

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

October 15, 2025

[REDACTED]
AB DRESHER OPERATOR LLC
[REDACTED]

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

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/11/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: DRESHER ESTATES **License #:** 14424 **License Expiration:** 07/02/2026
Address: 1405 NORTH LIMEKILN PIKE, DRESHER, PA 19025
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: AB DRESHER OPERATOR LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 86 **Waking Staff:** 65

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 09/11/2025

Inspection Dates and Department Representative

09/11/2025 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
License Capacity: 112 **Residents Served:** 60
Secured Dementia Care Unit
In Home: Yes **Area:** Along the Journey **Capacity:** 25 **Residents Served:** 15
Hospice
Current Residents: 11
Number of Residents Who:
Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 60
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 26 **Have Physical Disability:** 0

Inspections / Reviews

09/11/2025 Partial
Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/29/2025

09/29/2025 - POC Submission
Submitted By: [REDACTED] **Date Submitted:** 10/14/2025
Reviewer: [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 10/15/2025

Inspections / Reviews *(continued)*

10/15/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/14/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] Resident # [redacted] was yelling and screaming stating that a staff member had attacked them. The home did not submit an incident report to the Department.

Plan of Correction

Accept [redacted] 09/29/2025)

Action: Documentation in chart on 8/9/25 revealed resident [redacted] made statement of allegedly being harmed. On 9/18/25, the Reportable Incident was submitted for resident [redacted]. The 24 hour report was reread for 8/1/25 - 9/22/25 to ensure no other documentation was present to warrant a report to the Department.

Training: On 9/23/25, The Executive Director and Director of Nursing were re-inserviced on regulation 2600.16C incident reporting to the regional office. All staff training will be completed by 9/29/25. Training record documentation will be kept in accordance with regulation 2600.65i.

Ongoing: Effective 9/29/25, Director of Nursing or Executive Director will review 24 hour report on a daily basis x 30 days, then weekly review of 24 hour report x 3 months to ensure documentation in chart does not warrant a reportable incident to the regional office. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning October 16, 2025 by the Executive Director. Starting 9/29/25, Executive Director will monitor completion of 24 hour report review.

Licensee's Proposed Overall Completion Date: 10/08/2025

Implemented [redacted] - 10/15/2025)

103e - Left Overs

2. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated, uncovered bowl of sherbert ice cream in the memory care kitchenette fridge on [redacted] at 9:34 A.M.

Plan of Correction

Accept [redacted] 09/29/2025)

Action: During rounds on 9/11/25, there was a bowl of uncovered sherbet left in the memory care refrigerator by a staff member. On 9/11/25, Executive Director removed the uncovered bowl of sherbert from the memory care refrigerator and was discarded. Executive Director checked the memory care refrigerator the same day after lunch and after dinner, no issues were noted.

Training: Staff will be educated by 9/26/25 by the Executive Director or Department Manager on regulation 2600.103e as it relates to ensuring that leftover food must be kept covered, labeled and dated. Training record documentation will be kept in accordance with regulation 2600.65i.

Ongoing: Effective 9/29/25, the Memory Care Director, Director of Nursing or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure there is no leftover food unlabeled or not dated in the memory care refrigerator. Documentation of findings will be kept and reviewed at monthly Quality Assurance

103e Left Overs (continued)

meeting beginning October 16, 2025, by the Executive Director. Starting 9/29/25, the Executive Director will monitor completion of rounds in regards to left over food not being covered nor labeled/dated.

Licensee's Proposed Overall Completion Date: 10/08/2025

Implemented [redacted] - 10/15/2025)

227h - Support Plan Refuse Sign

3. Requirements

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident [redacted] was unable to participate in the development of [redacted] support plan on [redacted]. The resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability to sign.

Plan of Correction

Accept [redacted] - 09/29/2025)

Action: Resident admission support plans had no audit system in place, upon review of Resident [redacted] file it was identified there was no signature nor notation made of inability to sign. Upon Resident's [redacted] upcoming support plan review in December, notation will be made on support plan in regards to resident's inability to sign, if indicated. The Executive Director will review support plans for those residing in the memory care unit to ensure inability to sign notation is in place if indicated.

Training: On 9/23/25, The Executive Director and Director of Nursing were inserviced on regulation 2600.227h, in regards to documenting resident's inability to sign on the support plan by the Regional Director of Operations.

Training records will be kept in accordance with regulation 2600.65i.

Ongoing: Effective 9/29/25, Director of Nursing or Executive Director will review completion of new support plans for those residing in the memory care unit daily x 30 days, then weekly x 3 months, to ensure inability to sign is noted on the support plan where indicated. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning October 16, 2025, by the Executive Director. Starting 9/29/25, the Executive Director will monitor completion of verbiage of resident's inability to sign document when/where applicable. Documentation to be kept.?

Licensee's Proposed Overall Completion Date: 10/08/2025

Implemented [redacted] - 10/15/2025)

234a - Admission Support Plan

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

Plan of Correction

Accept [redacted] - 09/29/2025)

Action: There was no tracking system in place to check the admission support plans completion and due dates. On 9/11/25, during the inspection, it was found that Resident [redacted] did not have the support plan completed in the

234a Admission Support Plan (continued)

required time frame after admission to the Secured Dementia Care Unit. On 7/18/25, the Director of Nursing developed and implemented a tickler file system which included review of admission support plans that were audited from 6/26/25 to 7/18/25. The next scheduled review dates of Support Plans are noted on the tickler tracking form.

Training: Director of Nursing and Executive Director were educated on 9/23/25 by the Regional Director of Operations on regulation 2600.234a as it relates to Admission Support Plan being completed within 72 hours of the admission to a Secured Dementia Care Unit. Training records will be kept in accordance with regulation 2600.65i.

Ongoing: Effective 9/29/25, for 3 months, the Director of Nursing and Executive Director will review the Admission Support Plan for new admissions into the Secured Dementia Care Unit to ensure its completion within 72 hours of the admission. Audit documentation will be kept. Starting 9/29/25, the Executive Director will monitor completion of the Support Plans by checking that all new Support Plans are done in accordance with regulation 2600.234a before filing it in the resident's medical record. Audit documentation to be kept. This area will be discussed at the monthly Quality Assurance meetings beginning October 16, 2025, for 3 months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: 10/08/2025

Implemented [REDACTED] - 10/15/2025)