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

July 15, 2026

[redacted]
ARCADIA AT LIMERICK POINTE LLC
[redacted]

RE: ARCADIA AT LIMERICK POINTE
51 WEST ARCADIA DRIVE
LIMERICK, PA, 19468
LICENSE/COC#: 14795

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/14/2026 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: *ARCADIA AT LIMERICK POINTE* **License #**: *14795* **License Expiration**: *05/18/2027*

Address: *51 WEST ARCADIA DRIVE, LIMERICK, PA 19468*

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

Administrator

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

Legal Entity

Name: *ARCADIA AT LIMERICK POINTE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/12/2021* **Issued By**: *Limerick Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *107* **Waking Staff**: *80*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *05/14/2026*

Inspection Dates and Department Representative

05/14/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *122* **Residents Served**: *76*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Compass Neighborhood* **Capacity**: *48* **Residents Served**: *31*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *76*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *31*

Have Physical Disability: *0*

Inspections / Reviews

05/14/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/08/2026*

07/02/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/15/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/10/2026*

Inspections / Reviews *(continued)*

07/15/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at approximately 7:45 am, resident [redacted] reported to staff person A that [redacted] was treated roughly by an overnight staff person when [redacted] was assisting them up from a chair. A small red area noted on the resident's left wrist near their watch. However, this allegation of abuse was not reported to the local Area Agency on Aging.

Plan of Correction ***Accept [redacted] - 07/02/2026)***

Immediate Action:
5/1/26: Incident was reported to Executive Director by Resident [redacted]. Executive Director immediatly reported the event to Department of Human services but failed to report to Area Agency on Aging.
5/15/26 at 10:15am Executive Director called Montgomery County Area office on Aging-Protective services and reported the the allegation.

Preventative Action: *Any alleged abuse incidents will be reported immediately by the Executive Director of Designee on the date of discovery to the appropriate authorities, including the Montgomery County, Area Agency on Aging as required.*

Compliance Monitoring: *The Exeutive Director or Designee will be responsible for oversight and ongoing monitoring. A review of the abuse policy reporting procedures and compliance will be conducted including Executive Director, Director of Nursing, and all department managers will be conducted by 6/12/26. Any reports of alleged will be reviewed at quarterly Quality Assurance Meetings.*

Licensee's Proposed Overall Completion Date: *06/12/2026*

Implemented ([redacted] - 07/15/2026)

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], at approximately 7:45 am, resident [redacted] reported to staff person A that "someone attacked them and dragged them to their bedroom." Staff person A assessed the resident and observed a red mark on the resident's left forearm. On [redacted], resident [redacted] reported to an agent of the Department that "a staff person grabbed [redacted] by their wrist and pushed them down the hallway until they arrived at the resident's bedroom door.
The resident stated they were sitting in the common room when staff person B told them, "Not on my watch" grabbed [redacted] to stand up, and they pushed each other as they walked towards the residents room. The resident stated that [redacted] did not understand what [redacted] did wrong. Progress note dated [redacted] noted a small redness area on [redacted] left wrist near their wristwatch. Progress note dated [redacted], noted a bruise on the resident's left wrist above [redacted] watch.

42b - Abuse (continued)

Staff person B stated that resident [redacted] repeatedly exited [redacted] bedroom every two hours on the overnight shift. Staff person B stated that the resident came into the common area at approximately 4:30 am - 5:00 am and sat on the chair in the common area, leaned [redacted] head back and closed [redacted] eyes. Staff person B disclosed that [redacted] stated to resident [redacted] "You are not going to sleep on the chair, let's go to your room," and asked the resident, "Wouldn't it be better to sleep in your bed?" Staff person B stated that the resident did not respond to the question. Staff person B stated that [redacted] assisted the resident with standing by holding [redacted] belt loop and staff person B placed their hand on the resident's back to support the resident while getting [redacted] up from the chair and walked beside [redacted] to their bedroom. Staff person B stated that [redacted] assisted the resident with getting up from the chair because [redacted] thought it was uncomfortable for the resident to fall asleep on the chair.

Staff person C disclosed that at approximately 6:00 am, [redacted] observed resident [redacted] in the common area standing with [redacted] eyes closed. Staff person C reported asking resident [redacted] if [redacted] was okay and the resident responded that [redacted] was okay. Staff person C stated that when [redacted] attempted to redirect the resident to their bedroom, [redacted] expressed fear about returning to their bedroom. Staff person C stated that resident [redacted] stated that someone scared them and [redacted] was scared to go into their room. Staff person C stated that [redacted] assumed the resident was referring to a "ghost." Staff person C explained checked the resident's room to reassure [redacted] that no one was in the bedroom. Resident [redacted] asked if [redacted] was sure that they were going to be safe in their room.

Resident [redacted] was admitted to the secured dementia care unit on [redacted] Resident [redacted] assessment and support plan dated [redacted] states the resident is independent with transfers in and out of the bed and chair. Resident [redacted] is independent with turning and positioning in a bed and chair. Resident [redacted] has a cognitive need for orientation to time, place and person listed as a minimal problem and staff to provide prompting and cueing as needed. Resident [redacted] has a behavior need for hallucinations listed as a moderate problem and, if hallucinations occur, staff to reassure, comfort and monitor for safety as needed.

Plan of Correction ***Accept [redacted] - 07/02/2026)***

Immediate Action: *5/1/26: Upon receiving the report of the alleged allegation, staff member B was suspended and instructed not to return to the community until further notice pending investigation. Investigation by Executive Director, Director of Nursing and Human Resources Director was conducted. The conclusion of the investigation found that the allegation was founded, and the employment relationship between staff member B and Arcadia at Limerick pointe was terminated.*

Preventative Action: *Director of Nursing completed a training on 5/28/26 for Nursing Supervisors, Med-Techs and Caregivers, the training included the following: resident rights, abuse, and abuse reporting, being a compassionate caregiver, and proper lifting techniques. Director of Nursing will review with Nursing Supervisors the expectation to monitor personal care assistants throughout their shifts. by 6/19/26.*

Compliance Monitoring: *Director of Nursing, or Designee will round the residents population and conduct resident interviews asking about the care that they receive, and how they feel that are treated while receiving care. One interview will be conducted each week over the next 8 weeks. The results of the interviews will be documented. Reportable incidents will be reviewed at each quarterly quality assurance meetings.*

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

Implemented [redacted] - 07/15/2026)

65e - 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received only 7.5 hours of annual training in training year 2025.

Plan of Correction ***Accept[redacted] 07/02/2026)***

Immediate Action: *Human Resources Director will do a full audit of all employees by 06/30/26 to ensure that all training requirements have been met for 2025. Any employees found to be out of compliance for the 2025 training year will be scheduled to complete all necessary trainings.*

Preventative Action: *Human Resources Director will complete a quarterly audit of all annual training records and completion status of each employee. At the quarterly Quality Assurance meeting Human Resources Director will provide each department director with an update on the status of their employee's completion of annual training. Any employees that did not attend the training during their quarter of hire will be required to complete the training in the next quarter. All employees will be required to fulfil their annual training requirements no later than the last training of the year in mid-December.*

Compliance Monitoring:
Human Resources Director will complete a quarterly audit of all annual training records and completion status of each employee. Human Resources Director will provide each department director with an update on the status of their employee's completion of annual training. Any employees that did not attend the training during their quarter of hire will be required to complete the training in the next quarter. All employees will be required to fulfil their annual training requirements no later than the last training of the year in mid December. Human Resources Director will do a full audit of all employees annually by 11/30 to ensure that all
training requirements have been met for the year or they will be scheduled to attend the final annual training which is held annually in mid-December.

Licensee's Proposed Overall Completion Date: *07/10/2026*

Implemented [redacted] - 07/15/2026)

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

Colgate total active prevention toothpaste, with a manufacture's label indicating " if more than used for brushing is accidentally swallowed, get medical help or contact poison control center right away" was unlocked, unattended, and accessible to residents on residents [redacted] bathroom sink. Not all the residents of the home, including resident [redacted], have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Power stick deodorant, Medicated body powder, and Vicks VapoRub with a manufacture's label indicating "if swallowed get medical help or contact poison control center immediately for advice", was unlocked, unattended, and accessible to residents on top of resident [redacted] bureau. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 07/02/2026)***

Immediate Corrective Actions: *On the date of the inspection, 5/14/26, the homes Director of Nursing removed the unlocked items in residents rooms immediatley placed them in the locked cabinets in the residents rooms, also on 5/14/26 all memory care resident rooms were checked by individaul personal care assistants on each floor.*

Preventative Actions: *Training willbe conducted by Memory Care Director by 6/17/26, on the safety and security of poisonous materials for the homes Nursing Supervisors , Med Tech's and Resident Care Assistants.*

Compliance Monitoring: *Memory Care Diretor or Designee to complete weekly inspections with a minimum of 5 aparments per week over the next 4 weeks to assure compliance. Patterns trends and findings will be reviewed during each of the homes ongoing quarterly quality assurance meetings.*

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

Implemented [redacted] - 07/15/2026)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted], at approximately 9:47 am, resident [redacted]'s bathroom sink and toilet seat had a brown substance smeared on them.

Plan of Correction ***Accept [redacted] 07/02/2026)***

Immediate Corrective Actions: *On the date of the inspection, 5/14/26, the homes housekeeper cleaned the residents aparment thouroughly. the brown colored substances were cleaned and disinfected immediatly.*

Preventative Actions: *Training will be conducted by Memory Care Director on sanitary conditions and keeping all bathrooms clean and disinfected. Housekeepers, and all nursung staff will be trained to inspect each residents room on memory carre daily and document any issues needing attention. Memory care apartments are cleaned weekly. Memory Care Diretor or Designee will complete a weekly checklist randomely inspecting a minimum of 5 aparments per week over the next 4 weeks to assure housekeeping and cleanliness compliance.*

Compliance Monitoring: *The homes Memory Care Director, Nursing Supervisors and Managers on Duty, or Designee will complete a daily walk through for the next two weeks and report any immediate needs via housekeeping work order. Patterns trends and findings will be reviewed during each of the homes ongoing quarterly quality assurance meetings.*

85a - Sanitary Conditions (continued)

Licensee's Proposed Overall Completion Date: *06/26/2026*

Implemented [redacted] - 07/15/2026)

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 approximately 10:06 am, the outside dumpster filled with trash was left opened.

Plan of Correction ***Accept [redacted] - 07/02/2026)***

Immediate Corrective Action: *On the date of the inspection, 5/14/26, Arcadia's Maintenance Director immediatly closed the open lid of the dumpster that was open.*

Preventative Actions: *Director of Dining Sevices and Diretor of Maintenance will conduct trainings for each person responsible for the removal of trash, including kitchen utility, cooks, servers, housekeepers, and laundry personnel. The training will include the importance of keeping the lids closed on the trash disposal dumpsters to prevent the penetration of pests and rohdents. Signs have been ordered by Maintenance Director and will be posted when received. The signs will be posted on each of the dumpsters reminding personell to keep the dumpster lids closed at all times.*

Ongoing Compliance: *Starting on 6/8/26 Maintenance Director or Designee will document compliance daily over the next 30 days to assure compliance, random weekly momitoring following. Findings will be documented and reported at quarterly quality assurance meetings to maintain compliance.*

Licensee's Proposed Overall Completion Date: *06/26/2026*

Implemented [redacted] - 07/15/2026)

91 - Telephone Numbers

7. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room [redacted] for resident [redacted]

Repeated Violation - [redacted], et al.

Plan of Correction ***Accept [redacted] - 07/02/2026)***

Immediate Action: *On 10/29/25 Director of Facilities placed an emergency phone list sticker on the telephone in*

91 - Telephone Numbers (continued)

apartment

Preventative Action: *Prior to 6/12 training will be conducted by the Director of Facilities for all housekeeping staff on*
the requirement of emergency telephone numbers in resident apartments. Emergency phone number listings have been created and posted in each memory care and personal care apartmentt, postings will be completed by 6/19/26. Director of Facilities and Housekeeping Supervisor or Designee to complete a full audit of all apartments personal care and memory care prior to 6/19/26.

Compliance Monitoring: *Monthly auditing will be completed by the Director of Facilities or Housekeeping Supervisor or Designee through 8/31/26. Quarterly auditing of the emergency telephone numbers will be completed and reported by Housekeeping Supervisor or Designee at the quarterly Quality Assurance meeting.*

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented (07/15/2026)

105g - Lint Removal and Duct Cleaning

8. 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 , at approximately 9:31 am, there was a large accumulation of lint in the lint trap of the 2nd floor laundry room in the secured dementia care unit. There were no clothes in the dryer at the time.

Plan of Correction ***Accept - 07/02/2026)***

Immediate Action: *On 5/14/26 Director of Maintenance and Housekeeping Supervisor checked all commercial and residential clothes dryers for any lint in dryer traps. Any lint discovered in dryer traps was immediatly cleaned and disposed of.*

Preventative Action: *All Personal Care Assistants, Housekeeping, and Laundry personnel will be trained by Director of Maintenance, Housekeeping Supervisor or Designee, by 6/18/26 on the proper checking and cleaning the dryer lint traps following each dryer use Signs have been posted at every residential and commercial dryer to clean dryer lint traps following every dryer use.*

Ongoing Monitoring: *Director of Maintenance and Housekeeping Supervisor of Designee will monitor the compliance of the lint removal daily for the next 30 days to assssure compliance. Lint removal log will be reviewed at the next quarterly assurance meeting to maintain adherence to the regulation.*

Licensee's Proposed Overall Completion Date: *06/18/2026*

Implemented - 07/15/2026)

231c - Preadmission Screening

9. 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, resident [redacted] written cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept [redacted] 07/02/2026)***

Immediate Action: *Resident [redacted] pre-screen documentation was corrected by Director of Nursing on 5/14/26.*

Preventative Action: *On 05/20/26 Director of Nursing conducted an audit of all current memory care residents prescreen forms for proper completion, any further findings needing correction have been completed. Beginning 6/15/26 Memory Care Director or Designee will audit all new resident move-in pre-screen forms for completion and accuracy.*

Ongoing Monitoring*: To ensure ongoing adherence, compliance monitoring will be conducted monthly and reported by Memory Care Director or Director of Nursing, at each Quarterly Quality Assurance meeting.*

Licensee's Proposed Overall Completion Date: *06/11/2026*

Implemented [redacted] 07/15/2026)