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

June 30, 2026

[redacted], COO
IVQ LANSDALE OPCO LP
[redacted]

RE: TRADITIONS OF LANSDALE
1800 WALNUT STREET
LANSDALE, PA, 19446
LICENSE/COC#: 14521

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/04/2026, 05/05/2026 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: *TRADITIONS OF LANSDALE* **License #**: *14521* **License Expiration**: *02/28/2027*

Address: *1800 WALNUT STREET, LANSDALE, PA 19446*

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

Administrator

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

Legal Entity

Name: *IVQ LANSDALE OPCO LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *11/12/2024* **Issued By**: *Hatfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/05/2026*

Inspection Dates and Department Representative

05/04/2026 - On-Site: [redacted]

05/05/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *71* **Residents Served**: *21*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

05/04/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/31/2026*

06/01/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/30/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/30/2026*

Inspections / Reviews *(continued)*

06/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2026*

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

65g - Annual Training Content

1. Requirements

2600.
65.g. 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.

Description of Violation

Staff Person A, B, C and D did not receive training in 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 during training year January 2025 to December 2025.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions: *Staff Persons A, B, C, and D were scheduled to complete fire safety training with Environmental Director by 5/27/2026. The Administrator and Business Office Director will maintain documentation of the training, including the training date, trainer name and qualification, staff attendance sheet, and training topic.*

Additional Corrective Actions: *The Administrator or Business Office Director will maintain documentation of the training, including the training date, trainer name and qualification, staff attendance sheet, and training topic. The Administrator or Business Office Director will also audit all current staff annual training records by 6/15/2026 to verify that fire safety training has been completed and documented for the current training year. Any staff requiring fire safety training will complete it by 6/30/2026.*

Ongoing Quality Assurance Actions: *Beginning 6/1/2026 the Business Office Director will review a 5% sample of staff training records each month as part of the communities QA process to ensure required annual training is completed and documented. Beginning 7/9/26, the QA Meeting will include a review of Q2 training records for April, May, and June 2026. Ongoing compliance will continue to be tracked through monthly QA review and follow-up for any identified training gaps.*

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

88a - Surfaces

2. 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 5/4/2026, an unknown brown substance was observed on the door frame of room C49 in the memory care.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions:
Housekeeping staff immediately cleaned the affected door frame in the memory care area on 5/4/2026. The area was inspected by Environmental Director after cleaning to confirm the substance was removed and the surface was clean, in good repair, and free of hazards.

Additional Corrective Actions:

88a - Surfaces (continued)

Environmental Director, Maintenance Tech or Memory Care Director will review the affected area and surrounding memory care surfaces by 5/5/2025 to ensure doors, door frames, walls, and other surfaces are clean and in good repair. Housekeeping staff will be reminded to report and clean any spills, unknown substances, stains, or surface concerns immediately when observed.

Ongoing Quality Assurance Actions:
Beginning 5/11/2026, the Environmental Director, Maintenance Tech, or Memory Care Director will conduct daily inspections of memory care resident room doors, door frames, walls, and other visible surfaces to ensure they remain clean, in good repair, and free of hazards. Any identified concerns, including stains, residue, damage, or other unsanitary conditions, will be corrected promptly and documented. Beginning 7/9/2026, the Quarterly QA Meeting will include a review of Q2 inspection records for May and June 2026. Ongoing compliance will continue to be tracked through QA review and follow-up for any identified concerns or corrective actions.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

103g - Storing Food

3. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/4/2026, ground beef patties located in the walk-in freezer were opened and unsealed.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions: *The Administrator immediately corrected the issue by ensuring the ground beef patties were properly sealed and stored in sealed packaging in the walk-in freezer on 5/4/2026.*

Additional Corrective Actions: *The Administrator and Dining Service Director reeducated dietary staff on proper food storage procedures, including the requirement that all food items must be stored in closed or sealed containers when placed in the refrigerator, freezer, or dry storage areas on 5/29/2026.*

Ongoing Quality Assurance Actions: *The new Dining Services Director began on [redacted] and will inspect the walk-in freezer, refrigerator, and dry storage areas weekly for four weeks to verify that all food is stored in closed or sealed containers. Findings and any corrective actions will be documented and reviewed during the Quarterly QA Meeting on 7/9/2026, including Q2 inspection records for May and June 2026.*

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled, undated half eaten brownie and a container of macaroni salad and chicken

103i - Outdated Food (continued)

in the refrigerator located in memory care.

Plan of Correction ***Accept (- 06/01/2026)***

Immediate Corrective Actions: *At the time the concern was identified on 5/4/2026, the Memory Care Director immediately removed and discarded the unlabeled and undated food items from the memory care refrigerator.*

Additional Corrective Actions:*The Memory Care Director reeducated all memory care staff on proper food labeling and storage procedures, including the requirement that food items must be labeled, dated, covered or sealed, and discarded when expired, spoiled, unlabeled, or undated on 5/29/2026.*

Ongoing Quality Assurance Actions: *Beginning 5/5/2026, the Memory Care Director or Memory care associates will inspect the memory care refrigerator daily, for four weeks to verify that food items are labeled, dated, covered or sealed, and free from outdated or spoiled food. Findings and any corrective actions will be documented and reviewed during the Quarterly QA Meeting on 7/9/2026, including Q2 inspection records for May and June 2026.*

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented (- 06/30/2026)

105g - Lint Removal and Duct Cleaning

5. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 5/4/2026, there was an approximate .5 inch accumulation of lint and hair, in the lint trap of the dryer located in memory care. There were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 06/01/2026)***

Immediate Corrective Actions: *At the time the concern was identified on 5/4/2026, the Memory Care Director immediately removed the lint and hair from the dryer lint trap in memory care. The dryer lint trap and drum were checked to ensure they were clean and free of lint.*

Additional Corrective Actions: *The Memory Care Director reeducated memory care staff on dryer safety procedures, including the requirement that lint must be removed from the lint trap and dryer drum after each use on 5/29/2026.*

Ongoing Quality Assurance Actions: *Beginning 6/1/2026, the Memory Care Director or caregivers will check the memory care dryer lint trap and drum daily to verify lint is removed after use. Findings and any corrective actions will be documented and reviewed during the Quarterly QA Meeting on 7/9/202 including Q2 inspection records for May and June 2026.*

105g - Lint Removal and Duct Cleaning *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

124 - Notice to Fire Department

6. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions: *The Administrator will send written notification to the local fire department with the home's address, location of resident bedrooms, and the assistance residents may need to evacuate in an emergency by 5/29/2026.*

Additional Corrective Actions: *A copy of the written notification will be maintained in the home's fire safety records as documentation of compliance. The Administrator or Environmental Director will also review the fire safety file monthly to confirm the required fire department notification is current and available for review, beginning on 6/1/2026.*

Ongoing Quality Assurance Actions: *The Administrator will review the fire department notification annually and update it whenever there is a change to the home's address information, bedroom locations, evacuation assistance needs, or emergency contact information. Documentation of the notification and any updates will be maintained in the fire safety file and reviewed during the Quarterly QA Meeting beginning 7/9/2026.*

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

132g - Fire Drills Days/Times

7. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of the month as evidenced by the following drills 1/25/2025 at 7:30a, 2/28/2025 at 8:05p, 3/28/2025 at 11:20p, 4/30/2025 at 9:05a, , 6/30/2025 at 2:35p, 7/31/2025 at 7:50p, 9/25/2025 at 1:30p, 10/28/2025 at 3:15p, 11/29/2025 at 11:15a, 12/22/2025 at 7:10p, and 1/23/2026 at 10:15a.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions:

132g - Fire Drills Days/Times (continued)

The Administrator and Environmental Director reviewed the requirements for fire drill and home's schedule on 5/6/2026. We identified that drills were being conducted too routinely near the end of the month.

Additional Corrective Actions:

The Environmental Director created a revised fire drill schedule on 5/6/2026, to ensure drills are conducted on varied days of the week and at varied times of the day and night. The revised fire drill schedule will ensure drills are conducted on different days of the week, different days of the month, and at varied times, including daytime and evening hours. The schedule will also be monitored to ensure drills are not routinely held during periods of increased staffing or when resident participation is expected to be low.

Ongoing Quality Assurance Actions:

The Environmental Director will conduct a quarterly review of the fire drill schedule to ensure that drills are consistently held on different days and at varying times. During the Quarterly Quality Assurance Meeting, we will examine fire drill records, focusing on resident participation, staff attendance, drill timing, and compliance with scheduling requirements for April, May, and June 2026. This review will also confirm that we are meeting all necessary protocols.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

183e - Storing Medications

8. 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 5/5/2026, the following medications were observed with punctures on the blister packs and the pills still in place:

- *Aspirin 81mg chewable tab for Resident 1 was punctured in slot 7.*
- *Memantine 10mg tab for Resident 1 was punctured in slot 13.*
- *Metformin HCL 1000mg Tab for Resident 2 was punctured in slot 12.*
- *Calcium Antacid 750mg chew for Resident 3 was punctured in slot 15.*
- *Donepezil HCL 10mg Tab for Resident 4 was punctured in slot 21.*

Repeat Violation: 6/5/2025 and 2/19/2025

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions: *The Resident Care Director or Wellness Supervisor reviewed the affected blister packs, removed and destroyed the punctured medications according to the home's medication destruction procedure, and completed a medication reorder form to replace the pills where the seal was broken on 5/5/2026.*

Additional Corrective Actions:

183e Storing Medications (continued)

The Resident Care Director or Wellness Supervisor reeducated medication administration staff on proper medication storage and handling procedures on 5/22/2026. Staff were instructed that blister packs must remain intact until the medication is administered. If a blister pack is found to be punctured or otherwise compromised, staff must identify the affected medication, remove the affected medication from blister card, complete the medication destruction process, and submit a medication reorder request to the pharmacy for replacement.

Ongoing Quality Assurance Actions:
The Resident Care Director or Wellness Supervisor will audit medication carts and medication storage areas weekly on an ongoing basis beginning 5/11/2026 using the weekly Medication Cart Audit Form to verify that medications are organized, stored properly, and free from damaged or punctured packaging. Any damaged packaging, storage concern, or medication handling issue will be corrected immediately and documented. Audit findings, corrective actions, and any identified trends will be reviewed during the Quarterly QA Meeting beginning 7/9/2026. The QA review will include follow up on completed audits, documentation of corrective actions, and continued monitoring to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

185a - Implement Storage Procedures

9. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident 2 is prescribed blood sugar checks on Mondays and Thursdays, twice per day. On 4/24/2026, the glucometer for Resident 2 reported a reading of 418 but 414 was documented on the MAR. On 5/2/2026, the glucometer for Resident 2 reported a reading of 370 but 371 was documented on the MAR.

On 5/1/2026, the home accepted a total of 15 pre filled syringes of Morphine Sulfate 100mg/5ml for Resident 5. The home's policy states, "A maximum quantity of only 3 days pre filled morphine syringes may be accepted at a time".

Repeat Violation: 2/19/2025

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions *The Administrator and Resident Care Director reviewed Resident 2's glucometer readings and MAR documentation for 4/24/2026 and 5/2/2026. The Resident Care Director confirmed that the MAR entries did not match the glucometer readings exactly. The documentation discrepancies were reviewed with the medication staff involved, and the resident's record was reviewed to ensure the blood sugar monitoring order remained active and accurate on 5/6/2026.*

The Administrator and Resident Care Director also reviewed Resident 5's medication order and the quantity of

185a Implement Storage Procedures (continued)

Morphine Sulfate 100mg/5ml pre filled syringes accepted by the home on 5/1/2026. The medication was confirmed to belong to Resident 5 and was reviewed against the active physician's order. The medication was secured in the designated medication storage area with access limited to authorized medication staff. The controlled substance count was reviewed to confirm that the medication quantity on hand was accounted for on 5/5/2026.

Additional Corrective Actions: *The Resident Care Director will retrain all medication administration staff by 5/22/2026 on accurate glucometer documentation, MAR/eMAR entry requirements, and the process for reporting medication documentation errors. Blood sugar readings must be documented exactly as displayed on the glucometer. If an error is identified, staff must notify the Resident Care Director or Wellness Supervisor immediately. The Resident Care Director or Wellness Supervisor will compare the MAR/eMAR entry to the glucometer reading and the physician/practitioner order, document the discrepancy, and complete any correction in accordance with the home's Medication Documentation Correction Procedure. The discrepancy will be documented to include the date of the error, the incorrect entry, the correct glucometer reading, the action taken to correct the documentation, and the staff member notified.*
The Administrator and Resident Care Director will revise the medication policy by 6/5/2026 to remove the 3 day limit for pre filled morphine syringes. The revised policy will state that the quantity accepted will be based on the physician/practitioner order, pharmacy dispensing instructions, resident care needs, and the home's ability to safely store, secure, document, administer, and account for the medication. All medication administration staff will be trained on the revised policy and will sign a training attendance sheet by 6/30/2026.

Ongoing Quality Assurance Actions: *Med Techs will complete the Shift Change Responsibilities each shift to verify that blood sugar documentation is accurate and complete, including confirming that glucometer readings match the MAR/eMAR entries. The Resident Care Director will review a 5% sample of completed Med Tech Shift Change Responsibilities monthly to ensure the forms are being completed and that blood sugar documentation is accurate. Any identified discrepancies or incomplete documentation will be corrected immediately and addressed through staff follow up, retraining, or additional monitoring as needed. Blood sugar documentation compliance will also be reviewed through the home's QA process to monitor trends, verify compliance, and document any corrective actions.*
.
Med Techs will complete controlled substance counts as part of the Shift Change Responsibilities each shift to verify that controlled substances are safely stored, accurately documented, and accounted for. The Resident Care Director will review a 5% sample of completed controlled substance count records monthly to ensure the counts are being completed, documentation is accurate, and any discrepancies are identified and addressed timely. Any identified concerns will be corrected immediately and addressed through staff follow up, retraining, or additional monitoring as needed. Controlled substance documentation will also be reviewed quarterly through the home's QA process beginning 7/9/2026.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)

185b - Medication Procedures

10. Requirements

185b - Medication Procedures *(continued)*

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's medication policy states " A maximum quantity of only 3 days pre-filled morphine syringes may be accepted at a time", Resident 5 had a total of 15 pre-filled syringes of Morphine Sulfate 100mg/5ml with orders that read "1 syringe orally daily".

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Actions *The Administrator and Resident Care Director reviewed Resident 5's medication order and confirmed that the Morphine Sulfate 100mg/5ml pre-filled syringes were present for Resident 5 and matched the active physician's order of "1 syringe orally daily." The medication was secured in the medication storage area with limited access to authorized medication staff. The controlled substance count was reviewed to confirm accountability of the medication on hand.*

Additional Corrective Actions *The Administrator and Resident Care Director will revise the medication policy by 6/5/2026 to remove the 3-day limit for pre-filled morphine syringes. The revised policy will state that the quantity accepted will be based on the physician/practitioner order, pharmacy dispensing instructions, resident care needs, and the home's ability to safely store, secure, document, administer, and account for the medication. All medication administration staff will be trained on the revised policy and will sign a training attendance sheet by 6/30/2026.*

Ongoing Quality Assurance Actions *Med Techs will complete controlled substance counts as part of the Shift Change Responsibilities each shift to verify that controlled substances are safely stored, accurately documented, and accounted for. The Resident Care Director will review a 5% sample of completed controlled substance count records monthly to ensure the counts are being completed, documentation is accurate, and any discrepancies are identified and addressed timely. Any identified concerns will be corrected immediately and addressed through staff follow-up, retraining, or additional monitoring as needed. Controlled substance documentation will also be reviewed quarterly through the home's QA process beginning 7/9/2026.*

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 06/30/2026)