up Date: 03/23/2026) and 03/30/2026 - POC Submission (Submitted By: [Redacted], Date Submitted: 04/17/2026, Reviewer: [Redacted], Follow-Up Type: Document Submission, Follow-Up Date: 04/09/2026).

Inspections / Reviews *(continued)*

04/13/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/18/2026

04/20/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

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

Description of Violation

On [redacted] Resident [redacted] passed away. The home did not report this incident to the department until [redacted].

Plan of Correction

Accept [redacted] - 03/30/2026)

The RCD and Managers have been re-trained by the Executive Director as to this regulatory standard on 3/20/26.

The incident not reported for resident [redacted] happened outside of normal business operating hours. Beginning 3/23/26, incidents that occur outside of normal business operating hours will be reported to either the RCD or ED at which time, the person receiving notification will be responsible to follow through for reporting requirements of this regulation to the licensing agency.

Incidents will continue to be reviewed as part of the Stand up Meeting by the Executive Director, Resident Care Director or Designee.

The Manager on Duty and Medication Technicians will continue to be responsible to report any incidents to the RCD or ED if they are not at the community for review and completion of a written incident report to the Department, if applicable.

Managers and Resident Care Director were educated to this plan by the Executive Director on 3/20/26. Beginning at the next QM meeting on 4/15/26, The ED will be responsible to report on the effectiveness of this plan monthly x 60 days then resume quarterly as part of Quality Management throughout 2026.

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

Implemented [redacted] 04/13/2026)

28e - Death of a Resident

2. 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

Resident [redacted] passed away on [redacted] Resident [redacted] personal belongings were removed from [redacted] room on [redacted] however, the home did not issue a refund until [redacted]

Plan of Correction

Accept [redacted] 03/30/2026)

Company policy has been to refund resident accounts within 60 days from move out date. Company policy has been adjusted to meet the requirements of this regulation. Beginning 2/24/26, resident refunds will be within 30 days of move out date.

28e Death of a Resident (continued)

Administration educated the Business Office Manager on revised company policy, process and regulation 2600.28e on 3/20/26. Documentation shall be kept.

Beginning 3/23/26 the BOM will be responsible to review the resident move out report weekly with the ED. The ED will be responsible to ensure that a refund check has been processed within the 30 day requirement of this regulation.

Beginning at then next QA meeting on 4/15/26, the ED will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly through 2026.

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

Implemented [REDACTED] - 04/20/2026)

42c - Treatment of Residents**3. Requirements**

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [REDACTED] former Staff Member A posted a video of Resident [REDACTED] Resident [REDACTED] and Resident [REDACTED] taken in the home, to Tik Tok. Resident [REDACTED] Resident [REDACTED] and Resident [REDACTED] reside in the secured dementia care unit and did not consent to having a video taken by this former Staff Member and did not consent to it being posted to the Internet.

Plan of Correction

Accept [REDACTED] - 03/30/2026)

A certified letter will be issued by 3/24/26 by the Executive Director to the previous employee in further attempts to make contact regarding the Tiktok incident reported to us on 12/31/25 and request that it be removed from all social media. Documentation shall be kept.

Staff have been re trained as to the requirements of this regulation and the TikTok incident was reviewed as it relates to video and social media expectations both regulatory and indicated in company policy by the Executive Director on 2/26/26. Docementation shall be kept.

The Executive Director or Designee will be responsible to ensure education to address Treatment of Residents under this regulatory requirement will continue monthly in Staff Town Hall throughout 2026 to support compliance.

Beginning the next QA Meeting on 4/15/26, the Executive Director will report on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly through 2026.

42c - Treatment of Residents *(continued)*

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

Implemented (████) - 04/20/2026)

82c - Locking Poisonous Materials

4. Requirements

2600.

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

Description of Violation

Antibacterial Denture Cleanser, with a manufacture's label indicating "in case of accidental ingestion, seek professional attention or contact a Poison Control Center immediately", was unlocked, unattended, and accessible to residents in Resident █████'s bedroom. Not all the residents of the home, including Resident █████ have been assessed capable of recognizing and using poisons safely.

Arm & Hammer Moisture Absorber & Odor Eliminator, with a manufacture's label indicating "if ingested, seek professional call a Poison Control Center or get immediate medical attention", was unlocked, unattended, and accessible to residents in Resident █████'s bedroom. Not all the residents of the home, including Resident █████ have been assessed capable of recognizing and using poisons safely.

Listerine Cool Mint Mouthwash, with a manufacture's label indicating "if more than used for rinsing is accidentally swallowed, get medical help or contact Poison Control right away", was unlocked, unattended, and accessible to residents in Resident █████'s bedroom. Not all the residents of the home, including Resident █████ have been assessed capable of recognizing and using poisons safely.

Crest ProHealth Advantage Mouthwash, with a manufacture's label indicating "if more than used for rinsing is accidentally swallowed, get medical help or contact Poison Control Center right away", was unlocked, unattended, and accessible to residents in Resident █████'s bedroom. Not all the residents of the home, including Resident █████ have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept (████) - 03/30/2026)

On 2/24/26 at time of survey, the unlocked items in resident room #'s 6, 7, 8, 9 and 10 were locked up at time of survey by Maintenance and care staff.

Staff were re-trained as to this regulation and requirements on 2/26/26 by the Executive Director. Documentation shall be kept.

Beginning 2/24/26, care staff will be responsible to lock poisonous materials in resident rooms where applicable to remain in compliance. Beginning 3/27/26, a daily random audit of 4 resident rooms will be done by Programming department staff or Designee to ensure that poisonous materials are locked.

Beginning 3/27/26, the RCD or Designee will be responsible to complete a random audit of 4 resident rooms twice

82c Locking Poisonous Materials (continued)

weekly to ensure compliance to this regulation and will report on the effectiveness of this plan as part of monthly QA beginning 4/15 x 60 days then resume quarterly through 2026.

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

Implemented [redacted] - 04/13/2026)

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at 9:58 A.M., there was a brown substance that appeared to be feces on the light switch of the common bathroom in the secured dementia care unit.

Plan of Correction

Accept [redacted] - 03/30/2026)

On 2/24/26 at time of survey, the brown substance on the light switch of the common bathroom in the secured dementia care unit was cleaned at time of survey by maintenance and housekeeping staff.

Staff was in serviced as to this regulatory requirement on 2/26/26 by the Executive Director. Documentation shall be kept.

Care, Housekeeping and Maintenance staff will be trained by the Executive Director as to this plan by 3/30/26. Documentation shall be kept.

Beginning 3/30/26, the overnight care staff will check all common area restrooms in memory care for cleanliness at least once per shift and will address as needed.

Beginning 3/30/26, the housekeeping staff will complete a check of all common area restrooms upon arrival to shift each morning to ensure compliance.

Beginning 3/30/26, the Housekeeping Lead or Designee will be responsible to complete random audits of the common area restrooms in the secured dementia care unit on a weekly basis and report on the effectiveness of this plan as part of monthly QM beginning 4/15/26 x 60 days then resume quarterly through 2026.

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

85a - Sanitary Conditions *(continued)**Implemented* [REDACTED] - 04/13/2026)

85e - Trash Outside Home

6. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [REDACTED] at 9:28 A.M. two dumpsters outside the home were filled with trash and the side access doors of both dumpsters were open.

Plan of Correction*Accept* [REDACTED] - 03/30/2026)

The two side access doors of both dumpsters open at time of survey had been damaged during routine trash service by the trash provider and were repaired at time of survey to ensure further incidences do not occur.

Staff will continue to take trash directly to the dumpster as per our current plan of correction and the Maintenance Director and Dining Services Director will continue to do random audits to ensure compliance to this regulation.

Staff was re-trained as to this regulation and requirements on 2/26/26 by the Executive Director. Documentation shall be kept.

Beginning 3/23/26, any issues related to compliance to this regulation will be reported by staff at the community to the weekend MOD for timely resolution. Beginning 3/23/26, the weekend MOD will be responsible to perform an audit of the trash receptacles and storage to ensure compliance to this regulation.

The MOD Director Team has been in-serviced as to this plan on 3/20/26 by the Executive Director. Documentation shall be kept.

The ED will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly through 2026.

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

Implemented [REDACTED] 04/13/2026)

88a - Surfaces

7. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [REDACTED] at 9:28 A.M. two ceiling tiles near resident bedroom [REDACTED] had water stains present.

88a - Surfaces (continued)

Plan of Correction**Accept** [REDACTED] - 03/30/2026)

The ceiling tiles with water stains outside of room [REDACTED] were changed at time of survey by maintenance personnel.

Ceiling tiles will continue to be audited as part of a daily community walk through by the Maintenance Director or Designee and replaced if they do not meet the requirements of this regulation.

Beginning 3/27/26 and ongoing, regular audits by the Executive Director to ensure compliance to this regulation will take place 3 times weekly.

The Maintenance Director and Executive Director have been in-serviced as to this plan and regulatory requirement on 3/20/26 by the Executive Director. Documentation shall be kept.

Beginning at the next QA meeting on 4/15/26, the Maintenance Director and Executive Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

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

Implemented [REDACTED] - 04/13/2026)

95 - Furniture and Equipment

8. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On [REDACTED] the following areas were inspected and had toilet paper present but no toilet paper holder:

1. The common bathroom in the secured dementia care unit.
2. Resident bathroom located in room [REDACTED]
3. Resident bathroom located in room [REDACTED]

Plan of Correction**Accept** [REDACTED] - 03/30/2026)

The toilet paper holders in the secured dementia common area bathroom and room 220 were placed back on the wall at time of survey by maintenance personnel.

Room 201 is currently under renovations including the bathroom and will have a new toilet paper holder installed before completion by Maintenance personnel.

Staff was in-serviced as to this regulation and requirements on 2/26/26 by the Executive Director. Documentation shall be kept.

An audit of all resident rooms was completed as of 2/28/26 by maintenance personnel to ensure toilet paper holders are properly affixed to the wall. Any toilet paper holders not meeting this regulatory requirement were replaced with a new model toilet paper holder.

95 Furniture and Equipment (continued)

Beginning 3/1/26, this new toilet paper holder will be installed to replace current holders in any rooms undergoing room prep after a resident moves out to prepare for a new resident to the room.

Beginning 3/23/26, Housekeeping staff will be responsible to check resident rooms at time of routine room cleaning to ensure the toilet paper holder meets the requirements of this policy and report those needing replacement for follow up by Maintenance personnel.

The Maintenance Director was in serviced as to this regulation and plan on 3/20/26 by the Executive Director. Documentation shall be kept.

Beginning 3/27/26, the Maintenance Director will be responsible to perform bi weekly audits of random resident rooms to ensure compliance to this regulation.

Beginning at the next QA meeting April 15th, 2026, the Maintenance Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

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

Implemented (████) - 04/13/2026)

101j3 - Bed/Linens/Pillows/Blankets

9. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for Resident █████ had no linens, pillows, or blankets present on both beds on █████ at 10:08 A.M.

Plan of Correction

Accept █████ 03/30/2026)

Care staff was actively gathering clean sheets in the linen storage area for resident █████ and returned to the room momentarily to place the clean linens on the bed at time of survey.

Beginning on 2/26/26, any staff changing bed linens for a resident will ensure that clean linens, pillows and blankets are present in the room at time of changing dirty bed linens. Staff was in serviced on 2/26/26 by the Executive Director as to the requirements of this regulation. Documentation shall be kept.

Beginning on 3/27/26, the Resident Care Director or Designee will be responsible to ensure through regular,

101j3 - Bed/Linens/Pillows/Blankets (continued)

random audits of linen changes twice weekly, that the requirements under this regulation are being met. The Resident Care Director was in-serviced by the Executive Director on 3/20/26 as to this regulation and plan. Documentation shall be kept.

Beginning at the next QA meeting on 4/15/26, the Resident Care Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

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

Implemented [REDACTED] 04/13/2026)

183b - Meds and Syringes Locked**10. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [REDACTED] at 9:58 A.M. [REDACTED] and [REDACTED] were unlocked, unattended, and accessible in Resident [REDACTED]'s bathroom. Resident [REDACTED] has not been assessed to self-medicate.

On [REDACTED] at 10:08 A.M. [REDACTED] and [REDACTED] were unlocked, unattended, and accessible in Resident [REDACTED]'s bedroom. Resident [REDACTED] has not been assessed to self-medicate.

On [REDACTED] at 10:00 A.M. [REDACTED] was unlocked, unattended, and accessible in Resident [REDACTED]'s bathroom. Resident [REDACTED] has not been assessed to self-medicate.

On [REDACTED] at 10:10 A.M. [REDACTED] was unlocked, unattended, and accessible in shared resident bedroom [REDACTED]. Resident [REDACTED] and Resident [REDACTED] have not been assessed to self-medicate.

Plan of Correction

Accept ([REDACTED] - 03/30/2026)

The unlocked OTC, CAM, syringes and OTC medications for resident's 6,7, 8, 11 and 12 were removed and locked at time of survey by the Maintenance Director.

Staff was in-serviced on 2/26/26 as to the requirements of this regulation and plan by the Executive Director. Documentation shall be kept.

Beginning 2/26/26, care staff are responsible to lock all items as it relates to this regulatory requirement in resident rooms during the shift they are scheduled to work.

Beginning 3/27/26, Programming staff will be responsible to perform 4 random room audits 3 times weekly x 60 days, then resume weekly x 30 days.

Beginning 3/27/26, the Resident Care Director will be responsible to perform a weekly audit of 4 resident rooms x 30 days to ensure compliance to this regulation. The Programming staff and Resident Care Director were in-serviced

183b - Meds and Syringes Locked (continued)

as to this plan on 3/20/26 by the Executive Director. Documentation shall be kept.

Beginning at the next QA meeting on 4/15/26, the Resident Care Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

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

Implemented [REDACTED] - 04/20/2026)

183e - Storing Medications**11. 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.

Description of Violation

On [REDACTED] at 2:51 A.M. [REDACTED] subcutaneous auto injector solution was present on the cart for Resident [REDACTED]. This medication expired on [REDACTED].

Resident # 13's [REDACTED] had a tear in the foil of the blister pack at number 11. The medication was still present in the blister pack.

Plan of Correction

Accepted [REDACTED] - 03/30/2026)

The prescription medication zegaloue for resident [REDACTED] was removed from the medication cart and destroyed per company policy by the Resident Care Director at time of survey. The Lorazepam for resident #13 was removed from the cart and destroyed per company policy by the Resident Care Director at time of survey.

Medication Technicians were re-trained on the requirements of this regulation and to the below plan by the Executive Director on 2/26/26. The Resident Care Director will be responsible to hold additional staff training for medication technicians regarding this regulatory requirement by 3/31/26. Documentation shall be kept.

Cart audits will continue daily as per the current plan of correction by the 11-7 LPN or medtech to ensure compliance to this regulation. The Resident Care Director will continue to review completed cart audits to look for any patterns that may need addressed with medication administration. The Pharmacy will complete a full medication cart audit a cart by April 30th, 2026 to help support compliance to this regulation and documentation shall be kept.

Beginning at the next QA meeting on 4/15/26, the Resident Care Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [REDACTED] - 04/20/2026)

231c - Preadmission Screening

12. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department’s preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the Resident [redacted]’s written cognitive preadmission screening was not completed.

Plan of Correction

Accept [redacted] - 03/30/2026)

Resident [redacted] no longer resides at the community.

The Resident Care Director will be responsible to audit current Secured Dementia Resident records to identify any missing pre-admission screenings for completion by 4/15/26. Documentation shall be kept. The Resident Care Director was re-trained on the requirements of this regulation and to the below plan by the Executive Director 3/20/26. Documentation shall be kept.

Beginning 2/24/26, the Resident Care Director will be responsible to ensure all new admissions to the Secured Dementia Care Unit have a cognitive preadmission screening completed within 72 hours prior to admission. Beginning 2/24/26, the Executive Director will audit new move ins to ensure compliance to this regulation for 60 days. Documentation shall be kept.

Beginning at the next QA meeting on 4/15/26, the Resident Care Director and Executive Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

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

Implemented [redacted] - 04/20/2026)

234a - Admission Support Plan

13. Requirements

2600.

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

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident’s initial support plan was not completed.

Plan of Correction

Accept [redacted] - 03/30/2026)

Resident [redacted] no longer resides at the community.

The Resident Care Director will audit current Secured Dementia Residents records to identify any missing Support Plans for completion by 4/15/26. Documentation shall be kept. The Resident Care Director was re-trained on the requirements of this regulation and to the below plan by the Executive Director 3/20/26. Documentation shall be kept.

234a Admission Support Plan (continued)

Beginning 2/24/26, the Resident Care Director will be responsible to ensure all new admissions to the Secured Dementia Care Unit have a Support Plan completed within 72 hours prior to admission. Beginning 2/24/26, the Executive Director will audit new move ins to ensure compliance to this regulation for 60 days. Documentation shall be kept.

Beginning at the next QA meeting on 4/15/26, the Resident Care Director and Executive Director will be responsible for reporting on the effectiveness of this plan as part of Quality Management monthly x 60 days then resume quarterly throughout 2026.

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

Implemented [REDACTED] - 04/13/2026)