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

May 6, 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 03/19/2026 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**: *137* **Waking Staff**: *103*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/20/2026*

Inspection Dates and Department Representative

03/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *92*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st floor* **Capacity**: *19* **Residents Served**: *16*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *92*

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

Have Mobility Need: *45* **Have Physical Disability**: *0*

Inspections / Reviews

03/19/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/23/2026*

04/24/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/04/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/04/2026*

Inspections / Reviews *(continued)*

05/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/04/2026*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted] for resident [redacted] indicates the resident requires assistance with showers. On [redacted], the resident did not receive this assistance as required.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

Resident [redacted] reported this issue to Pinnacle staff. Pinnacle staff reported the matter to The Department as part of an Act 13 report. However, at first, Resident [redacted] indicated [redacted] received a shower from the staff member involved in the incident. Resident [redacted] later reported [redacted] failed to receive a shower. When this report changed, staff offered and completed a shower to fulfil the missed intervention.

All staff will receive Support Plan training by April 30th, 2026, from The Interim Executive Director, Wellness Director, or Designee to become reacquainted with resident individualized needs and required interventions.

All staff will be trained on the Point of Care system for global awareness of the system and generalized support in the use of the system, by the Wellness Director or Designee by April 30th, 2026.

The Point of Care system is currently being used to track laundry and bathing interventions for residents at The Pinnacle.

The Point of Care system will be checked weekly by the Wellness Director, or Designee, to ensure that laundry and bathing tasks are completed as assigned. Refusals or missing interventions will be addressed with the residents via offers to reschedule services at the resident's convenience.

Results of the reviews by the Wellness Director will be a part of the Plans of Correction monitoring at the Quality Assurance Meetings, held by the last Friday of each month.

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

Implemented [redacted] 05/06/2026)

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], between the hours of 11:00 PM and 7:00 AM, staff member A told resident [redacted] in a nasty tone and with profanity that [redacted] was working on two floors and could not provide a shower, resulting in double-briefing while resident [redacted] was changed for toileting. Resident [redacted] stated that being double briefed felt like, "I was treated like a piece of meat." Resident [redacted]s RASP dated [redacted] designates staff as responsible for providing toileting and peri care.

42c Treatment of Residents (continued)

Repeat Violation [redacted]

Plan of Correction ***Accept*** [redacted] ***04/24/2026)***

Several Pinnacle staff members reacted and met with Resident [redacted] *s regarding the incident* [redacted] *reported. The use of profanity on the part of the agency staff member was never mentioned until The Department visited and interviewed the resident.*

Resident was consistent in [redacted] *statement regarding how the interaction made* [redacted] *feel. This incident was immediately reported as part of an Act 13 report to Protective Services and The Department.*

The staff member involved in the incident was relieved of duty and has not been scheduled at The Pinnacle since this incident.

All staff will receive Support Plan training by April 30th, 2026, by The Interim Executive Director, Wellness Director, or Designee to become reacquainted with resident individualized needs and required interventions to comprehensively meet identified needs.

All staff will receive Resident Rights training by April 30th, 2026, from the Interim Executive Director, or Designee as a reminder of resident's rights and attention to the importance of how staff make residents feel.

Resident Rights will be reviewed at the April 2026 Personal Care Resident Roundtable Meeting, by the Interim Executive Director or Designee, to encourage all residents to express any incidents in which they feel their rights are violated.

Incidents of Resident Rights violations will be reported to The Department and AAA, per the regulatory guidelines.

Incidents and reportables will be reviewed monthly as part of the Quality Assurance Meeting, held by the last Friday of each month.

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

Implemented [redacted] ***- 05/06/2026)***

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted] *at 9:45 am, resident* [redacted] *had a sign outside the door that specified the resident's medication regimen: if the blood pressure is under* [redacted] *do not give Lisinopril; if the blood pressure is over* [redacted] *do give* [redacted]*. This information is posted on the door for visitors and residents to see.*

42s - Privacy *(continued)*

Plan of Correction ***Accept [redacted] - 04/24/2026)***

The sign was removed from Resident [redacted]s room door in SDCU and relocated inside the resident's room the day immediately following The Departments tour of the community.

This sign was created, laminated and hung by Resident [redacted]s [redacted] who resides in Independent Living at The Pinnacle. Pinnacle Staff who have received consistent training on reporting resident rights violations and abuse noted that when the Independent Living resident hung the sign the day prior to The Department's visit, staff were apprehensive to violate [redacted] rights by removing the sign [redacted] placed for [redacted] father (Resident [redacted]

Management at The Pinnacle, met with Resident [redacted]s [redacted] to explain why the sign was moved and how the posting violated [redacted] father's right to [redacted] privacy regarding [redacted] medication regimen.

All staff will receive Resident Rights training by April 30th, 2026, from the Interim Executive Director, or Designee as a reminder of resident's rights and attention to the importance of how staff make residents feel and how actions of others, even family members can violate resident rights and should be reported to management.

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

Implemented [redacted] - 05/06/2026)

60a - Staff/Support Plan

4. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted] resident [redacted] did not receive toileting, as required by [redacted] assessment and support plan. According to resident interviews, these services could not be provided due to lack of available direct care staffing in the home. Resident [redacted] rang [redacted] call bell at 8:45 am and at 7:36 pm and waited over 45 minutes for someone to come and help with toileting.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

The Pinnacle meets and exceeds designated staffing rations. Resident [redacted] prefers female caregivers for all intimate care. This preference is a part of the Support Plan, and all staff are aware of this requirement. Staff assigned by floor must often come from other floors to assure that female caregivers are available. However, this fact does not justify a 45-minute delay in care.

All staff will be retrained regarding the Call Bell policy, by The Executive Director or Designee, by April 30th, 2026.

Average call bell response times will be posted and reviewed as part of the daily All Staff Monday to Friday morning communication meeting.

60a Staff/Support Plan (continued)

The Wellness Director, or Designee, will pull one random resident's individual call report per week for the next thirty days to ensure that individual call times are answered expediently and that prolonged waits are not going unnoticed secondary to low wait times captured in the aggregate daily average.

Identified delays will be investigated by the Wellness Director, or Designee, and assigned staff will be coached and counseled.

Monthly call response timeframes will be reviewed by the Wellness Director, or Designee, as part 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: *05/04/2026*

Implemented [redacted] - 05/06/2026)

81b - Resident Personal Equipment

5. Requirements

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

Description of Violation

Resident [redacted] uses a PureWick Urine Collection system as an incontinence tool. The resident's RASP dated [redacted] indicates staff of the home is responsible for providing care of the resident's toileting and per care needs. On [redacted], the PureWick incontinence equipment was soiled and not clean causing a strong urine odor.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

Resident [redacted] previously resided with [redacted] spouse who maintained and supported residents' use of the Pure Wick, by [redacted] own preference.

Residents Support Plan has been updated to indicate that resident's spouse will continue to support the placement of the Pure Wick at bedtime, and the spouse or family will order and supply the replacement canisters per the timeframe recommended by the manufacturer.

Staff will empty the canister daily as part of the peri care regimen provided to resident [redacted] per the Support Plan.

All Direct Care and Med Tech staff will be trained in the use and emptying of the Pure Wick by April 30th, 2026, by the Wellness Director, or Designee.

All staff will be retrained on the regulatory responsibility of maintaining residents' personal equipment and overall sanitary practices by April 30th, 2026, by the Interim Executive Director, or Designee to prevent this type of issue from occurring in the future.

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

Implemented [redacted] - 05/06/2026)

100a - Exterior - Free of Hazards

6. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On [redacted], at approximately 10:15 am, the walk-through of the PC's courtyard grounds revealed a trash bag on the floor instead of in the trash can, along with broken pots on the ground nearby.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

The trash bags and pots were cleared by the Facilities Management Team on the day of the survey.

The Facilities Director has been trained by The Interim Executive Director regarding the expectations of 2600.100a.

Beginning 4/1/2026 and continuing for the next thirty workdays the Facilities Director will conduct daily tours, on [redacted] workdays, of the exterior grounds and areas of egress to ensure that the area is in good repair and free of obstructions. Issues will be addressed as they are found.

Findings and trends identified via the daily tour by the Facilities Director or the monthly community tour by the Executive Director will be reviewed as a part of the Plans of Correction at the Quality Assurance Meeting held by the last Friday of each month.

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

Implemented [redacted] - 05/06/2026)

102h Toilet Paper

7. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On [redacted] and [redacted], there was no toilet paper for the toilet in resident [redacted] bathroom.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

Resident [redacted]s toilet paper was replaced prior to the survey exit conference on 3/19/26. Resident [redacted] is a resident in SDCU.

The Interim Executive Director, or Designee, will complete an all-staff training by April 30th, 2026, on the sanitary practice of placing and replacing toilet paper in all rooms, especially SDCU, as residents often remove the paper and place the paper rolls intact into the commode.

Internal self-audits in SDCU identified the toilet paper issue in February 2026. The SDCU Director began daily audits at random times in the SDCU resident rooms on 2/18/26. This audit will continue until 4/30/26 on days that the SDCU Director works as a means of reinforcing paper placement for residents and staff.

Results of the audits by the SDCU Director will be a part of the Plans of Correction review at the Quality Assurance Meetings held by the last Friday of each month.

102h - Toilet Paper (continued)

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

Implemented [redacted] - 05/06/2026)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 10:15 am, plant trimmings on the ground blocked egress from the second-floor PC courtyard's exit ramp.

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 04/24/2026)***

The plant trimmings were cleared when this citation was identified. All other points of egress throughout the community were found to be in compliance with this regulatory standard.

The Facilities Director was retrained to this standard by The Department on 3/19/26 during the physical plant tour [redacted] was hosting with the surveyor when this violation was identified.

Beginning on 4/1/26 The Facilities Director will conduct daily tours for the next thirty workdays of all areas of egress to assure that the egress routes are free from any obstructions. These same areas shall be audited by the Facilities Director, or Designee, within 24 hours of a weather event such as but not limited to snow, heavy rain, heavy winds to ensure that the areas remain unobstructed.

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 by the last Friday of each month.

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

Implemented [redacted] - 05/06/2026)

233c - Key-Locking Devices

9. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU). The exit door from the memory care unit leading to the courtyard and the side doors in the home had the incorrect code to open them.

233c Key Locking Devices *(continued)*

Plan of Correction ***Accept [redacted] - 04/24/2026)***

The day prior to The Departments visit, one resident in SDCU was witnessed punching numeric sequences into the memory care keypad. The resident disengaged the lock using the code. Although the resident was easily redirected and did not leave SDCU the staff noted that the door was indeed disengaged using the code. Staff proactively requested that the Facilities Director change the code for all the SDCU doors to prevent unexpected or unwitnessed resident egress.

Pinnacle staff, upon finding that the new codes were not posted at all the doors, immediately replaced the postings with the new correct code.

The Facilities Director, who is the person responsible for changing the code, has been retrained to the requirements of this regulation by the Interim Executive Director.

The Facilities Director will develop and utilize a standard checklist to assure that each door code is changed, when required, and the new code is summarily posted at each door location each time the code is reset.

The SDCU Director, or Designee, will audit the posting of the door codes one time per month beginning in April of 2026 and continuing once per month for the next 90 days to assure posting compliance.

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

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

Implemented [redacted] - 05/06/2026)