

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

June 11, 2026

[REDACTED]
DRESHER MC OPCO, LLC
[REDACTED]

RE: VIVA MEMORY CARE AT DRESHER
1424 DRESHER TOWN ROAD
DRESHER, PA, 19025
LICENSE/COC#: 15164

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/23/2026 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: VIVA MEMORY CARE AT DRESHER **License #:** 15164 **License Expiration:** 06/11/2026
Address: 1424 DRESHER TOWN ROAD, DRESHER, PA 19025
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: DRESHER MC OPCO, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 12/12/2019 **Issued By:** Township of Dublin

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 80 **Waking Staff:** 60

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 04/23/2026

Inspection Dates and Department Representative

04/23/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 66 **Residents Served:** 40

Secured Dementia Care Unit

In Home: Yes **Area:** All **Capacity:** 66 **Residents Served:** 40

Hospice

Current Residents: 12

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 40
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 40 **Have Physical Disability:** 1

Inspections / Reviews

04/23/2026 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/25/2026

06/11/2026 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 05/26/2026
Reviewer: [REDACTED] **Follow-Up Type:** Bypass Document Submission

Inspections / Reviews *(continued)*

06/11/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/11/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

15c - Supervision

1. Requirements

2600.

15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [REDACTED] at approximately 9:10am, Staff person A was involved in an incident that resulted in an allegation of abuse. Staff person A was initially suspended on [REDACTED] but the home then reinstated Staff person A, who returned to work on [REDACTED] without a plan of supervision developed in conjunction with the Department.

Plan of Correction

Accept [REDACTED] - 05/29/2026)

Immediate Action

On 4/19, the staff person was suspended pending investigation and the department was notified. In the notification to the Department, there was a plan for the staff person to be reinstated that included:

- Staff education on the procedure to report a resident incident, safe transfer training and communicating with residents with Dementia
- A plan for the staff person to not be assigned the resident claiming abuse and the resident who was handled roughly.
- A plan for supervision of the staff person for two weeks following reinstatement.

In the email that contained the final report and findings of the investigation, the Home asked for the Department to reach out the next day to discuss the plan so the individual could be brought back to work. With staffing being so challenging, it was imperative to have the worker back, even in a supervised capacity, to remain compliant with staffing ratios in the Home. When the Department did not call to discuss the plan of supervision, after waiting 2 days, and knowing the Department had not responded to the self reported abuse from 4 weeks prior, or the rib fracture from 12 weeks prior, it was decided to move forward with the plan as indicated and discuss with the Department when available.

Staff Person A was educated as indicated above, was informed that [REDACTED] is not to work the assignment for either resident involved, and that [REDACTED] will be monitored for the following 2 weeks by various staff to assure appropriate interaction with residents.

The Department came to the Home on 4/24/26 to investigate this incident and at that time, the plan was discussed.

Ongoing Compliance

In the case where a staff person is suspended for inappropriate interaction with a resident - and is not terminated - the ED or designated person will submit a plan of supervision to the Department and wait for the Department to contact the Home and discuss the plan. The ED has revised the Incident Report Log to include a space to indicate if a Plan of Supervision is pending Department approval. The log will be reviewed by the ED and RCD in their weekly 1:1.

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

Implemented [REDACTED] 06/11/2026)

42b - Abuse

2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED] around 8:15 pm, staff person B was in resident [REDACTED] room to prepare the resident for bed. When the staff member attempted to change resident [REDACTED], the resident requested a different incontinence product than what was offered by the staff person and then resisted changing their clothing. A struggle ensued in which staff person B held resident [REDACTED] down on the bed by the resident's arms when the resident was being combative and then staff person B struck the resident in the mouth with their hand, hard enough to cause the resident to bleed from their mouth. Another staff member, who was busy providing care to a different resident in the adjoining room, heard this interaction and reported that the resident called staff person B a racial slur and could hear the resident and staff person arguing, but could not clearly hear all that was said. Staff member B left resident [REDACTED] room, without finishing incontinence care or changing the residents clothing, confronted the other staff person in the adjoining room, asking if they had overheard what occurred and then staff member B informed the other staff person that they 'popped' the resident in the mouth. Staff person B then left the adjoining room and the other staff person continued to provide care to their resident. Resident [REDACTED] then rang their call bell for help at 8:18pm, shortly after this altercation. Staff person C, responded to the bell and found resident [REDACTED] crying and with a mouth full of blood. Resident [REDACTED] informed staff person C that the caregiver who was just in the room punched them in the face. Resident [REDACTED] was concerned that they had missing teeth because of their bloody mouth and the resident also suffered a bruise to forehead and a cut on the left shin during the altercation. When staff person C inquired about which caregiver the resident was referencing, Resident [REDACTED] was able to clearly describe staff person B as the caregiver that hit them, and then identified staff person B immediately on sight as well. Staff person B was immediately suspended and subsequently terminated from employment. Staff person B reported during an interview with the Department that an altercation did occur but indicated that they did not intentionally hit the resident, but that the injury to the resident occurred because the resident was combative during care and was somehow inadvertently hit in the mouth by their own hands/arms.

Plan of Correction

Accept [REDACTED] 05/29/2026)

Immediate Action

The home and its administration did exactly what it was supposed to do in an Abuse situation. The Home self-identified and reported the abuse to all required parties including AAA, DHSL, and law enforcement. The Home took action to separate the resident and the abuser by suspending Staff Person B and subsequently firing them the following day. The Home performed a detailed investigation and assisted law enforcement in their investigation. The Home notified family and physician and sent the resident to the hospital for evaluation. The home reviewed the incident, the actions of the Home and the hospital report with the family the day after the incident. The Home has supported the family and the resident as needed since the incident.

The Executive Director provided all staff, from all departments, education on Abuse and Neglect, Mandatory Reporting, and the organization's zero-tolerance policy for abuse and neglect the day after the incident.

Abuse, Neglect and Mandatory reporting is part of new employee orientation and is part of the Home's annual training schedule.

No further action should be required.

Licensee's Proposed Overall Completion Date: 05/26/2026

Implemented [REDACTED] - 06/11/2026)

42c - Treatment of Residents

3. Requirements

2600.

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

Description of Violation

On [REDACTED] at approximately 9:10 am, residents were gathered in the activity room, watching a TV show. Staff member A brusquely ushered resident [REDACTED], who was using a walker to ambulate, into the room, pushing resident [REDACTED] by the back toward a chair and then pulling the resident down into the chair from behind in an impatient and haphazard manner.

Less than a minute later, resident [REDACTED] entered the activity room, positioned a chair to face the TV, and attempted to lower themselves from their walker into the chair. Staff member A rushed over and placed a hand on the resident's lower back, causing the resident to fall forward on their knees. The fall resulted in a bruise to resident [REDACTED] right knee. Staff member A immediately bent down and grabbed resident [REDACTED] upper back, attempting to hoist the resident from the floor. Staff member D then joined to assist. Staff members A and D each grabbed resident [REDACTED] under an armpit and brusquely pulled the resident from the floor into the chair in which the resident had tried to sit.

Staff member A left the room and returned about a minute later, pushing another resident in a wheelchair. A different resident approached staff member A and informed them that resident [REDACTED] was accusing staff member A of intentionally causing their fall. Staff member A abruptly left the resident they were pushing in a wheelchair in the back of the room and approached resident [REDACTED]. In a heated manner, staff member A paced in front of resident [REDACTED] and then sat down on resident [REDACTED] walker and rolled it back and forth, while trying to explain to resident [REDACTED] that they had intended to prevent the resident from falling into a poorly positioned chair rather than having pushed them to the floor deliberately.

While staff person A did not push the resident, the manner in which they handled the resident in an effort to prevent them from falling, as well as the rough nature of the attempt to assist the resident after falling, and the staff persons demeanor and actions when speaking with the resident afterwards was abrupt and disrespectful.

Plan of Correction

Accepted [REDACTED] 05/29/2026)

Immediate Action

On 4/19, the staff person was suspended pending investigation and the department was notified. In the notification to the Department, there was a plan for the staff person to be reinstated that included:

- Staff education on the procedure to report a resident incident, safe transfer training and communicating with residents with Dementia.
- A plan for the staff person to not be assigned the resident claiming abuse and the resident who was handled roughly.
- A plan for supervision of the staff person for two weeks following reinstatement.

Staff person A was presented the resident's rights poster on 5/26/26 to review and ask questions as an additional step in [REDACTED] reeducation process in relation to this citation.

Ongoing Compliance

All Clinical staff were trained on safe transfer techniques by Fox Rehab on 5/22/26 and 5/28/26. All staff, in all

42c - Treatment of Residents (continued)

departments, were given the resident rights poster to review, discuss, and ask questions on 5/27/26, 5/28/26 and 5/29/26.

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

Implemented [REDACTED] 06/11/2026)