pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **DOUGLASSVILLE AID II OPCO LLC**
LEGAL ENTITY

To operate **AMITY PLACE**
NAME OF FACILITY OR AGENCY

Located at **139 OLD SWEDE ROAD, DOUGLASSVILLE, PA 19518**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **100**
(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 **August 27, 2026** until **August 27, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226560**

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: August 31, 2026

[redacted]
Douglassville AID II OPCO LLC
[redacted]

RE: Amity Place
139 Old Swede Road
Douglassville, Pennsylvania 19518
License #226560

Dear [redacted],:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on June 23, 2026, 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

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

August 27, 2026

[redacted]
DOUGLASSVILLE AID II OPCO LLC
[redacted]

RE: AMITY PLACE
139 OLD SWEDE ROAD
DOUGLASSVILLE, PA, 19518
LICENSE/COC#: 22656

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/23/2026 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: *AMITY PLACE* **License #**: *22656* **License Expiration**: *08/27/2026*

Address: *139 OLD SWEDE ROAD, DOUGLASSVILLE, PA 19518*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *DOUGLASSVILLE AID II OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/19/2009* **Issued By**: *Amity Township*

Staffing Hours

Resident Support Staff: *49* **Total Daily Staff**: *123* **Waking Staff**: *92*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *06/23/2026*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *47*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

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

Inspections / Reviews

06/23/2026 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/18/2026*

07/20/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/30/2026*

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

Inspections / Reviews *(continued)*

07/23/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/30/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/30/2026*

08/27/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/30/2026*

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

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff person A was hired on [redacted]/26. They began unsupervised direct care on [redacted]/26. Staff person A does not have a U.S. high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept[redacted] - 07/23/2026)***

*• Immediate Resolution: on June 23, 2026 the personnel file of the identified employee was immediately reviewed. Verification of the employee's qualifications was obtained and placed in the personnel file. If documentation could not be obtained immediately, the employee was removed from direct care duties until compliance was achieved or an approved waiver was obtained from the Department. Waiver was sent out to families as well DHS. * Request for waiver was sent July 13, 2026, letter to families was created on the same date and sent out. Employee A has high school diploma outside of the USA. Staff A will not work direct care until waiver approved.*
• Training Plan: June 29, 2026 - training of Review of PA DHS 2600 regulation regarding direct care staff qualifications. Have all department mangers in the hiring process
• Monitoring & Audit Plan: The Administrator or Business Office Manager will audit all newly hired direct care employee files prior to orientation completion. Monthly personnel file audits will be conducted for three months and quarterly thereafter. Any deficiencies identified during audits will be corrected immediately and reviewed with Human Resources.
• Sustainability Plan: Effective June 29, 2026 All newly hired managers involved in the hiring process will receive this training during orientation. Any deficiencies identified during audits will be corrected immediately, and retraining will be provided as needed.

Proposed Overall Completion Date: 08/03/2026

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented[redacted] - 08/03/2026)

82c - Locking Poisonous Materials

2. 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

At 10:05a.m., a bottle of spectrum clinical antibacterial soap was in the resident laundry room. The laundry room does not lock, and resident #1 is not assessed to safely avoid poisons.

Plan of Correction ***Accept[redacted] - 07/20/2026)***

• Immediate Resolution: immediately upon discovery, all poisonous and hazardous materials, including cleaning supplies, chemicals, and maintenance products, were removed from resident-accessible areas and secured in locked

82c - Locking Poisonous Materials (continued)

storage cabinets and/or closets. The area was inspected to ensure no hazardous materials remained accessible to residents, including resident laundry room.

• Training Plan: Staff receive education on June 29, 2026 identifying poisonous or hazardous materials, proper storage requirements, and reporting unsecured materials immediately. New employee orientation will include instruction on the facility's hazardous material storage policy.

• Monitoring & Audit Plan: Weekly environmental rounds will be conducted by the Administrator or designee for four (4) weeks, then monthly thereafter for three (3) months. Findings will be documented and reviewed during management meetings. Any identified concerns will be corrected immediately and additional staff education will be provided as needed.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented ([redacted] - 08/03/2026)

96a - First Aid Kit

3. 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

At approximately 1:00 p.m., the first aid kit stored in the medication room did not include adhesive bandages.

Plan of Correction ***Accept [redacted] - 07/20/2026)***

• Immediate Resolution: Immediately upon discovery of the deficiency, adhesive bandages were added to the medication room first aid kit, restoring the kit to full compliance with the requirements

• Training Plan: On June 29, 2026 the Administrator provide training to medication technicians, and department managers responsible for emergency preparedness and first aid supplies on the requirements of Training will include: Required contents of every first aid kit according to PA DHS regulations. Proper inspection of first aid kits for completeness and expired supplies. Procedures for immediately replacing missing or used items. Documentation of monthly first aid kit inspections.

• Monitoring & Audit Plan: On Juney 29 , 2026 first aid kits throughout the community were inspected to verify that each contains all required items as outlined in the regulation. Any missing supplies were replenished immediately.

• Sustainability Plan: The Resident Wellness Director or Administrator will complete and document monthly inspections of every first aid kit using a standardized checklist. All first aid kits will be included in routine environmental and safety rounds. Missing, damaged, or expired supplies will be replaced the same day they are identified. Quarterly quality assurance audits will be conducted by the Administrator to verify continued compliance with DHS regulations and identify opportunities for improvement.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented [redacted] - 08/03/2026)

132d - Evacuation

4. Requirements

2600.

132d - Evacuation *(continued)*

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill conducted on 6/22/26 at 4:50 a.m., resident # 2 was not evacuated to a fire safe area. During a resident interview with resident # 2 on 6/23/26, the resident stated that they were told by staff to stay in bed when the fire alarm sounded on 6/22/26. Resident # 2 requires a Hoyer lift and assistance from two staff persons for all transfers.

Plan of Correction ***Accept [redacted] - 07/20/2026)***

• Immediate Resolution: Upon identification of the deficiency, the Administrator immediately reviewed the community's emergency evacuation procedures and confirmed all exits and evacuation routes were unobstructed and accessible. A complete fire drill was conducted with residents and staff to assess current evacuation performance and identify opportunities for improvement.

• Training Plan: On June 26, 2026 employees received mandatory retraining on: Emergency preparedness procedures. Fire evacuation responsibilities by position. Resident evacuation techniques, including assisting residents with mobility or cognitive impairments. Location and use of evacuation equipment. Fire-safe area designation and evacuation routes. Documentation requirements for fire drills.

• Monitoring & Audit Plan: The Administrator and or Maintenance Director will monitor all monthly fire drills to ensure evacuation procedures are followed and evacuation times are documented. Drill documentation will be reviewed after each drill to verify compliance with the evacuation time established by the independent fire safety expert. Quarterly audits will be completed to ensure: Annual fire safety expert documentation remains current. Fire-safe area designation is maintained. Staff training requirements are current. Resident evacuation assistance plans remain accurate. Findings will be reviewed during Quality Assurance/Performance Improvement (QAPI) meetings, and corrective action will be implemented immediately if deficiencies are identified.

• Sustainability Plan: Annual evaluations by an independent fire safety expert will be scheduled prior to expiration of the previous assessment. Emergency preparedness policies will be reviewed annually and revised as regulations or operational needs change. Fire drills will continue to be conducted on all shifts in accordance with PA DHS regulations, with results trended for continuous improvement. Emergency preparedness and evacuation compliance will remain a standing agenda item during leadership meetings and QAPI reviews. The Administrator will maintain oversight of all fire safety documentation to ensure continuous compliance with PA DHS Chapter 2600 requirements.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented [redacted] 08/03/2026)

183b - Meds and Syringes Locked

5. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 2:30p.m., Resident #3 had clobetasol, Cetaphil, protect barrier cream, and triamcinolone acetonide cream in their bathroom. The medications were unlocked, unattended, and accessible.

183b - Meds and Syringes Locked *(continued)*

Plan of Correction ***Accept [redacted] - 07/20/2026)***

• Immediate Resolution: Immediately upon identification of the deficiency, all medications located in Resident #3's bathroom were removed and secured in the resident's locked medication storage area. Staff verified that no medications remained unsecured in the resident's apartment. Resident does have an order to

• Training Plan: On June 29, 2026 The Administrator has re-educated all medication technicians, caregivers, and nursing staff on the requirements of emphasizing that all prescription medications, over-the-counter medications, creams, topical medications, CAM, and syringes must be stored in a locked location at all times, including when kept in a resident's room. Staff were instructed that medications may never be left unattended or unsecured.

• Monitoring & Audit Plan: The Resident Wellness Director (or designee Administrator) will conduct and document weekly audits of resident medication storage for four (4) consecutive weeks.0 Administrator, and corrective action will be implemented immediately if any unsecured medications are identified.

• Sustainability Plan: Medication storage expectations will be reviewed during new employee orientation, annual mandatory training, and whenever medication management policies are updated. Staff competency observations will include verification of proper medication security practices. Any staff member found leaving medications unsecured will receive immediate coaching, retraining, and corrective action in accordance with the community's progressive disciplinary policy.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented [redacted] - 08/03/2026)

183e - Storing Medications

6. 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

At 2:30p.m. Resident #4 and resident #5 Lispro pens were being stored in the medication cart, prior to being opened. According to the manufacturer's instructions the pens are to be stored under refrigeration until they are opened.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

• Immediate Resolution: Immediately upon identification of the deficiency, the unopened Lispro insulin pens for Resident #4 and Resident #5 were removed from the medication cart. The medication refrigerator temperature was verified to be within the acceptable range.

• Training Plan: On July 1, 2026 Medication Technicians, Licensed Nurses, and staff responsible for medication administration will receive re-education on medication storage requirements, including: Following manufacturer storage instructions for all medications. Proper storage of refrigerated medications before and after opening. Daily monitoring of medication storage areas. Documentation of refrigerator temperatures according to facility policy.

• Monitoring & Audit Plan: To prevent recurrence, the Resident Wellness Director or Administrator, designee will: Complete weekly medication storage audits for four (4) consecutive weeks. Complete monthly medication storage audits thereafter for three (3) months. Review audit findings with medication staff immediately and provide additional education or corrective action when indicated.

• Sustainability Plan: The Resident Wellness Director or designee will maintain a current list of medications that require refrigeration and post it in the medication room as a reference for medication administration staff. Any

183e - Storing Medications (continued)

temperature variances will be reported immediately and addressed according to policy. The Resident Wellness Director or designee will conduct monthly medication storage audits to verify that all medications are stored according to manufacturer recommendations. Audit results will be reviewed with the Administrator during the Quality Assurance and Performance Improvement (QAPI) meetings

Proposed Overall Completion Date: 08/03/2026

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented [redacted] - 08/03/2026)

185a - Implement Storage Procedures

7. 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

At approximately 2:00 p.m., resident #6's PRN medications Nystatin 100,00 U/GM Powder and Saline Mist 0.65 % nose spray were not available in the home.

Plan of Correction ***Accept [redacted] - 07/23/2026)***

• Immediate Resolution: the medication discrepancy involving Resident #6's PRN medications (Nystatin 100,000 U/GM Powder and Saline Mist 0.65% Nasal Spray) was immediately investigated. Resident had an order to have PRN meds in apartment. The resident was assessed, and there were no adverse outcomes resulting from the temporary unavailability of the medications.
*** On July 24, 2026 Resident Care Coordinator confirmed resident had an order from the doctor resident can have medications in the room. RCC confirmed resident had all orders for PRN meds available and were valid. Paperwork (order) was in resident chart confirmed. BH **
• Training Plan: On July 1 2026 The Administrator will st complete the education with all current medication staff within 30 days of the Plan of Correction. Newly hired Medication Technicians and medication staff will receive this training during orientation and prior to independently administering medications.
• Monitoring & Audit Plan: The Resident Wellness Director (or Administrator) will conduct a weekly audit of all medication carts and medication storage areas for 90 days to verify that prescribed routine and PRN medications are present, properly stored, and available for administration. Any discrepancies identified will be corrected immediately, documented, and staff will receive additional education as indicated.
• Sustainability Plan: To ensure ongoing compliance, the community will implement the following quality assurance measures: Medication Technicians will verify the availability of all routine and PRN medications during each medication cart check and report any low supplies immediately. Medication refill requests will be submitted before a medication reaches a critically low supply to prevent interruptions in availability. The Resident Wellness Director or designee will complete weekly medication inventory audits for 90 days to verify that all prescribed medications are present and available.. Any identified deficiencies will be corrected immediately, with follow-up staff education and competency reviews as needed. After demonstrating sustained compliance for 90 days, medication availability audits will transition to monthly monitoring as part of the community's ongoing quality assurance program.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented [redacted] - 08/03/2026)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #3 is prescribed D-Mannrose w/ cran 500mg orally twice a day. However, resident #3 was administered 1300MG in error twice a day from 6/1/26 through 6/23/26.

Plan of Correction ***Accept [redacted] - 07/20/2026)***

Immediate Resolution: Upon discovery of the medication error, the prescribing provider was notified immediately for clinical guidance. The medication was corrected to match the physician's order of D-Mannose with Cranberry 500 mg by mouth twice daily. The resident's responsible party was notified of the medication error and the corrective actions taken.

• Training Plan: on July 1, 2026 Medication technicians and licensed nursing staff received re-education on: Following physician orders exactly as written. Accurate transcription of medication orders to the MAR. Verification of medication strength prior to administration. Prompt reporting of medication discrepancies and medication errors. The facility's medication administration policy was reviewed with all medication administration staff.

• Monitoring & Audit Plan: The Resident Wellness Director or designee will conduct weekly audits of physician orders compared to the MAR for four (4) weeks, followed by monthly audits for two (2) additional months. Any discrepancies identified will be corrected immediately, staff will receive coaching or corrective action as appropriate, and findings will be reviewed during the facility's Quality Assurance/Performance Improvement (QAPI) meetings.

• Sustainability Plan: Through routine auditing, staff education, leadership oversight, and continuous quality improvement, Amity Place will maintain compliance with physician orders, reduce medication administration errors, and promote the health, safety, and well-being of all residents.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented ([redacted] - 08/03/2026)

224a - Preadmission Screen Form

9. 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 #7 was admitted to the home on [redacted]/26, but a preadmission screening form was not completed.

Plan of Correction ***Accept ([redacted] 07/20/2026)***

• Immediate Resolution: on June 23, 2026 comprehensive review of Resident #7's admission records was completed. The required DHS Preadmission Screening Form was completed to document that the resident's needs are appropriate for the services provided by the community. The resident's record has been updated to ensure all required admission documentation is complete.

• Training Plan: on July 1, 2026 the Administrator and all staff responsible for admissions, assessments, and resident record management will receive retraining on the requirements, Preadmission Screening Form within 30 days prior to admission. Training will emphasize the importance of ensuring all required documentation is completed before

224a - Preadmission Screen Form (continued)

a resident is accepted into the community.

• Monitoring & Audit Plan: The Administrator or designee will audit 100% of all new admissions for compliance with preadmission screening requirements for the next 90 days.

• Sustainability Plan: The DHS Preadmission Screening Form will remain a mandatory component of every admission packet and must be completed within 30 days prior to admission. An Admission Checklist will be used for every new resident. The Administrator or designee will verify that all required admission documents, including the DHS Preadmission Screening Form, are complete before approving a resident's move-in.

Licensee's Proposed Overall Completion Date: *08/03/2026*

Implemented [redacted] - 08/03/2026)