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

November 19, 2026

[redacted] REGIONAL DIRECTOR OF OPERATIONS
AB DRESHER OPERATOR LLC
[redacted]

RE: DRESHER ESTATES
1405 NORTH LIMEKILN PIKE
DRESHER, PA, 19025
LICENSE/COC#: 14424

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/18/2026, 05/19/2026 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: *DRESHER ESTATES* **License #**: *14424* **License Expiration**: *07/02/2026*

Address: *1405 NORTH LIMEKILN PIKE, DRESHER, PA 19025*

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

Administrator

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

Legal Entity

Name: *AB DRESHER OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/25/2001* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/19/2026*

Inspection Dates and Department Representative

05/18/2026 - On-Site: [redacted]

05/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *25* **Residents Served**: *15*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *51*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *20*

Have Physical Disability: *3*

Inspections / Reviews

05/18/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/21/2026*

Inspections / Reviews *(continued)*

06/23/2026 POC Submission

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

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/26/2026*

06/29/2026 POC Submission

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

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/27/2026*

11/10/2026 Document Submission

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

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

42b - Abuse

1. 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 1:45 pm, staff person A was standing behind a serving counter in the dining room of the Secure Dementia Care Unit, cleaning up from lunch. The staff person cleared the silverware of resident #1, who was sitting at the counter. Resident #1, who has moderate to severe problems with judgment, irritability, aggression, hallucinations, and orientation, sometimes clings to their silverware, believing it to be a gift from family. The resident became upset when the silverware was taken from them. The resident stood up, walked around the counter, and kicked staff person A in the leg. Staff person A responded by slapping resident #1 across the face with an open hand. Resident #1 cried out, and had a red mark on their face as a result. The incident occurred in front of at least one other staff member and one other resident. When staff person A was questioned about the incident, they stated that the resident kicked them and that the resident had pulled their hair earlier in the day while receiving care from staff.

Repeated Violation-

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – Staff person A was immediately suspended by Operations Specialist on [redacted] Investigation conducted by Operations Specialist on [redacted]. Abuse allegation was founded and Staff was terminated on [redacted] by Operations Specialist and Director of Nursing.

Training – By 6/27/2026, The Director of Nursing will provide education to all staff on regulation 2600.42b, abuse prevention, appropriate staff conduct, mandatory reporting requirements, and profession communication standards.

Ongoing - Beginning 5/25/26, The Executive Director or Director of Nursing will conduct 5 random weekly resident interviews for a period of 4 weeks, then monthly for 2 months to ensure staff compliance with resident rights. Any concerns identified during audits will be addressed immediately. Documentation of trainings/audits will be reviewed monthly at the Quality Assurance meeting for 3 months, and documentation will be kept for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/27/2026)

42x - Safeguard

2. Requirements

2600.
42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

The home does not provide a system for safeguarding residents' valuables.

42x Safeguard *(continued)*

Plan of Correction ***Accept ([redacted] - 06/29/2026)***

Action On 6/11/2026 2 lock boxes were purchased by the operations specialist. The lock boxes will be kept in the Executive Directors office and offered to anyone who requests a place to store their valuables.

Training By 6/27/2026 all staff and managers will be trained on Regulation 2600.42x. This training will be completed by the Operations Specialist.

Ongoing Beginning, 6/11/2026, The Executive Director or Director of Nursing will audit the amount of lock boxes we have on site weekly for 4 weeks and then monthly for 2 months. 2 Lockboxes will always be on site. If one is distributed to a resident, another will be purchased. Documentation of trainings/audits will be reviewed monthly at the Quality Assurance meeting for 3 months, and documentation will be kept for review. QA is scheduled for July 8th, 2026.
In the contract it addresses the Theft and Loss Prevention program to include the steps used to ensure the regulation 42x is met. We will ensure a copy of this Program is given to all current residents and is mailed out to all responsible parties no later than 7/7/2026. We will review this program at all resident councils for the next 3 months. Documentation of trainings/audits will be reviewed monthly at the Quality Assurance meeting for 3 months, and documentation will be kept for review. QA is scheduled for July 8th, 2026.

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

Implemented ([redacted] - 10/27/2026)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff persons B and C did not receive training on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2025.

Repeated Violation 6/26/2025

65f Training Topics *(continued)*

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action Staff Member B and C were trained by the Director of Nursing on meeting the needs of the residents on 5/26/2026.

Training By 6/27/2026 all staff including managers will be trained on Regulation 2600.65f. This training will be completed by the Operations Specialist.

Ongoing Beginning 6/22/2026 all direct care staff will be retrained on all the topics listed in 2600.65f. This training will be done in the community by the Director of Nursing or the Executive Director. All direct care staff will have these trainings bi annually. The Executive Director or Director of Nursing will do a monthly audit of the monthly trainings to ensure that each Direct Care Staff has the training listed in Regulation 2600.65f for 6 months Documentation of trainings/audits will be reviewed monthly at the Quality Assurance meeting for 6 months, and documentation will be kept for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/14/2026)

65g - Annual Training Content

4. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons B and C did not receive training in emergency preparedness procedures and resident rights during training year 2025.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action Staff Member B and C were trained by the Director of Nursing on Emergency Preparedness and Resident Rights on 5/26/2026.

Training By 6/27/2026 all staff including managers will be trained on Regulation 2600.65g. This training will be completed by the Operations Specialist.

Ongoing Beginning 6/22/2026 all direct care staff will be retrained on Resident Rights and Emergency Preparedness. This training will be done in the community by the Director of Nursing or the Executive Director. All direct care staff will have these trainings bi annually. The Executive Director or Director of Nursing will do a monthly audit of the monthly trainings to ensure that each Direct Care Staff has the training listed in Regulation 2600.65f for 6 months Documentation of trainings/audits will be reviewed monthly at the Quality Assurance meeting for 6 months, and documentation will be kept for review. QA is scheduled for July 8th, 2026

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

65g - Annual Training Content *(continued)*

Implemented ([redacted] - 10/14/2026)

66b - Training Plan Content

5. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include the dates, times and locations of the scheduled training for each staff person for the upcoming year. Most trainings are scheduled to be completed via Relias computer training program, however, it does not specify a date by which the trainings are to be completed by and the training plan does not include any information relating to required in-person trainings for fire safety, etc.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action - On 5/22/2026 the Operations Specialist reviewed the training plan for 2026. The Operations Specialist notified the Regional Director of Operations that the training plan from Relias did not meet the standards set by 2600.66b.
Training - By 6/27/2026 all staff and managers will be trained on Regulation 2600.66b by the Operation Specialist.
Ongoing - The Executive Director and/or Director of Nursing will review the annual training plan for the following year prior to the end of the current year to ensure that it meets the requirements for Regulation 2600.66b. Changes will be made immediately when required. Documentation of trainings/audits will be reviewed monthly at the Quality Assurance meeting for 3 months, and documentation will be kept for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/14/2026)

82c - Locking Poisonous Materials

6. 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

On 5/18/2026 at 9:35 am, a tube of Colgate Total toothpaste, with a manufacturer's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible on resident #2's bathroom sink in room 1, in the Secure Dementia Care Unit (SDCU).

At 9:42 am, on top of resident #3's bureau in SDCU room 3, there was a tube of Sodium Fluoride 5000ppm toothpaste, with a manufacturer's label indicating, "Do not swallow," and a bottle of Clean Works hand sanitizer, with a manufacturer's label indicating, "If swallowed, get medical help or contact a Poison Control Center right away."

On resident #3's bathroom sink, there was a bottle of Head & Shoulders shampoo, with a manufacturer's label

82c - Locking Poisonous Materials (continued)

indicating, "If swallowed, get medical help or contact a Poison Control Center immediately," There was also a tube of Neosporin + Pain Relief Ointment on the sink, with a manufacturer's label indicating, "If swallowed, get medical help or contact a Poison Control Center immediately."

Not all the residents of the home, including residents #2 and #3, have been assessed as capable of recognizing and using poisons safely.

Repeated Violation- 6/26/25, 4/22/25

Plan of Correction ***Accept (- 06/23/2026)***

Action – Items were immediately removed from the rooms and stored in the supply closet on 5/18/2026 by the Memory Care Coordinator.

Training – By 6/27/2026, The Executive Director or Director of Nursing will provide re-training on regulation 2600.82c, to include proper storage of poisonous materials, and resident safety requirements.

Ongoing – Beginning, 6/21/26 The Executive Director or Memory Care Coordinator will complete weekly audits x 4 weeks to ensure continued compliance with poison storage requirements, then monthly for 2 months. Any findings will be corrected immediately. Audits will be reviewed at the monthly Quality Assurance meeting for 3 months and documentation will be kept for review. QA is scheduled for July 8th, 2026

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

Implemented (- 11/10/2026)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 5/18/2026 at approximately 9:50 am, room 238 had a strong odor of urine while resident was out of the room.

Plan of Correction ***Accept (- 06/23/2026)***

Action – On 5.18.2026 Operations Specialist notified Maintenance Director that room 238 must be deep cleaned. Maintenance Director informed housekeeping to deep cleaned room 238, which was completed on 5/19/2026.

Training – By 6/27/2026, the Executive Director and Director of Nursing will educate all staff on regulation 2600.85a, sanitation expectations, infection control, and environmental safety standards.

85a - Sanitary Conditions (continued)

Ongoing – Beginning 6/21/2026, the Executive Director or Maintenance Director will complete weekly sanitation audit for all resident rooms and common areas for 1 month and then monthly for 2 months. Any concerns will be addressed immediately. The results of the audits will be reviewed at the monthly Quality Assurance meeting for 3 months, and documentation will be kept. QA is scheduled for July 8th, 2026

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

Implemented (- 11/10/2026)

86b - Bathroom

8. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 5/18/2026, the bathrooms in rooms 231 and 238 did not have an operable window or ventilation fan. The ventilation fans were inoperable and there were no windows in the bathroom.

Repeated Violation- 6/25/25

Plan of Correction ***Accept (- 06/23/2026)***

Action – Maintenance Director contacted Tustin about the broken exhaust fans on 5/20/2026. Repair person scheduled to come on 5/21/26 to fix the exhaust fans.

Training – On 6/2/2026, the Executive Director educated the maintenance department on regulation 2600.86b, the ventilation requirements and the importance of maintaining proper airflow in resident-use areas.

Ongoing - Beginning 6/21/2026, the Executive Director and/or Maintenance Director will conduct environmental rounds weekly x 4 weeks, then monthly x2 months, to verify all bathroom exhaust fans are present, operational, and in good working condition. The audits will be reviewed monthly at the Quality Assurance meeting x 3 months, and documentation will be kept on file for review. QA is scheduled for July 8th, 2026.

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

Implemented (- 10/14/2026)

88a - Surfaces

9. 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 5/18/2026, there was a circular, brown water stain covering most of a ceiling tile in the hallway of the Secure Dementia Care Unit, near room 3.

88a Surfaces (continued)

Repeated Violation 6/26/2025.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action Maintenance Director replaced ceiling tile on 6/2/2026 with a new one.
Training By 6/27/26, the Operation Specialist will educated the Maintenance Director and all staff on regulation 2600.88a, floors, walls, ceilings, windows, doors and other surfaces must be clean and in good repair, and free of hazards.

Ongoing Beginning 6/21/2026, the Executive Director and/or Maintenance Director will conduct environmental rounds weekly x 4 weeks, then monthly x2 months to identify and address damaged surfaces. The findings will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/27/2026)

96a - First Aid Kit

10. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 5/18/2026, the home did not have a first aid kit containing a breathing shield, eye covering, or thermometer.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action On 5/22/26 an audit of all the 1st aid kits was completed by the Operations Specialist. The Operations Specialist purchased all missing items on 5/23/2026 and placed them in the kits.

Training By 6/27/26 , the Operations Specialist will educate the Directors and staff on regulation 2600.96a, the requirements for maintaining complete and properly stocked first aid kits.

Ongoing Beginning 6/21/2026, the Executive Director and or Administrative Assistant will conduct monthly audits of all first aid kits to verify completeness and expiration dates of all supplies x 3 months. The results will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/14/2026)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f - Refrigerator/Freezer Temps *(continued)*

Description of Violation

On 5/18/2026 at 9:24 am, the temperature in the standing refrigerator in the kitchen was 43 degrees Fahrenheit, and on 5/19/26 at 11:18 am, it was still 43 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/20/2026 the Dining Director reached out to Hersch to schedule them to come check and repair the refrigerator. A technician was scheduled to come to the community on 5/28/2026.

Training – By 6/27/2026, the Executive Director will educate the Dining Director and all dietary staff on regulation 2600.103f, food storage requirements, proper temperature monitoring, and corrective actions to take when temperatures fall outside the acceptable ranges.

Ongoing – Beginning 6/21/2026, the Executive Director and/or Dining Director will audit refgerator temperature logs daily for 30 days, then monthly x 2 months to ensure compliance with proper refrigerator temperatures. Results will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/14/2026)

103i - Outdated Food

12. Requirements

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

Description of Violation

On 5/18/2026 at 9:26 am, there was a tray of cheese cubes in the main refrigerator with a label stating, "Use by 5/13."

Repeated Violation- 6/26/2025, 4/22/2025.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/18/2026 the cook discarded the food that was outdated.

Training – By 6/27/26, the Executive Director will educate all dining staff, including the Dining Director, on regulation 2600.103i, proper food storage practices, including checking for expiration dates upon receipt, rotating stock, and conducting routine inspections of all food storage areas.

Ongoing – Beginning 6/21/2026, the Executive Director and/or Dining Director will conduct weekly inspections of all food storage areas x 4 weeks, then monthly x 2 months to verify that food items are within acceptable dates, and

103i - Outdated Food (continued)

are properly rotated. Findings will be reviewed monthly at the Quality Assurance meetings x 3 months. Documentation to be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented (- 10/14/2026)

124 - Notice to Fire Department

13. 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 (- 06/23/2026)***

Action – On 5/20/2026 the Operations Specialist wrote the letter to the fire department and brought a copy to the fire department.

Training –By 6/27/26, the Operations Specialist will educate all management on regulation 2600.124, the need to maintain written notification and supporting documentation. Currently the community does not have a permanent Executive Director.

Ongoing – Beginning 6/21/2026, the Executive Director will review fire safety records monthly x 3 months and whenever there is a significant change in a resident's evacuation needs. Findings will be reviewed at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented (- 10/14/2026)

141b1 - Annual Medical Evaluation

14. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on

Repeated Violation- 6/26/2025, 4/22/2025.

Plan of Correction ***Accept (- 06/23/2026)***

Action – On 5/20/2026 the Director of Nursing contacted the primary physician and request a DME to be completed for Resident #1. This was completed on 5/21/2026.

141b1 - Annual Medical Evaluation (continued)

Training – By 6/27/2026, the Operations Specialist will educate all staff including the Director of Nursing and the Memory Care Coordinator on regulation 2600. 141b, including obtaining, documenting, and maintaining required medical evaluations within the prescribed timeframes.

Ongoing – Beginning 6/21/2026, the Executive Director/Director of Nursing/Memory Care Coordinator will conduct weekly audits of DME x 4 weeks, then monthly x 2 months to verify compliance. Findings will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented (- 10/14/2026)

144b - Policy on Smoking

15. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

On 5/18/2026, the home did not have signage indicating whether smoking was permitted at the entrance of the building or at the designated smoking area.

Plan of Correction ***Accept (- 06/23/2026)***

Action – On 5/19/2026 the Operations Specialist hung a No Smoking sign with location of the smoking area in the entrance way of the community.

Training – By 6/27/2026 all staff including all managers will be educated on regulation 2600.144b, the importance of maintaining required safety signage in accordance with regulatory standards.

Ongoing – Beginning 6/21/2026, the Executive Director and/or Maintenance Director will conduct monthly audits x 3 months to ensure proper signage is posted. The results will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented (- 10/14/2026)

162c - Menus Posted

16. Requirements

2600.

162c - Menus Posted *(continued)*

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 5/18/2026 at 9:30 am, the home's menu for the week of 5/17-5/23/26 was posted outside of the dining room. However, the menu for the following week was not posted.

Repeated Violation- 4/22/25

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/19/2026 the dining director hung the menu for 2 weeks.

Training – By 6/27/2026 the Operations Specialist will educate the Dining Director and all dietary staff on regulation 2600.162c, the requirements to maintain and post menus for resident view.

Ongoing – Beginning 6/21/2026, the Executive Director and/or Dining Director will do weekly audits x 4 weeks to ensure menus are prepared and posted for at least 2 weeks in advance, then monthly x2 months. Findings will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented ([redacted] - 10/14/2026)

171b5 - First Aid Kit

17. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kits in both the SUV and the bus used to transport residents did not include breathing shield, eye covering, or thermometer.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/22/26 an audit of all the 1st aid kits was completed by the Operations Specialist. The Operations Specialist purchased all missing items on 5/23/2026 and placed them in the kits.

Training – By 6/27/26 , the Operations Specialist will educate the Directors and staff on regulation 2600.96a, the requirements for maintaining complete and properly stocked first aid kits.

171b5 - First Aid Kit (continued)

Ongoing – Beginning 6/21/2026, the Executive Director and or Administrative Assistant will conduct monthly audits of all first aid kits to verify completeness and expiration dates of all supplies x 3 months. The results will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July 8th, 2026

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

Implemented (- 10/14/2026)

183e - Storing Medications

18. 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 5/19/2026, a container of Latanoprost .005% ophthalmic solution for resident #5, opened on 1/12/26, was on the med cart. The med cart also contained Latanoprost .005% ophthalmic solution for resident #6, opened on 2/29/26. According to the manufacturer's instructions, the unused portions of this medication should be discarded six weeks after opening.

On 5/19/26, there was no date indicating when resident #2's Spiriva Respimat 2.5 mcg inhaler was opened. According to the manufacturer's instruction, the unused portion of this medication should be discarded three months after opening.

Plan of Correction ***Accept (- 06/23/2026)***

Action – On 5/20/26 an audit of the medication carts was completed by the memory care coordinator. This audit ensured all multidose medications and treatments had date open stickers and that none had expired.

Training – By 6/27/2026 the Operations Specialist will educate the Director of Nursing, Memory Care Coordinator, all nurses and all Certified Medications Technicians on regulation 2600.183e, verification of medication labels upon receipt, routine monitoring of medication containers for accurate labeling, and reporting procedures when labeling discrepancies are identified.

Ongoing – Beginning 6/21/2026, the Executive Director or Director of Nursing will audit the weekly med cart audits x 4 weeks then monthly x 2 months to verify that all medications are properly labeled and maintained in compliance with regulatory requirements. Findings will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA meeting is scheduled for July 8, 2026.

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

Implemented (- 11/10/2026)

184a Resident's Meds Labeled

19. 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.
5. The name and title of the prescriber.

Description of Violation

On 5/19/2026, resident #2's Diclofenac Sodium 1% gel, prescribed to be applied bilaterally to resident's knees twice daily, did not have a pharmacy label with any of the required information.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/20/26 an audit of the medication carts was completed by the memory care coordinator. This audit ensured that all medications and treatments had labels.

Training – By 6/27/2026 the Operations Specialist will educate the Director of Nursing, Memory Care Coordinator, all nurses and all Certified Medications Technicians on regulation 2600.184a, verification of medication labels upon receipt, routine monitoring of medication containers for accurate labeling, and reporting procedures when labeling discrepancies are identified.

Ongoing – Beginning 6/21/2026, the Executive Director or Director of Nursing will audit the weekly med cart audits x 4 weeks then monthly x 2 months to verify that all medications are properly labeled and maintained in compliance with regulatory requirements. Findings will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA meeting is scheduled for July 8, 2026.

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

Implemented ([redacted] - 11/10/2026)

187d Follow Prescriber's Orders

20. Requirements

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

Description of Violation

Resident #1 is prescribed two 3-mg Melatonin tablets at bedtime. However, this medication was not administered to resident from 5/13 to 5/19/2026, because the medication was not available in the home.

Repeated Violation- 4/22/2025.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/20/2026 an audit of the medication carts was completed by the memory care coordinator and/or director of nursing. This audit ensured all medications and treatments were present in the medication cart.

187d - Follow Prescriber's Orders (continued)

Training – By 6/27/2026 the Operations Specialist will educate the Director of Nursing, Memory Care Coordinator, all nurses and all Certified Medications Technicians on regulation regulation 2600.185a, maintaining adequate medication supplies, verifying the presence of all prescribed medications during medication cart checks, and promptly reordering medications before supplies are depleted.

Ongoing – Beginning 6/21/2026, the Executive Director or Director of Nursing will audit the weekly med cart audits x 4 weeks then monthly x 2 months to verify that all medications are properly labeled and maintained in compliance with regulation 2600.187d, to verify that all medications are available, and maintained in compliance with regulatory requirements. Findings will be reviewed monthly at Quality Assurance meetings x 3 months. Documentation will be kept for review. QA is scheduled for July 8th , 2026.

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

Implemented ([redacted] - 11/10/2026)

233a - Lock Approval

21. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the locking device used on the exit doors from the Secure Dementia Care Unit.

Plan of Correction ***Accept ([redacted] - 06/23/2026)***

Action – On 5/26/26 the Operations Specialist reachd out to Upper Dublin township and requested they come in and inspect the locks and ensure they are appropriate. They are going to call with their availability.

Training – By 6/27/2026 the Operations Specialist will educate all management on regulation 2600.233b, timely completion of completion, submission, and retention of township notification documentation, and accurate record maintenance.

Ongoing - Beginning 6/21/2026, the Executive Director and/or Maintenance Director will audit required township documentation weekly x 4 weeks then monthly x 2 months to verify documentation is completed, maintained, and readily available for review. Findings will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review. QA is scheduled for July8, 2026.

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

Implemented ([redacted] - 10/14/2026)