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

June 11, 2026

[redacted], CEO
LUTHERCARE INC
[redacted]

RE: THE MUHLENBERG LODGE
300 ST. MARK AVENUE
LITITZ, PA, 17543
LICENSE/COC#: 32182

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/30/2026 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 MUHLENBERG LODGE* **License #**: *32182* **License Expiration**: *03/13/2027*

Address: *300 ST. MARK AVENUE, LITITZ, PA 17543*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *LUTHERCARE INC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/28/2000* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/30/2026*

Inspection Dates and Department Representative

04/30/2026 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st floor Gardenia* **Capacity**: *26* **Residents Served**: *27*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *71*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *27*

Have Physical Disability: *0*

Inspections / Reviews

04/30/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/14/2026*

05/08/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/28/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/29/2026*

Inspections / Reviews *(continued)*

06/11/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/28/2026*

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

13b - Capacity

1. Requirements

2600.
13.b. The maximum capacity specified on the license may not be exceeded.

Description of Violation

On 4/30/26, there were 27 residents residing in the home's Secured Dementia Care Unit (SDCU), however, the licensed capacity for the SDCU is 26.

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

Immediate Corrective Action:
-Census was immediately reviewed and compared with licensed capacity on 4/30/26.
-Admissions were paused on 4/30/26 until compliance with licensed capacity is confirmed.
-Administration verified current DHS license parameters related to total building capacity and Memory Care census limits.
-Letter submitted to DHS showing apartments with the request that secured capacity increase from 26 to 30 given we have 4 apartments that can accommodate double occupancy. This would support our max census of 90.
-Senior Executive Director is working with DHS licensing officials to extend occupancy to 30 for SDU.
Root Cause:
• Misinterpretation of licensed occupancy parameters for Memory Care versus total building census.
Ongoing Monitoring / Audits
• Daily census reports are reviewed by the PCHA and Executive Director.
• Weekly licensed capacity review will be conducted and documented x4 and then monthly.

Staff Education
• PCHA, CCC and Team Leaders re-educated on DHS licensing requirements and unit-specific census limits.
Responsible Party
-SNR Executive Director
-PCHA
Completion & Ongoing Dates
• Immediate hold on 1st floor admissions: 4/30/26
• Weekly Audits started: 5/6/26

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

Implemented ([redacted] - 06/11/2026)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 4/30/26 at 9:20 AM, a computer cart was unlocked, unattended, and accessible in the open doorway to Resident 1's bedroom. The drawer of the cart contained an unzipped blue vinyl storage pouch full of emptied pill packs labeled with resident names, medications, and diagnosis information including for Resident 2's Omeprazole 20 MG capsule, take

17 - Record Confidentiality (continued)

once daily for GERD.

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

Immediate Corrective Action (Completed 4/30/26)
• Packs immediately removed and disposed of securely per HIPAA and facility policy. 4/30/26
• Unit staff reminded to secure all equipment and PHI at all times.
Root Cause
• Failure to follow procedure for securing mobile equipment and disposal of PHI.
Ongoing Monitoring / Audits
• Random weekly audits of unit workstations and COW security x4 then monthly. (tracker attached)
Staff Education
• All direct care staff re-educated on HIPAA, PHI handling, and proper disposal procedures.
Responsible Party
• PCHA
Completion & Ongoing Dates
• Immediate correction completed:4/30/26
• Audits initiated: 5/6/26 and ongoing

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

Implemented (- 06/11/2026)

103d - Storing Food Off Floor

3. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 4/30/26 at 2:50 PM, there were two packages of pulled pork stored on the floor in the back right corner of the walk-in freezer.

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

Immediate Corrective Action:
The two packages of pulled pork were immediately removed and disposed of at the time of inspection (4/30/26). The affected area of the walk-in freezer was cleaned and sanitized. All remaining food items in the freezer were checked and confirmed to be properly stored at least 6 inches off the floor.
Root Cause:
This occurred due to staff error and lack of adherence to proper food storage procedures, along with insufficient reinforcement of storage standards during routine operations.
Corrective Actions and Preventive Measures:
All dietary and kitchen staff will be re-educated on proper food storage requirements, including maintaining food at least 6 inches off the floor at all times. Training will include a review of food safety standards and will be documented with a staff sign-in sheet. This will be completed by 5/15/2026.
A weekly audit of all storage areas, including the walk-in freezer, walk-in refrigerator, and dry storage, will be conducted for four consecutive weeks to ensure compliance. After the initial four weeks, audits will transition to monthly ongoing monitoring. All audit results will be documented and maintained.
The Kitchen Manager or designee will be responsible for ensuring compliance. Any deficiencies identified during

103d - Storing Food Off Floor (continued)

audits will be corrected immediately and addressed with staff as needed.
Shelving and storage capacity will be evaluated to ensure adequate space is available to maintain proper off-floor storage at all times.
Completion Date:
Immediate correction was completed on 04/30/2026. Full implementation of staff education and audit processes will be completed by 05/15/2026, with ongoing monitoring thereafter.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented ([redacted] - 06/11/2026)

183b - Meds and Syringes Locked

4. 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 4/30/26 at 11:20 AM, Resident #3 was in possession of a bottle of 750 MG antacid tablets. The resident is not assessed to self-administer this medication.

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

Immediate Corrective Action (Completed 4/30/26)
• Medication was immediately removed.
• Physician was contacted for an order for resident to self-administer this medication
Root Cause
• Inadequate monitoring of resident personal belongings and OTC medications.
Ongoing Monitoring / Audits
• Monthly room audits conducted by direct care staff. (See attached Order Checklist)
• Team Leader will conduct random room audits weekly x4 to ensure compliance and then monthly (see tracker)
• Resident memo issued on 5/6/2026 reminding residents and POAs of the home rules around medication administration.
Staff Education
• Nursing and caregiving staff educated on identifying and managing unauthorized medications.
Responsible Party
-Team Leader
-PCHA
-Direct care staff
Completion & Ongoing Dates
• Immediate correction completed: 4/30/26
• Weekly audits initiated: 5/6/26
Staff education will be completed by 5/29/2026

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

Implemented ([redacted] - 06/11/2026)

183e - Storing Medications

5. 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 4/30/26, an opened bottle of Refresh Tears eye drops prescribed to Resident #4 was present in the medication storage drawer in the resident's room. According to the manufacturer's instructions, the bottle should be discarded 90 after opening. The bottle was not dated when it was opened, however, the medication administration record indicated that the drops were first administered on 1/15/26.

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

Immediate Corrective Action (Completed 4/30/26)
• Expired medication was immediately removed and discarded.
• Resident's current medication profile reviewed to ensure accuracy.
Root Cause
• Inconsistent monitoring of medication expiration tracking.
Ongoing Monitoring / Audits
• DCS complete Monthly med box checks on every resident (see order and checklist attached)
• Clinical Care Coordinator will complete random audits on each floor weeklyx4 to ensure compliance and then monthly (see attached tracker)
Staff Education
• DCS staff re-educated on medication expiration requirements, including eye drop dating protocols. All direct care staff will be educated by 5/29/26.
Responsible Party
• Clinical Care Coordinator
• PCHA
Completion & Ongoing Dates
• Immediate correction completed: 4/30/26
• Weekly audits begun: 5/6/26

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

Implemented (- 06/11/2026)

184a - Resident's Meds Labeled

6. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

*Resident #5 is prescribed Travaprost 0.004% eye drops, instill 1 drop in both eyes at bedtime ***allow a 5 min period before instilling additional ophthalmic medications. The box containing the eyedrops did not have a pharmacy label containing the resident's name, name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration, and the name and title of the prescriber.*

Resident #6 is prescribed Lantus Solostar insulin pen. The pen that was stored in the locking drawer in the resident's room did not have a pharmacy label containing the resident's name, name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration, and the name and title of the prescriber.

The pharmacy label on the box for Resident 6's Lantus Solostar pen, which was stored in the medication office, contained the incorrect prescription information stating to inject 40 units daily Mon - Sat and 34 units on Sundays which does not match the current order to inject 35 units subcutaneously once daily and to inject 7 units subcutaneously at bedtime and hold for BG < 100.

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

Immediate Corrective Action (Completed 4/30/26)
• Medications removed immediately and labels affixed with current instructions.
Root Cause
• Improper handling during medication setup.
Ongoing Monitoring / Audits
• Monthly med box audits conducted by direct care staff (See order and Checklist)
• Clinical Care Coordinator will conduct random audits weekly x4 then monthly (See tracker)
Staff Education
• Direct care staff re-educated on medication labeling and pharmacy. All direct care staff will be educated by 5/29/26 on these requirements.
Responsible Party
• PCHA
• Clinical Care Coordinator
• Direct care staff
Completion & Ongoing Dates
• Immediate correction completed: 4/30/26
• Ongoing Audits Started:5/6/26

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

Implemented ([redacted] - 06/11/2026)

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 4/30/26, a bottle of Energy B12 500 MCG gummies belonging to Resident #7 was in the medication storage drawer in the resident's room and was not labeled with the resident's name.

184b - Labeling OTC/CAM *(continued)*

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

Immediate Corrective Action (Completed 4/30/26)
• Medication was immediately removed and properly labeled.
• Resident medication storage reviewed.
Root Cause
• Failure to follow medication labeling procedures.
Ongoing Monitoring / Audits
• Monthly med box audits conducted by direct care staff (See attached order and checklist)
• Clinical Care Coordinator will conduct random audits weekly x4 then monthly to ensure compliance (see attached tracker)
Staff Education
• Direct care staff re-educated on medication labeling, including OTC supplements. All direct care staff will be educated on this requirement by 5/29/2026
Responsible Party
• PCHA
• Clinical Care Coordinator
• Direct Care team
Completion & Ongoing Dates
• Immediate correction completed: 4/30/26
• Monthly audits ongoing beginning 5/6/26

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

Implemented (- 06/11/2026)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #6 is prescribed Novolog insulin, inject 5 units subcutaneously three times daily with meals; hold for BS less than 90. However, this medication was not administered correctly on the following days and times:

- on 4/25/26, nighttime BS was 77 and Novolog was administered
- on 4/18/26, midday BS was 74 and Novolog was administered
- on 4/13/26, midday BS was 143 and Novolog was held
- on 4/4/26, midday BS was 86 and Novolog was administered
- on 4/4/26, morning BS was 88 and Novolog was administered

Repeated Violation - 10/17/26

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

Immediate Corrective Action (Completed 4/30/26)
• Order reviewed with nursing staff.
Root Cause

187d Follow Prescriber's Orders (continued)

• Staff failure to follow physician parameters consistently.
Ongoing Monitoring / Audits
• Will complete a weekly audit for all residents under a physician's parameter order including Blood Sugar, Blood Pressure, and Heart Rate weekly x4 and then monthly.
Staff Education
• Direct care staff re educated on following parameters and documentation requirements by 5/29/2026.
Responsible Party
• PCHA
• Team leader
Completion & Ongoing Dates
• Immediate correction completed: 4/30/26
• Weekly audits begin: 5/6/26

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

Implemented (- 06/11/2026)

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 doors from the SDCU dining room to the courtyard or from the courtyard to the lot.

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

Immediate Corrective Action (Completed 4/30/26)
• Exit code was immediately posted per facility policy.
Root Cause
• Environmental safety checklist not consistently utilized.
Ongoing Monitoring / Audits
• Weekly environmental safety roundsx4 and then monthly by PCHA to verify exit signage verification. (see tracker attached)
Staff Education
• Direct care staff will be educated on need for signage to be present by 5/29/2026
Responsible Party
PCHA
•immediate completion 4/30/26
Weekly ongoing audits started 5/6/26

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

Implemented (- 06/11/2026)