pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **INSPIRIT MACUNGIE OPERATOR LLC**
LEGAL ENTITY

To operate **THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY**
NAME OF FACILITY OR AGENCY

Located at **6488 ALBURTIS ROAD, MACUNGIE, PA 18062**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **67**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 6, 2025** until **December 6, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226810**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: June 5, 2026

[redacted]
Executive Director
Inspirit Macungie Operator LLC
[redacted]

RE: The Willow, An Inspirit Senior Living Community
License # 226810

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on October 30, 2025, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

June 4, 2026

[redacted]
INSPIRIT MACUNGIE OPERATOR LLC
[redacted]

RE: THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY
6488 ALBURTIS ROAD
MACUNGIE, PA, 18062
LICENSE/COC#: 22681

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/30/2025 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY* **License #**: *22681* **License Expiration**: *12/06/2025*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *INSPIRIT MACUNGIE OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/06/2003* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/12/2026*

Inspection Dates and Department Representative

10/30/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *50*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *5* **Have Physical Disability**: *1*

Inspections / Reviews

10/30/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/22/2026*

01/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/22/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/31/2026*

Inspections / Reviews *(continued)*

05/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/20/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/24/2026*

06/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/22/2026*

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

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At 2:30 P.M., resident Edward Nosek's bed was equipped with a bedside mobility device. The mobility device was uncovered at the top. The opening was approximately 9 inches X 6 inches.

Plan of Correction ***Accept [redacted] - 01/26/2026)***

Immediate Resolution: The open area at the top of the resident's bedside mobility device was covered with tubi-grip.
Training Plan: The Wellness/Care Team will be trained by 01/29/2026 regarding the need to report any bedside mobility devices found in resident apartments that are not on the list of approved rooms with devices, as well as to report any existing or new devices they find without a cover. This training will be included in New Hire Orientation for Wellness/Care staff going forward.
Monitoring & Audit Plan: To monitor this regulation, the Resident Care Director and/or designee, will audit the resident apartments monthly for use of bedside mobility devices and covers. The Resident Care Director and/or designee will review any new devices identified in the apartments with the Resident Wellness Director to ensure that they are approved and included on the resident's service plan. The Resident Care Director and/or designee will cover any devices that are found to be uncovered during the monthly audit. The audit log will be kept in the Wellness office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all POC audits and logs beginning January 2026 through March 2026 or until consistent compliance is noted. Minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

Implemented [redacted] - 06/04/2026)

85e - Trash Outside Home

2. 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

At 12:30 p.m., the dumpster lid was observed opened exposing the contents to insects and rodents.

Plan of Correction ***Accept [redacted] - 01/26/2026)***

Immediate Resolution: The Executive Director notified the Dining Services Director of the open dumpster upon completion of the Exit Interview and instructed [redacted] to have the dining team go out to the parking lot to ensure that all three dumpster lids and doors were closed. The Dining Services Director confirmed with the Executive Director that they had been closed.
Training Plan: All Dining and Housekeeping staff were provided with re-education regarding closing the dumpster doors and lids each time they dispose of trash, as the primary departments removing trash from the building. The remaining departments will be provided with this re-education during the monthly Town Hall Meeting scheduled for 01/27/2026.
Monitoring & Audit Plan: To monitor this regulation, the Maintenance Director and/or designee, will complete the

85e Trash Outside Home (continued)

Daily/Weekly Rounds Checklist in TELS which includes ensuring the dumpsters are closed and the area is clean. The logs will be maintained in the TELS portal. The Executive Director will review the checklist weekly for completion.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all POC audits and logs beginning January 2026 through March 2026 or until consistent compliance is noted. Minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented [redacted] - 06/04/2026)

132c - Fire Drill Records

4. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on [redacted] indicates 57 residents were present in the home and that 57 residents were evacuated. However, Resident [redacted] who is receiving hospice services, was not evacuated.

Plan of Correction ***Accept[redacted] - 01/26/2026)***

Immediate Resolution: The Executive Director provided the Fire Safety Expert who facilitated the drill with retraining regarding the proper completion of the fire drill record.
Training Plan: The Leadership Team was provided with retraining regarding the requirements for evacuation during a fire drill with regards to a resident on hospice service on 10/31/2025. Due to changes in the Leadership Team, retraining was provided again on 01/22/2026. All department staff will be provided with re training during the monthly Town Hall Meeting on 01/27/2026.
Monitoring & Audit Plan: To monitor this regulation, the Maintenance Director and/or designee, will review the fire drill records completed by the Fire Safety Expert for accuracy and compliance with the regulation upon completion of the drill. The fire drill records will be maintained in the Fire Drill Records Binder in the Executive Director's office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all POC audits and logs beginning January 2026 through March 2026 or until consistent compliance is noted. Minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented [redacted] - 06/04/2026)

132h - Designated Meeting Place

5. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on [redacted] at 7:36 a.m., Resident [redacted] who is receiving hospice services, was not evacuated to a

132h Designated Meeting Place (continued)

designated meeting place away from the building or within the fire safe area. The home does not have a physician's statement certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Repeat Violation [redacted]

Plan of Correction ***Accept*** [redacted] ***- 01/26/2026)***

Immediate Resolution: The resident's hospice service had verbally reported to the Wellness team on shift the evening of 10/22/2025 that the resident was considered actively dying. A physician's statement had not been obtained prior to the fire drill at 7:36am the following morning. The Wellness team made a decision, in the resident's best interest, not to physically move [redacted] *during the drill as* [redacted] *was experiencing pain in* [redacted] *final days. The resident passed 2 days later on 10/25/2025.*

Training Plan: The Leadership Team was provided with education regarding this regulation on 10/31/2025. Due to changes in the Leadership Team, retraining was provided again on 01/22/2026, specifically the Resident Wellness Director and the Resident Care Director with regards to the requirements of the regulation that need to be put into place to allow a hospice resident who is actively dying remain in their apartment during a drill.

Monitoring & Audit Plan: To monitor this regulation, the Resident Wellness Director and/or designee, will audit the records of residents receiving hospice services monthly to ensure all documentation is current and accurate, to include the initiation of documentation required in 2600.29a b1 5 upon hospice notification of an "actively dying" hospice status. The audit log will remain in the Executive Director's office.

Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all POC audits and logs beginning January 2026 through March 2026 or until consistent compliance is noted. Minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented [redacted] ***- 06/04/2026)***

141a 1-10 Medical Evaluation Information

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted] *s medical evaluation dated* [redacted] *did not include a checked box in section 4 Poisonous materials.*

141a 1 10 Medical Evaluation Information *(continued)*

Plan of Correction ***Accept [redacted] - 01/26/2026)***

Immediate Resolution: Resident [redacted]s medical evaluation was corrected with box 4 checked off. An audit of all current resident medical evaluations was completed by the Area Operations Director on 11/21/2025 to ensure that all sections were completed in their entirety.
Training Plan: The current Resident Wellness Director and Resident Care Director will be provided training regarding the requirements for completion of a medical evaluation to ensure all sections are completed. This training will be completed by 01/29/2026.
Monitoring & Auditing: The Resident Wellness Director and/or Designee will audit all initial, annual and change of condition medical evaluations each month to ensure compliance with the regulatory for completion of evaluations. The log will be maintained in the audit binder in the Wellness office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all audits and logs beginning January 2026 through March 2026 or until consistent compliance is noted. Meeting minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

Implemented [redacted] - 06/04/2026)

183d - Prescription Current

7. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

[redacted]*. prescribed for resident [redacted] was noted in the medication cart. The medication was not listed on the resident's medication administration record, and a discontinued order was not on file.*
[redacted]*. prescribed for resident [redacted] was noted in the medication cart. The medication administration record indicates the medication was discontinued on [redacted].*

Plan of Correction ***Accept[redacted] - 01/26/2026)***

Immediate Resolution: The Resident Wellness Director removed the [redacted] for Resident [redacted] from the medication cart. The order was discontinued. [redacted] also removed the [redacted] for Resident [redacted] from the medication cart. HealthDirect Pharmacy was brought in to complete a medication cart audit.
Training Plan: The Resident Wellness Director and/or designee will provide all Medication Technicians will education regarding auditing the medications in their carts to ensure that there is a current order for every medication in the cart, removing any medications from the cart that do not have an active order and alerting the RWD to these medications to ensure a discontinuation order has been received by 01/29/2026.
Monitoring & Audit Plan: The Resident Wellness Director and/or designee will conduct weekly med cart audits to monitor for accuracy of medications in the cart with active orders. The audit binder will be maintained in the Wellness Office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all audits and logs January 2026 through March 2026 or until consistent compliance is noted. The minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

183d - Prescription Current *(continued)*

Implemented [redacted] - 06/04/2026)

187a - Medication Record

8. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident [redacted] is prescribed [redacted] 4 puffs each morning. Resident [redacted] s medication administration record was not initialed by staff on [redacted], [redacted] and [redacted] to indicate the medication was administered as directed.

Plan of Correction ***Accept [redacted] - 01/26/2026)***

Immediate Resolution: In reviewing Resident [redacted] s medication administration record, it was noted that the medication had been listed in the eMAR as a PRN medication rather than a scheduled medication. It was also listed for 2 puffs not 4 puffs as noted in the LIS. The original order was discontinued to remove the incorrect medication status from the eMAR. A new order was provided and verified in the eMAR as a daily scheduled medication.
Training Plan: The Resident Wellness Director and/or designee will provide the Medication Technicians with education regarding the proper steps in administering medications, to include verifying that the order in the eMAR matches the label on the medication and bringing any inconsistencies found to [redacted] attention immediately for resolution. This training will be completed by 01/29/2026.
Monitoring & Audit Plan: The Resident Wellness Director and/or designee will conduct weekly med cart audits to monitor for accuracy of medication orders in the eMAR and the labels of the medications in the cart. The audit binder will be maintained in the Wellness Office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all POC audits and logs beginning January 2026 through March 2026 or until consistent compliance is noted. Minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

Implemented [redacted] - 06/04/2026)

225a - Assessment 15 Days

9. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment and support plan was not completed for resident [redacted] who was admitted to the home on [redacted].

Plan of Correction ***Accept [redacted] - 01/26/2026)***

Immediate Resolution: Resident [redacted] s records were audited for this assessment and support plan as it had been

225a - Assessment 15 Days (continued)

noted to be in place during an audit for the inspection in February of 2025. It could not be located. At the time of the 10/30/2025 inspection, the resident was hospitalized. The resident returned from a rehab stay to the community on 11/20/2025. An assessment and support plan was completed after [redacted] return based on [redacted] current diagnoses and care needs.
Training Plan: The current Resident Wellness Director and Resident Care Director will be provided with training regarding the assessment and support plan regulations, specifically the finalization timeframes for initial, annuals and significant change plans by 01/29/2026.
Monitoring & Audit Plan: The Resident Wellness Director and/or designee will conduct monthly audits of the resident assessment and support plans for all initials, annuals and significant changes that have occurred in the month to ensure they have been completed within the regulatory timeframes. The audit binder will be maintained in the Wellness Office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all audits and logs January 2026 through March 2026 or until consistent compliance is noted. The minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

Implemented ([redacted] - 06/04/2026)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. The resident's assessment does not include the date the document was finalized.

Resident [redacted]s most recent assessment was completed on [redacted]. A new annual assessment was not completed in the required timeframe.

Resident [redacted] uses a bedside mobility device for stabilization. The resident's most recent assessment, dated [redacted], does not include any documentation of the resident's use of the bedside mobility device.

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

Immediate Resolution: A new resident assessment and support plan was completed for Resident [redacted] with all dates documented. A new resident assessment and support plan was completed for Resident [redacted]. Resident #[redacted]s assessment and support plan was updated for [redacted] use of a bedside mobility device for stabilization.
Training Plan: The current Resident Wellness Director and Resident Care Director will be provided with training regarding the assessment and support plan regulations, specifically the finalization timeframes for initial, annuals and significant change plans and the addition of ongoing updates as the resident's needs change by 01/29/2026.
Monitoring & Audit Plan: The Resident Wellness Director and/or designee will conduct monthly audits of the resident assessment and support plans for all initials, annuals and significant changes that have occurred in the month to ensure they have been completed within the regulatory timeframes. The audit binder will be maintained in the Wellness Office.

225c Additional Assessment (continued)

Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all audits and logs January 2026 through March 2026 or until consistent compliance is noted. The minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

Implemented [redacted] - 06/04/2026)

251c - Standardized Forms

11. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident [redacted] medical evaluation was completed on [redacted] but was not completed on the Department's current standardized form.

Plan of Correction ***Accept[redacted] 01/26/2026)***

Immediate Resolution: The medical evaluation for Resident [redacted] completed on 10/03/2025 has been faxed to the physician completing the evaluation along with a copy of the new standard medical evaluation form. The physician has been requested to complete the new standardized form. The physician's office has also been instructed to shred any old blank medical evaluation forms that they have and only use the new version going forward.
Training Plan: The current Resident Wellness Director and Resident Care Director will be provided with training regarding the use of the new standardized form for the medical evaluations and verifying that all medical evaluations are completed on this form by 01/29/2026.
Monitoring & Audit Plan: The Resident Wellness Director and/or designee will conduct monthly audits of the medical evaluations for all initials, annuals and significant changes that have occurred in the month to ensure they have been completed on the required standardized form. The audit binder will be maintained in the Wellness Office.
Sustainability Plan: To monitor compliance, monthly quality management meetings are conducted ongoing on the third Thursday of the month. The leadership team will review all audits and logs January 2026 through March 2026 or until consistent compliance is noted. The minutes will be maintained by the Executive Director.

Licensee's Proposed Overall Completion Date: *01/29/2026*

Implemented [redacted] - 06/04/2026)