

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

October 21, 2026

[REDACTED], COO
EAGLEVIEW LANDING LP
[REDACTED]
[REDACTED]

RE: EAGLEVIEW LANDING
650 STOCKTON DRIVE
EXTON, PA, 19341
LICENSE/COC#: 14698

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/23/2026, 06/24/2026 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: EAGLEVIEW LANDING

License #: 14698

License Expiration: 09/13/2026

Address: 650 STOCKTON DRIVE, EXTON, PA 19341

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: EAGLEVIEW LANDING LP

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2

Date: 03/27/2019

Issued By: Uwchlan Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 103

Waking Staff: 77

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 06/24/2026

Inspection Dates and Department Representative

06/23/2026 - On-Site: [REDACTED]

06/24/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 121

Residents Served: 80

Secured Dementia Care Unit

In Home: Yes

Area: Along the Journey

Capacity: 27

Residents Served: 19

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 80

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 23

Have Physical Disability: 0

Inspections / Reviews

06/23/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 07/26/2026

08/04/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/13/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/09/2026

Inspections / Reviews (*continued*)

08/11/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/13/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/14/2026

10/21/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/13/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

63a - First Aid/CPR Training**1. Requirements**

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 6/7/2026, from 6:00 AM to 1:55 PM, approximately 80 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

On 6/18/2026, from 1:56 PM to 10:57 PM, approximately 80 residents were present in the home. During this time only one staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On 6/22/2026, from 5:00 PM until 6:00 AM on 6/23/2026, approximately 80 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction**Accept () - 08/04/2026)**

Action: Upon identification of the deficiency, an audit of all employee records was conducted to determine the status of CPR and First Aid certification for all staff. Employees requiring training completed CPR and First Aid certification on July 7, 2026. An additional CPR and First Aid training session will be scheduled to accommodate any newly hired employees or staff who were unable to attend the initial training, ensuring all required personnel maintain current certification.

Training: To prevent recurrence, the Director of Nursing and Assistant Director of Nursing were educated on regulation 2600.63a, CPR certification. Both will be responsible for monitoring CPR and First Aid certification for all nursing staff. Quarterly training sessions, as well as additional sessions as needed, will be scheduled to ensure all staff maintain current certification and remain compliant with DHS requirements. The next training will be scheduled in September 2026. A tracking log will be maintained to monitor certification expiration dates and ensure timely renewal.

Ongoing: CPR and First Aid certification records, training completion, and upcoming expiration dates will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)**65d - Initial Direct Care Training****2. Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d Initial Direct Care Training (continued)

Description of Violation

Direct Care Staff Person A, hired on [REDACTED] began providing unsupervised ADL services on [REDACTED]. However, the staff person did not complete and pass the Department approved direct care training course and pass the competency test as of 6/23/2026.

Plan of Correction

Accept [REDACTED] - 08/04/2026)

Action: Upon identification of the deficiency, an audit of all employee personnel files was completed on July 1, 2026, and July 2, 2026, to verify that all required training and documentation were present. The employee completed the required online training and competency evaluation to achieve compliance.

Training: The Executive Director was educated on regulation 2600. 65d, DHS competency training by the Regional Director of Operations. To prevent recurrence, a comprehensive New Hire Documentation Checklist was developed and implemented to ensure all required documentation, certifications, and training are completed prior to employee orientation. The Executive Director educated the Administrative Assistant on the new checklist and documentation process on July 1, 2026.

Ongoing: The Executive Director or designee will conduct audits of new hire personnel files monthly for three months and quarterly thereafter to verify compliance with all hiring, training, and personnel file requirements. Audits will begin in August. Audit findings will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented [REDACTED] - 10/21/2026)

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 Person B did not receive training in medication self administration during training year 1/1/2025 through 12/31/2025.

Plan of Correction

Accept [REDACTED] - 08/11/2026)

Action: The employee identified during the survey was re educated on Medication Self Administration by the Executive Director on 8/5/26.

65f - Training Topics (continued)

Training: All staff will be educated on regulation 2600.65f, medication self administration. To ensure all employees receive education on all DHS required training topics, Medication Administration and Self-Administration of Medications has been added to the mandatory 2026 staff education schedule for all employees. This training will be conducted on August 12, 2026.

Ongoing: To ensure ongoing compliance with DHS training requirements, the Executive Director will work collaboratively with the Director of Nursing and/or the Assistant Director of Nursing to develop and maintain an annual training calendar that includes all required training topics for every employee classification. All training topics will be reviewed monthly during QAPI beginning August 11, 2026 to ensure all topics meet DHS Regulatory requirements

Licensee's Proposed Overall Completion Date: 08/06/2026

Implemented () - 10/21/2026)

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 Person B did not receive training in resident rights during training year 1/1/2025 through 12/31/2025.

Staff Person C 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 1/1/2025 through 12/31/2025.

Staff Person 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, emergency preparedness procedures and recognition and response to crises and emergency situations, and/or resident rights during training year 1/1/2025 through 12/31/2025.

Plan of Correction

Accept () - 08/04/2026)

Action: To ensure compliance with DHS training requirements, Resident Rights training has been scheduled for 8/12/26 and Annual Fire Safety Training for 2026 has been scheduled for September 10, 2026, for all employees. The training will be conducted on-site by the Director of Maintenance, who is a certified Fire Safety Expert. Both the Director of Maintenance and the maintenance assistant are certified as fire safety experts.

65g - Annual Training Content (continued)

All newly hired employees will continue to receive PC Resident Rights and Fire Safety training on Day 1 of Orientation as part of the community's onboarding process.

Going forward, both Resident Rights and Fire Safety training will be incorporated into the community's annual education program and conducted in person to ensure all employees receive the required instruction and have the opportunity to ask questions and demonstrate understanding.

Ongoing: The Executive Director or designee will audit training records/sign in sheets to monitor completion of all required annual education monthly x 3 months. Audits will begin August 1, 2026. Training topics, attendance, and completion rates will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance and address any deficiencies promptly.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

103g - Storing Food**5. Requirements**

2600.

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

Description of Violation

On 6/23/2026, the banana cream pie in the main kitchen refrigerator was opened and unsealed.

Plan of Correction

Accept () - 08/04/2026)

Action: Upon identification of the deficiency, the uncovered and unlabeled banana cream pie was immediately discarded in accordance with safe food handling practices.

Training: The new Director of Culinary began on 7/6/26. On 7/24/26, the Director of Culinary educated all dietary staff on regulation 2600.103g, proper food storage procedures, including the requirement that all prepared and opened food items be covered, labeled with the product name and preparation or expiration date, and stored in accordance with food safety regulations.

Ongoing: Beginning 8/3/26, the Dining Services Director or designee will conduct routine audits weekly x 4 weeks, then monthly x 3 months and randomly thereafter. These kitchen inspections to verify that all food items are properly covered, labeled, and dated. Any deficiencies identified will be corrected immediately, and additional staff education will be provided as needed.

The Executive Director will monitor compliance through periodic kitchen audits to ensure ongoing adherence to food safety standards and regulatory requirements. These audits will be reviewed monthly during QAPI, starting August 11, 2026 to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

131f - Fire Extinguisher Inspection

6. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguishers in the home have not been inspected by a fire safety expert since April 2025.

Plan of Correction

Accept () - 08/04/2026)

Action: Upon identification of the expired fire extinguishers, the Director of Maintenance immediately contacted the fire protection vendor to schedule an inspection and ensure all fire extinguishers were serviced, inspected, and brought into compliance. All new extinguishers were immediately ordered by the Director of Maintenance. The extinguishers are set to be delivered and installed by 7/31/26.

Training: On 7/7/26, the Executive Director educated the Maintenance Director and Maintenance Assistant, on regulation 2600.131f, fire extinguishers. Going forward, the Director of Maintenance will maintain a log of all fire extinguisher inspection and service dates and will serve as the primary contact for the fire protection vendor. The Director of Maintenance will verify that all required monthly visual inspections and annual servicing are completed on time.

Ongoing: Beginning 8/3/26, the Maintenance Director and/or Maintenance Assistant will complete monthly audits of the fire extinguishers monthly x3 and annually thereafter. A tickler will be added to the maintenance TELs system for 2027 to ensure inspections are completed. The findings will be reviewed monthly at the Quality Assurance beginning August 11, 2026. Audits will be kept on file for review. Copies of all fire extinguisher inspection reports, service records, and certifications will be provided to the Executive Director for inclusion in the annual survey and regulatory compliance binder. The Executive Director will periodically review the documentation to ensure ongoing compliance with all applicable regulations.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

141a Medical Evaluation

7. 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.

Description of Violation

Resident 1's medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction

Accept () - 08/04/2026)

Action: The Director previously responsible for obtaining the required DME is no longer employed by the community. The community has since hired a new Director of Nursing (DON), who began employment on [REDACTED], and an Assistant Director of Nursing (ADON), who began employment on [REDACTED]

Training: On July 8, 2026, both the DON and ADON received training from the Corporate Clinical Trainer regarding the DME form, process and required time frames.

141a - Medical Evaluation (continued)

Ongoing: To prevent recurrence, the community's admission process will require verification that the initial medical evaluation has been obtained and completed within the DHS-required timeframe before the admission process is considered complete.

The Executive Director or designee will conduct monthly audits of all new admission paperwork to verify that initial medical evaluations and all required admission documentation have been completed within the DHS-required timeframes. These audits will begin 8/2026. Audit findings will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed. Audits will be kept on file for review.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

141b1 - Annual Medical Evaluation**8. Requirements**

2600.

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

Description of Violation

Resident 2's most recent medical evaluation was completed on [REDACTED]

Plan of Correction

Accept () - 08/04/2026)

Action: The resident's annual medical evaluation was not completed within the required timeframe. Upon identification of the deficiency, the resident's physician was contacted immediately, and the resident was seen on 7/9/2026. The required annual medical evaluation was completed on 7/9/2026.

Training: On 7/8/29, The Clinical Trainer educated the Director of Nursing and Assistant Director of Nursing on regulation 2600.141b1, DME. To prevent recurrence, the Director of Nursing or designee will add all annual medical evaluations into ECP. This system will create a tracking log will be reviewed monthly to identify evaluations that are due within the next 30 days.

Ongoing: The Director of Nursing or designee will contact the resident's physician and/or responsible party at least 30 days prior to the due date to schedule the required medical evaluation. If the evaluation has not been received within two weeks of the due date, follow-up contact will be made until the completed evaluation is obtained. Beginning 8/3/26, the Director of Nursing, Assistant Director of Nursing or designee will complete an audit of resident records monthly x 3 months then randomly thereafter to ensure all required documents are obtained within the regulatory guideline.

Audit findings will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed. Audits will be kept on file for review.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

162c - Menus Posted

9. Requirements

2600.

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

The home's menus for the weeks of 6/21 through 6/27/2026 and 6/28 through 7/4/2026 were not posted in either Personal Care or Memory Care.

Plan of Correction

Accept () - 08/04/2026

Action: The dining menus were posted immediately upon identification of the deficiency.

Training: On 7/10/26, the Executive Director reviewed with the Dining Director regulation 2600.162c, menus. To ensure ongoing compliance, bulletin boards have been hung in both the personal care area and the memory care unit. Menus will be prominently displayed in these locations as required at all times.

Ongoing: The Executive Director will conduct bi-weekly audits x 4 weeks, then monthly x 3 months to verify that the current menus are accurate, up to date, and properly displayed. These audits will begin 7/17/26. Compliance will be monitored on an ongoing basis, and any deficiencies identified will be corrected immediately. Audit findings will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed. Audits will be kept on file for review.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026

181d -Storing Medication

10. Requirements

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 3 self-administers medications and stores medications in [REDACTED] room. On 6/23/2026 at 11:02 AM, there were several unlocked and unlabeled medications in Resident 3's apartment.

Repeat Violation: 6/11/2025

Plan of Correction

Accept () - 08/04/2026

Action: The resident's medications were immediately reviewed by the nursing staff to ensure all medications were properly labeled in accordance with regulatory requirements.

Training: On 7/9/26, the Clinical Trainer educated the nursing staff on regulation 2600.181d, storing medications. The resident was re-educated on the community's self-medication policy, including the requirement that all medications be stored in a locked location when not in use. A lock box was purchased and provided to the resident for the secure storage of [REDACTED] medications.

181d Storing Medication (continued)

Ongoing: Beginning 8/3/26, to ensure ongoing compliance, the Director of Nursing or Assistant Director of Nursing or designee, will complete weekly audits of self medication assessments x 4 weeks then monthly x 3 months to verify that the resident remains capable of safely self administering medications, that all medications are appropriately labeled, and that they are stored in the resident's locked cabinet or the lock box provided.

Beginning August 11, 2026, Findings will be reviewed monthly at the Quality Assurance meetings. Audits will be kept on file for review.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

182b - Prescription Medication**11. Requirements**

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 6/5/2026, 6/7/2026 and 6/8/2026 at 12:00 AM Staff Person E administered medications to residents to include the following; Albuterol Neb 0.083% and Chest Conges Liq 100/5 ml. Staff Person E is not a physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic, a graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home, A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home, and/or a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On 6/15/2026, 6/20/2026 and 6/21/2026 at 7:00 AM Staff Person F administered medications to residents to include the following; Aspirin Low Chw 81 mg, CO Q 10 Cap 100mg and Memantine Tab HCL 10 mg. Staff Person F is not a physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic, a graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home, A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home, and/or a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

182b Prescription Medication (continued)

Plan of Correction

Accept () - 08/04/2026

Upon identification of the deficiency, the employees was immediately removed from medication administration duties until all Pennsylvania requirements were satisfied.

Action: Staff person E is no longer employed with the organization as of (). The remaining employee will refrain from administering medications until they have successfully completed the required Pennsylvania Medication Technician online training and competency observations.

Training: To ensure all medication technicians meet Pennsylvania Department of Human Services (DHS) requirements, every medication technician was required to successfully complete the DHS Medication Administration online training and pass the required examination. To prevent recurrence, the Director of Nursing or designee will review the Medication Technician training binder monthly to ensure all Medication Technicians maintain current Pennsylvania required training, competency documentation, and medication administration observations. Any deficiencies identified will be addressed immediately, and staff will not administer medications until all requirements have been met.

Ongoing: to prevent recurrence, the Director of Nursing or designee will review the Medication Technician training binder monthly to ensure all Medication Technicians maintain current Pennsylvania required training, competency documentation, and medication administration observations. Any deficiencies identified will be addressed immediately, and staff will not administer medications until all requirements have been met.

Training records, medication administration competencies, and observation requirements will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026

183e - Storing Medications

12. 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 6/24/2026:

- Timolol Maleate Ophthalmic Solution, USP 0.5%, prescribed to Resident 4, was open and undated in the Memory Care medication cart. According to the manufacturer's instructions this medication should be discarded 30 days after opening.
- Latanoprost Ophthalmic Solution .005%, prescribed to Resident 4, was open and undated in the Memory Care medication cart. According to the manufacturer's instructions this medication should be discarded 6 weeks after opening.
- Dorzolamide Hydrochloride and Timolol Maleate Ophthalmic Solution, USP 2%/0.5%, prescribed to Resident 5, was open and undated in the Memory Care medication cart. According to the manufacturer's instructions this

183e - Storing Medications (continued)

medication should be discarded 4 weeks after opening.

- *Levobionolol Hydrochloride Ophthalmic Solution USP .5%, prescribed to Resident 6, was in the Memory Care medication cart with an open date of 5/12/2026 indicated, and an expiration date of 6/10/2026 indicated. According to the manufacturer's instructions this medication should be discarded 4 weeks after opening.*
- *Acetaminophen 325 mg, prescribed to Resident 6, had a puncture on the back of the blister pack at spot 10; the medication was still in the pack.*
- *Aspirin Low Tab 81 mg EC, prescribed to Resident 6, had a puncture on the back of the blister pack at spot 10; the medication was still in the pack.*

Repeat Violation: 6/11/2025

Plan of Correction

Accept () - 08/04/2026)

Action: All improperly stored/undated medications were immediately discarded and replacement medications were ordered.

Training: To ensure all medication technicians meet Pennsylvania Department of Human Services (DHS) requirements, every medication technician was required to successfully complete the DHS Medication Administration online training and pass the required examination. Following completion of the coursework, Priority Life Care's clinical trainer conducted competency observations for each medication technician to verify that medications were being opened, administered, and stored correctly in accordance with regulatory requirements and community policy.

Ongoing: Now that our newly hired Director of Nursing and Assistant Director of Nursing have completed their initial onboarding training, beginning 8/3/26, Director of Nursing, and/or Assistant Director of Nursing will complete an audit of the medication carts weekly x 4 weeks, then monthly thereafter to ensure compliance. Findings will be reviewed monthly at the Quality Assurance meeting. Audits will be kept on file for review.

Beginning August 11, 2026, the results of all medication cart audits will be reviewed by the Executive Director during the monthly Quality Assurance and Performance Improvement (QAPI) meeting to monitor compliance, identify trends, and implement corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

184a - Resident's Meds Labeled

13. 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.

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

The pharmacy label for Resident 7's Lidocaine PA Pad 4% does not include the prescribed dosage and instructions for administration, and/or the name and title of the prescriber.

Plan of Correction

Accept () - 08/04/2026)

Action: The medication label was corrected immediately upon identification of the deficiency to ensure it accurately reflected the prescriber's order.

Training: To reinforce the importance of accurate medication labeling and adherence to prescriber orders, all medication technicians were required to successfully complete the Pennsylvania Department of Human Services (DHS) Medication Administration online training and pass the required examination. Following completion of the training, all medication technicians were observed administering medications by Priority Life Care's DHS Medication Administration Trainer to verify competency and compliance with medication administration standards.

Ongoing: Beginning 8/3/26, Director of Nursing, and/or Assistant Director of Nursing will conduct weekly audits of the medication carts x 4 weeks then monthly thereafter to ensure compliance. Audits will be kept on file for review. Beginning August 11, 2026, the results of all medication cart audits will be reviewed by the Executive Director during the monthly Quality Assurance and Performance Improvement (QAPI) meeting to monitor compliance, identify trends, and implement corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

185a - Implement Storage Procedures

14. 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

The following glucometer readings for Resident 7 were incorrectly documented on the resident's June 2026 medication administration record (MAR):

- a glucometer reading of 231 on 6/21 at 11:06 AM was documented in the MAR on 6/21 at 12:03 PM as 236.*
- a glucometer reading of 217 on 6/21 at 3:50 PM was documented in the MAR on 6/21 at 4:41 PM as 214.*

The following glucometer readings for Resident 8 were incorrectly documented on the resident's June 2026 medication administration record (MAR):

- a glucometer reading of 112 on 6/23 at 6:37 AM was documented in the MAR on 6/23 at 9:32 AM as 115.*

Plan of Correction

Accept () - 08/04/2026)

Action: Upon identification of the deficiency, an audit of all glucometers and corresponding blood glucose documentation was completed to ensure that all blood sugar readings were accurately transcribed into the

185a - Implement Storage Procedures (continued)

resident's medication administration record and clinical documentation.

Training: The community has hired a new Director of Nursing and Assistant Director of Nursing. Now that their initial onboarding and orientation have been completed, the Director of Nursing, Assistant Director of Nursing, will be conducting a training on 7/30/26 for all Certified Medication Technicians and Licensed Practical Nurses (LPNs) to re-educate them on regulation 2600.185a, the proper procedure for obtaining blood glucose readings, accurately documenting results, and ensuring that all readings are transcribed correctly in accordance with physician orders and facility policy

Ongoing: Beginning 8/3/26, Director of Nursing, Assistant Director of Nursing or designee, will conduct weekly glucometer audits x 4 weeks, monthly x 3 and randomly thereafter to ensure compliance. The Executive Director and Director of Nursing will review the audit findings during the monthly Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement additional corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented ([REDACTED] - 10/21/2026)

15. 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 9 is prescribed Chest Conges Liq 100/5ml, give 10 ml = 200 mg by mouth every 4 hours, as needed, and, Preparation Cre H, apply to affected area twice daily, as needed. On 6/24/2026 at 12:10 PM these medications were not available in the home.

Resident 10 is prescribed Loperamide Cap 2 mg, take 1 capsule by mouth twice daily as needed. On 6/24/2026 at 12:42 PM this medication was not available in the home.

Repeat violation: 4/16/2026, 1/28/2026

Plan of Correction

Accept ([REDACTED] - 08/04/2026)

Action: The missing prn medication was immediately ordered and delivered to the community from pharmacy.

Training: To reinforce the importance of medications being available and properly stored at all times, all medication technicians were required to successfully complete the Pennsylvania Department of Human Services (DHS) Medication Administration online training and pass the required examination. Following completion of the training, all medication technicians were observed administering medications by Priority Life Care's DHS Medication Administration Trainer to verify competency and compliance with medication administration standards.

Ongoing: The community has also hired a new Director of Nursing and Assistant Director of Nursing. Now that their initial onboarding and orientation have been completed, the Director of Nursing, Assistant Director of Nursing, or designee will conduct weekly medication cart audits x 4 weeks, then monthly thereafter to ensure compliance. These audits will begin the week of 7/26/26. The Executive Director will review the audit findings during the monthly Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing

185a Implement Storage Procedures (continued)

compliance, identify trends, and implement additional corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

187d - Follow Prescriber's Orders**16. Requirements**

2600.

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

Description of Violation

Resident 9 is prescribed Albuterol Aer HFA Inhale 2 puffs by mouth twice daily. However, this medication was not administered to Resident 9 on 6/18/2026 and 6/22/2026 at 7:00 AM because the medication was not available in the home.

Resident 11 is prescribed Levothyroxin Tab 88 mcg, take 1 tablet by mouth every morning. However, this medication was not administered to Resident 11 on 6/14/2026 at 5:30 AM because the medication was not available in the home.

Repeat Violation: 7/2/2025

Plan of Correction

Accept () - 08/04/2026)

Action: The medications were immediately ordered and delivered to the community.

Training: To reinforce the importance of medications being available and properly stored at all times, all medication technicians were required to successfully complete the Pennsylvania Department of Human Services (DHS) Medication Administration online training and pass the required examination. Following completion of the training, all medication technicians were observed administering medications by Priority Life Care's DHS Medication Administration Trainer to verify competency and compliance with medication administration standards.

Ongoing: The community has also hired a new Director of Nursing and Assistant Director of Nursing. Now that their initial onboarding and orientation have been completed, the Director of Nursing, Assistant Director of Nursing, or designee will conduct weekly medication cart audits x 4 weeks, then monthly thereafter to ensure compliance. These audits will begin the week of 8/3/26. The Executive Director will review the audit findings during the monthly Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement additional corrective actions as needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

190a - Completion Medication Course**17. Requirements**

2600.

190a - Completion Medication Course (continued)

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person C, who has not successfully completed the annual practicum for the Department-approved medications administration course, administered medications to residents to include the following:

- on 6/18/2026 at 5:00 PM, Diclofenac Gel 1 % to Resident 9.
- on 6/18/2026 at 7:00 PM, Budesonid sus 0.25 mg/2 and Melatonin Tab 3 mg to Resident 9.

Staff Person G, who has not successfully completed the annual practicum for the Department-approved medications administration course, administered medications to residents to include the following:

- on 6/2/2026, 6/3/2026, 6/4/2026 and 6/5/2026 at 9:00 AM, Acetaminophen 325 mg Tab, Levobunolol Sol 0.5% OP, and Metamucil Cap 400 mg to Resident 6.
- on 6/13/2026, 6/14/2026 and 6/16/2026 at 7:00 AM, Aspirin Low Chw 81 mg, CO Q-10 Cap 100mg, and Memantine Tab HCL 10 mg to Resident 10.

Plan of Correction**Accept () - 08/04/2026)**

Action: Upon identification of the deficiency, an immediate audit was conducted of all Certified Medication Technicians to verify that all required training, competency documentation, and medication administration observations were current. Any Medication Technician who did not have the required documentation on file was immediately removed from medication administration duties until all DHS requirements were met.

Training: To reinforce the importance of medication technicians being up to date with all DHS medication administration requirements, all medication technicians were required to successfully complete the Pennsylvania Department of Human Services (DHS) Medication Administration online training and pass the required examination. Following completion of the training, all medication technicians were observed administering medications by Priority Life Care's DHS Medication Administration Trainer to verify competency and compliance with medication administration standards. The two employees identified as requiring the course/observations, both completed the course. Test and observations by 6/30/26.

Ongoing: To prevent recurrence, the Director of Nursing or designee will review the Medication Technician training binder monthly to ensure all Medication Technicians maintain current Pennsylvania-required training, competency documentation, and medication administration observations. Any deficiencies identified will be addressed immediately, and staff will not administer medications until all requirements have been met.

The Executive Director or designee will conduct random audits of Medication Technician files to verify ongoing compliance. Audit findings will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor compliance, identify trends, and implement corrective action as needed.

190a - Completion Medication Course (continued)

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

224a - Preadmission Screen Form**18. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 1 was admitted to the home on () however, the resident's preadmission screening form in the resident's record was undated, therefore incomplete as of 6/24/2026.

Resident 12 was admitted to the home on (); however, the resident's preadmission screening form was not in the resident's record as of 6/24/2026.

Repeat Violation: 7/31/2025

Plan of Correction

Accept () - 08/04/2026)

Action: Upon identification of the deficiency, an audit was conducted to ensure that all residents' pre-admission screening (Prescreen) forms were completed and maintained in the resident's medical record. Any missing documentation was obtained and filed in the appropriate resident chart.

Training: On 7/9/26, the Clinical Trainer educated the Director of Nursing and Assistant Director of Nursing on regulation 2600.224a, prescreens. To prevent recurrence, the community's admission process was revised to require that the Prescreen be completed by the Director of Nursing (DON) or Assistant Director of Nursing (ADON), as part of the initial resident assessment prior to admission.

Ongoing The Executive Director or designee will conduct monthly audits of all new admission paperwork to verify that initial medical evaluations and all required admission documentation have been completed within the DHS-required timeframes. These audits will begin 8/2026. Audit findings will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed. Audits will be kept on file for review.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

225a - Assessment 15 Days**19. 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.

225a Assessment 15 Days (continued)**Description of Violation**

An assessment was not completed for Resident 12, who was admitted to the home on [REDACTED]

Plan of Correction

Accept ([REDACTED]) - 08/04/2026)

Action: The resident's annual RASP was completed and reviewed with the resident on 6/30/26

Upon identification of the deficiency, an audit of all resident RASPs and their due dates was completed to ensure compliance with regulatory requirements. A RASP tracking ("tickler") form was developed and implemented to monitor due dates and ensure all annual RASPs are completed within the required timeframe.

Training: The community recently hired a new Director of Nursing and Assistant Director of Nursing. Both employees received training from the Corporate Clinical Trainer on July 8, 2026, regarding the completion of RASPs, regulatory requirements, and required completion timeframes.

Ongoing: Now as the Director of Nursing and Assistant Director of Nursing have completed their initial onboarding training, beginning the week of 8/3/26, the Executive Director, Director of Nursing, and/or Assistant Director of Nursing will run a Due Date Report from ECP, and conduct weekly audits of resident records x 4 weeks then monthly x 3 months to ensure compliance.

In addition, all RASPs and scheduled care conferences will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to ensure ongoing compliance, identify trends, and promptly address any deficiencies.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented ([REDACTED]) - 10/21/2026)

225c - Additional Assessment**20. Requirements**

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 2's most recent assessment was completed on [REDACTED]

Repeat Violation: 7/2/2025

Plan of Correction

Accept ([REDACTED]) - 08/04/2026)

Action: The resident's annual RASP was completed and reviewed with the resident on 6/30/26

Training: The community recently hired a new Director of Nursing and Assistant Director of Nursing. Both employees received training from the Corporate Clinical Trainer on July 8, 2026, regarding the completion of RASPs, regulatory requirements, and required completion timeframes.

225c Additional Assessment (continued)

Ongoing: Now as the Director of Nursing and Assistant Director of Nursing have completed their initial onboarding training, beginning the week of 8/3/26, the Executive Director, Director of Nursing, and/or Assistant Director of Nursing will run a Due Date Report from ECP, and conduct weekly audits of resident records x 4 weeks then monthly x 3 months and randomly thereafter to ensure compliance.

In addition, all RASPs and scheduled care conferences will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to ensure ongoing compliance, identify trends, and promptly address any deficiencies

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

227g -Support Plan Signatures**21. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 1 participated in the development of support plan on However, the resident did not sign the support plan.

Resident 13 participated in the development of support plan on However, the resident did not sign the support plan.

Repeat Violation: 4/16/2026, 1/28/2026, 7/31/2025, 7/2/2025

Plan of Correction

Accept () - 08/04/2026)

Action: Resident participation in the development and review of the Resident Assessment and Support Plan (RASP) is essential to ensure that each resident is involved in decisions regarding their care and services. The resident and/or designated person must be given the opportunity to participate in the development and review of the RASP and provide a signature acknowledging their participation.

On 7/3/26, the affected RASPs were reviewed with the residents and the required signatures were obtained.

Training: The new Director of Nursing began employment on . On 7/8/26, the Director of Nursing and the new assistant Director of Nursing, received training from our Clinical Trainer regarding the RASP process, required completion timelines, resident and designated person participation, signature requirements, scheduled care conferences, and applicable regulations governing resident assessment and support plans.

Ongoing: Now as the Director of Nursing and Assistant Director of Nursing have completed their initial onboarding training, beginning the week of 8/3/26, the Executive Director, Director of Nursing, and/or Assistant Director of Nursing will conduct weekly audits of resident charts x 4 weeks then monthly x 3 months and randomly thereafter to ensure compliance.

In addition, RASP compliance and scheduled care conferences will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026. This ongoing monitoring process will

227g -Support Plan Signatures (continued)

be used to ensure continued compliance, identify trends or deficiencies, and implement corrective action promptly when needed.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

231c - Preadmission Screening**22. 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 1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's written cognitive preadmission screening was undated and therefore incomplete as of 6/24/2026.

Plan of Correction

Accept () - 08/04/2026)

Action: Upon identification of the deficiency, the missing information was documented, and an audit was conducted to ensure that all residents' pre-admission screening (Prescreen) forms were completed and maintained in the resident's medical record. Any missing documentation was obtained and filed in the appropriate resident chart.

Training: On 7/9/26, the Clinical Trainer educated the Director of Nursing and Assistant Director of Nursing on regulation 2600.224a, prescreens. To prevent recurrence, the community's admission process was revised to require that the Prescreen be completed by the Director of Nursing (DON) or Assistant Director of Nursing (ADON), as part of the initial resident assessment prior to admission.

Ongoing The Executive Director or designee will conduct monthly audits of all new admission paperwork to verify that initial medical evaluations and all required admission documentation have been completed within the DHS-required timeframes. These audits will begin 8/2026. Audit findings will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and implement corrective actions as needed . Audits will be kept on file for review.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)

234a - Admission Support Plan**23. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's initial support plan was completed on [REDACTED]

234a - Admission Support Plan (continued)

Repeat Violation: 1/28/2026, 7/2/2025

Plan of Correction**Accept () - 08/04/2026)**

Action: The Memory Care Coordinator responsible for completing RASPs is no longer employed by the community.

Training: To prevent this deficiency from recurring, the Executive Director will provide comprehensive training on RASP completion, Pennsylvania Department of Human Services (DHS) regulations, and required completion timeframes as part of the onboarding process for any newly hired Memory Care Coordinator.

In addition, the newly hired Director of Nursing and Assistant Director of Nursing received training from the Corporate Clinical Trainer on July 8, 2026, regarding RASP completion requirements, applicable DHS regulations, and required completion timeframes. The Director of Nursing and Assistant Director of Nursing will provide ongoing oversight of the RASP process to ensure compliance.

Ongoing: Beginning August 3, 2026, the Executive Director, Director of Nursing, and/or Assistant Director of Nursing will conduct weekly audits of resident records x 4 weeks then monthly x 3 months to ensure compliance. Audit results will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting, beginning August 11, 2026, to monitor ongoing compliance, identify trends, and ensure sustained adherence to DHS regulations.

Licensee's Proposed Overall Completion Date: 07/27/2026

Implemented () - 10/21/2026)