pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **NHI OPCO READING PA, LLC**
LEGAL ENTITY

To operate **LAUREL POINTE SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **2900 LAWN TERRACE, READING, PA 19065**
(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 **104**
(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 **February 6, 2026** until **August 6, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **233321**

ISSUING OFFICER

ACTING 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 628P – 04/23

Pennsylvania
Department of Human Services

Certified Mailing Date: February 6, 2026

[redacted]
[redacted]
NHI OpCo Reading PA, LLC
[redacted]
[redacted]

RE: Laurel Pointe Senior Living
2900 Lawn Terrace
Reading, Pennsylvania 190650
License #: 233321

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on December 11, 2025 of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because this is a new legal entity operating the home.

In accordance with 55 Pa. Code § 2600.11(b) (relating to procedural requirements for licensure or approval of personal care homes) a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

During the inspection, citations on the enclosed Licensing Inspection Summary were found. All citations specified on the Licensing Inspection Summary must be corrected by the dates specified on the Licensing Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Your PROVISIONAL license is enclosed, based on substantial but not complete compliance with 55 Pa.Code Ch. 2600.

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

Facility Information

Name: *Laurel Pointe Senior Living* **License #:** *233320* **License Expiration:**

Address: *2900 Lawn Terrace, Reading , PA 19065*

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

Administrator

Name: [redacted]

Legal Entity

Name: *NHI OpCo Reading PA LLC*

Addres [redacted]

Phone:

Certificate(s) of Occupancy

Type: *I-2* **Date:** *09/17/2014* **Issued By:** *Muhlenberg Township*

Staffing Hours

Resident Support Staff: *17* **Total Daily Staff:** *99* **Waking Staff:** *74*

Inspection Information

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

Reason: *Change Legal Entity* **Exit Conference Date:** *12/11/2025*

Inspection Dates and Department Representative

12/11/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *67*

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

Have Mobility Need: *15* **Have Physical Disability:** *0*

Inspections / Reviews

12/11/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/15/2026*

Inspections / Reviews *(continued)*

01/20/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/29/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/27/2026*

02/02/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/29/2026*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

65d - Initial Direct Care Training

1. 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.

Description of Violation

Direct care staff person A hired on [redacted] began providing unsupervised ADL services on 6/07/25. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept [redacted] - 01/20/2026)***

- *During the inspection on 12/11/25, documentation verifying successful completion of the Department-approved direct care training course and competency test for Direct Care Staff Person A was not immediately available.*
- *Upon further review, the Business Office Manager located the certificate, confirming that the staff person successfully completed and passed the competency test on 5/31/25, prior to providing unsupervised ADL services on 6/07/25. The certificate has since been placed in the staff member's personnel file.*
- *Business Office Manager conducted a review on 12/15/25, of all current direct care staff personnel files, to ensure documentation of completion of the DHS approved direct care training course and competency test is present and readily accessible.*
- *Business Office Manager implemented a personnel file checklist on 12/15/25 verifying all DHS approved training and competency certificates are obtained, verified and filed prior to clearing staff for unsupervised ADL services.*
- *Executive Director will audit newly hired personnel files quarterly to ensure compliance.*
- *Executive Director will report the personnel file audit to the Continuous Quality Control Improvement Committee quarterly beginning March 2026.*

Licensee's Proposed Overall Completion Date: *01/19/2026*

Implemented [redacted] - 01/30/2026)

85d - Trash Receptacles

2. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11:30 a.m., the kitchen trash can did not have a lid. Kitchen staff indicated that the trash can does not have a lid.

85d - Trash Receptacles *(continued)*

Plan of Correction ***Accept [redacted] - 01/20/2026)***

- *Upon identification of the deficiency on 12/11/25, the trash can was immediately removed from use and disposed of.*
- *Kitchen staff were instructed at the time of observation on 12/11/25, by the community food service specialist regarding the requirement that trash containers in food preparation areas remain covered.*
- *Executive Director reviewed sanitation and infection control policies with the dining staff on 12/23/25 including*
  - *Requirement that all trash receptacles in food preparation and service areas have tight-fitting lids*
  - *Proper waste handling and disposal*
- *Executive Director ensured that appropriate covered trash receptacles are available on 12/12/25*
- *Interim Dining Director/Designee will complete the following:*
  - *Daily kitchen sanitation checks for 14 days beginning 12/15/25*
  - *Weekly sanitation checks for 30 days beginning 12/29/25*
  - *Monthly sanitation checks ongoing beginning 1/26/26*
- *Executive Director will check the kitchen sanitation periodically beginning 12/15/25 to ensure compliance.*
- *Executive Director will report the findings of the kitchen sanitation findings to the Continuous Quality Control Improvement Committee monthly beginning January 2026.*

Licensee's Proposed Overall Completion Date: *01/26/2026*

Not Implemented [redacted] - 02/02/2026)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident's 1 and 3 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 01/20/2026)***

- *Upon identification of the deficiency 12/11/25, Director of Maintenance immediately provided bedside lighting was for Residents 1 and 3.*
- *Director of Maintenance placed the lights placed within reach of the residents and verified to be operational with an accessible on/off control on 12/11/25.*
- *Executive Director reviewed and reinforced environmental safety requirements with maintenance and nursing staff on 1/20/26, including:*
  - *Requirement that each resident has access to a functional bedside light with an accessible on/off control*

101j7 - Lighting/Operable Lamp (continued)

- *Verification of bedside lighting during room setup and after room changes*

- *Director of Maintenance will complete the following:*
  - *Room safety checks for all resident rooms by 1/26/26*
  - *Weekly room safety checks for all resident rooms for 30 days beginning 2/2/26*
  - *Monthly room safety checks for all resident rooms.*
- *Executive Director will conduct monthly random resident room safety checks beginning 2/2/26*
- *Executive Director will report the findings of the resident room safety checks to the Continuous Quality Control Improvement Committee monthly beginning February 2026.*

Licensee's Proposed Overall Completion Date: *02/02/2026*

Not Implemented [redacted] 02/02/2026)

103g - Storing Food

4. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 11:38 a.m., the Walkin freezer contained a plastic bag of frozen flatbreads that were not sealed.

Plan of Correction ***Accept [redacted] 01/20/2026)***

- *Upon identification of the deficiency on 12/15/25, of the unsealed bag of frozen flatbreads the community food service specialist immediately removed from the freezer and properly sealed.*
- *Dining staff was instructed at the time of observation on 12/15/25, by the community food service specialist regarding proper food storage and sealing requirements.*
- *Executive Director reviewed and reinforced food safety and storage procedures with dining staff on 12/23/25 including:*
  - *Requirement that all food items in freezers and refrigerators be stored in sealed, covered, or otherwise protected containers*
  - *Proper labeling and storage practices to prevent contamination*
- *Interim Dining Director ensured appropriate food storage supplies are available in the dietary department on 12/15/25.*
- *Interim Dining Director/Designee will conduct the following:*
  - *Daily freezer and refrigerator checks for 14 days beginning 12/15/25*
  - *Weekly freezer and refrigerator checks for 30 days on 12/29/25*
  - *Monthly freezer and refrigerator checks beginning 1/26/26*
- *Executive Director will check the freezer and refrigerator monthly beginning 12/15/25 to ensure compliance.*
- *Executive Director will report the findings of the freezer and refrigerator findings to the Continuous Quality Control Improvement Committee monthly beginning January 2026.*

103g - Storing Food (continued)

Licensee's Proposed Overall Completion Date: *01/26/2026*

Not Implemented [redacted] 02/02/2026)

103i - Outdated Food

5. Requirements

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

Description of Violation

At 11:35 a.m., a 6x6 inch plastic container contained what appeared to be chopped carrots that had a "use by" sticker that noted 11/23.

Plan of Correction ***Accept [redacted] - 01/20/2026)***

- *Upon identification of the deficiency on 12/11/25, the community food service specialist discarded the dated food item immediately.*
- *Dining staff was instructed by the community food service specialist, at the time of observation regarding proper food dating, use-by requirements, and disposal of expired food items.*
- *Executive Director reviewed and reinforced food labeling, dating, and storage policies with dietary staff on 12/23/25, including:*
  - *Requirement that all prepared and opened foods be clearly labeled with preparation and discard dates*
  - *Requirement that expired or out-of-date food items be discarded immediately*
- *Interim Dining Director/Designee will conduct the following:*
  - *Daily freezer and refrigerator checks for 14 days beginning 12/15/25*
  - *Weekly freezer and refrigerator checks for 30 days on 12/29/25*
  - *Monthly freezer and refrigerator checks beginning 1/26/26*
- *Executive Director will check the freezer and refrigerator monthly beginning 12/15/25 to ensure compliance.*
- *Executive Director will report the findings of the freezer and refrigerator findings to the Continuous Quality Control Improvement Committee monthly beginning January 2026.*

Licensee's Proposed Overall Completion Date: *01/26/2026*

Not Implemented [redacted] 02/02/2026)

105g - Lint Removal and Duct Cleaning

6. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At 10:30a.m., there was an approximate 1/2-inch accumulation of lint in the lint trap of the dryer in the second-floor

105g - Lint Removal and Duct Cleaning (continued)

laundry room. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] 01/20/2026)***

- *Upon identification of the deficiency on 12/11/25, the lint trap was immediately cleaned and cleared of all lint by the Director of Maintenance.*
- *Director of Maintenance instructed the nursing staff and the housekeeping staff at the time of observation on 12/11/25 regarding proper lint trap maintenance and fire safety requirements.*
- *Executive Director reviewed and reinforced laundry and fire safety procedures with housekeeping on 12/15/26 and care staff on 1/20/26, including:*
  - *Requirement that lint traps be cleaned before and after each dryer use*
  - *Requirement that dryers remain free of lint accumulation at all times.*
- *Director of Maintenance ensured lint trap cleaning is included in routine housekeeping procedures on 12/15/25.*
- *Housekeeping Supervisor/Designee will:*
  - *Conduct daily checks of dryer lint traps for 14 days beginning 12/15/25*
  - *Conduct weekly audits thereafter beginning 12/29/25*
- *Executive Director will check the dryer lint traps monthly beginning 12/15/25 to ensure compliance.*
- *Executive Director will report the findings of the freezer and refrigerator findings to the Continuous Quality Control Improvement Committee monthly beginning January 2026.*

Licensee's Proposed Overall Completion Date: *01/26/2026*

Not Implemented [redacted] 02/02/2026)

141b1 - Annual Medical Evaluation

7. Requirements

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

Description of Violation

Resident 3's most recent medical evaluation, dated [redacted]/25, indicates the residents' needs can be met safely at the Personal Care Home and the resident is nursing facility clinically eligible (NFCE) and the residents' needs cannot be met safely at the Personal Care Home.
Resident # 4 's most recent medical evaluation was completed on [redacted]25. The resident's previous medical evaluation was completed on [redacted]/24.

Plan of Correction ***Accept ([redacted] 01/20/2026)***

141b1 - Annual Medical Evaluation (continued)

- *Upon identification of the deficiency on 12/11/25, Resident #3's medical evaluation was reviewed, and clarification was requested from the medical provider to resolve the conflicting determinations regarding NFCE status and appropriateness for placement.*
- *Executive Director/Designee will review resident's medical evaluation forms when completed by physician to ensure completion and accuracy.*
- *Prior management failed to ensure resident medical evaluations were completed annually.*
- *Resident #4's medical evaluation was reviewed and completed by the physician on 10/14/25 to ensure the current evaluation is on file and accurately reflects the resident's current condition and service needs.*
- *Executive Director completed an audit on all resident's medical evaluations on 11/28/25 and obtained medical evaluations for any resident that was not in compliance.*
- *Executive Director implemented a tracking form on 11/28/25 to monitor resident's due dates for annual medical evaluations.*
- *Executive Director/Designee will continue to track due dates, utilizing tracking form for annual medical evaluations and schedule evaluations with physicians to ensure compliance.*
- *Executive Director will review resident's medical evaluations quarterly.*
- *Executive Director will report the findings of the medical evaluation reviews to the Continuous Quality Control Improvement Committee monthly beginning February 2026.*

Licensee's Proposed Overall Completion Date: *01/19/2026*

Implemented ([redacted] - 01/30/2026)

185a - Implement Storage Procedures

8. 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 2's Lorazepam Tab 0.5 mg medication card number 30 was opened and had tape on the back of the card holding the medication in place.

Plan of Correction ***Accept ([redacted] 01/20/2026)***

- *Upon identification of the deficiency, the Director of Nursing immediately removed the altered medication card from use and sent back to the pharmacy on 12/11/25.*
- *Director of Nursing obtained a replacement medication card from the pharmacy on 12/12/25 and verified the and reconciled per community procedure.*
- *Director of Nursing instructed the med techs assigned at the time of the inspection on 12/11/25 regarding proper medication handling and the prohibition of altering medication packaging.*

185a - Implement Storage Procedures (continued)

- *Executive Director reviewed medication management policies with medication technicians on 1/20/26 including:*
  - *Requirement that medications, including controlled substances, remain in original, unaltered packaging*
  - *Prohibition of taping, altering, or otherwise modifying medication cards*
  - *Requirement to notify pharmacy and nursing leadership immediately if medication packaging is damaged or compromised*
- *Lead med tech will complete the following:*
  - *Conduct random medication cart and controlled substance audits weekly for 30 days beginning 1/19/26*
  - *Conduct monthly audits beginning 2/16/26*
- *Executive Director will complete audits on random medications and controlled substances 1/26/26 to ensure compliance.*
- *Executive Director will report the findings of the medication and controlled substance audits to the Continuous Quality Control Improvement Committee monthly beginning February 2026.*

Licensee's Proposed Overall Completion Date: *02/16/2026*

Not Implemented [redacted] 02/02/2026)

225c - Additional Assessment

9. Requirements

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

Description of Violation

Resident 3's assessment, dated [redacted]25, was not updated to include that the resident was admitted to hospice on [redacted]/25.

Plan of Correction ***Accept [redacted] 01/20/2026)***

- *Prior management failed to ensure resident assessments were updated to reflect significant changes in condition and services.*
- *Upon identification of the deficiency, the Executive Director completed a new assessment and support plan for Resident #3 on [redacted]5 to reflect hospice admission and current care needs.*
- *Executive Director completed and audit in 12/30/25 on all hospice resident's assessment and support plans ensuring significant changes in condition, services, or care needs, including hospice admission.*
- *Executive Director/Designee will conduct the following:*
  - *Conduct monthly audits of assessments and care plans for 60 days beginning 1/26*
  - *Continue quarterly audits thereafter*
- *Executive Director will report the findings of the audits on the assessments and support plans to Continuous Quality Control Improvement Committee monthly beginning February 2026.*

225c - Additional Assessment (continued)

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] 02/02/2026)

227d - Support Plan Medical/Dental

10. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident 1's Assessment and Support Plan dated [redacted]/25 does mention the enabler bar device but does not include the specific need for the device, the intended use and any risks associated with such use, the resident's ability to use the device safely for its intended purpose, and an Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept [redacted] - 01/20/2026)***

- *Upon identification of the deficiency on 12/11/25, Executive Director reviewed and updated Resident #1's Assessment and Support Plan to include:*
  - *Specific need for the enabler bar device*
  - *Intended use of the device and associated risks*
  - *Resident's ability to use the device safely for its intended purpose*
  - *Protective cover is required to meet FDA guidelines*
- *Executive Director conducted an audit on 12/12/25 reviewing assessments and support plans on all resident's that utilize a bed mobility device.*
- *Director of Nursing/Designee will review assessments and support plans on all residents that utilize a bed mobility device monthly beginning 1/2026.*
- *Executive Director will review assessments and support plans on all residents that utilize a bed mobility device quarterly beginning 3/2026.*
- *Executive Director will report the findings of the audits on the assessments and support plans on all residents that utilize a bed mobility device to Continuous Quality Control Improvement Committee monthly beginning February 2026.*

Licensee's Proposed Overall Completion Date: *01/19/2026*

Implemented [redacted] - 01/30/2026)