



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to CARE HSL NEWTOWN OPCO LLC

LEGAL ENTITY

To operate THE BIRCHES AT NEWTOWN

NAME OF FACILITY OR AGENCY

Located at 70 DURHAM ROAD, NEWTOWN, PA 18940

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide Personal Care Homes

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 120
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 57

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 September 23, 2026 until September 23, 2027 ,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142300**


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: September 23, 2026

[REDACTED]
[REDACTED]
Care HSL Newtown OPCO LLC
[REDACTED]
[REDACTED]
[REDACTED]

RE: The Birches at Newtown
70 Durham Road
Newtown, Pennsylvania 18940
License #: 142300

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on June 2 and 3, 2026 and August 11, 2026, 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,

A handwritten signature in black ink that reads "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

August 25, 2026

[REDACTED]
CARE HSL NEWTOWN OPCO LLC
[REDACTED]
[REDACTED]

RE: THE BIRCHES AT NEWTOWN
70 DURHAM ROAD
NEWTOWN, PA, 18940
LICENSE/COC#: 14230

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2026, 06/03/2026 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: THE BIRCHES AT NEWTOWN

License #: 14230

License Expiration: 09/25/2026

Address: 70 DURHAM ROAD, NEWTOWN, PA 18940

County: BUCKS

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: CARE HSL NEWTOWN OPCO LLC

Address: [REDACTED]

Certificate(s) of Occupancy

Type: I-2

Date: 06/17/2006

Issued By: Newtown Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 150

Waking Staff: 113

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Provisional

Exit Conference Date: 06/03/2026

Inspection Dates and Department Representative

06/02/2026 - On-Site: [REDACTED]

06/03/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 120

Residents Served: 99

Secured Dementia Care Unit

In Home: Yes

Area: Daybreak

Capacity: 57

Residents Served: 42

Hospice

Current Residents: 12

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 99

Diagnosed with Mental Illness: 1

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 51

Have Physical Disability: 51

Inspections / Reviews

06/02/2026 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 07/12/2026

Inspections / Reviews (*continued*)

07/21/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/07/2026

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 08/07/2026

08/25/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/07/2026

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] 26, at 9:30 am, resident #1 had a fall that resulted in admission to the hospital for Rhabdomyolysis. The home did not report this incident to the Department until 03/12/26.

Repeated Violation - 04/03/2025.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions – The Department Directors were re-educated by the Executive Director on 7/7/2026 on DHS regulation 2600.16.c to ensure that the community shall report incidents or conditions to PA DHS regional office within 24 hours of the incident.

Additional corrective actions – The Executive Director, AED, and or the Resident Care Director will review incidents at the daily clinical huddle daily beginning on 7/13/26 and on an ongoing basis.

Ongoing quality assurance actions- The Ed and or AED will audit 5% sample of all incident reports each month as part of the quality assurance process to ensure all reportable incidents are completed timely, with the first 5% sample being completed by August 31, 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 07/31/2026

Evidence of Completion

Implemented [REDACTED] - 08/25/2026)

See attached.

28f - Resident's Funds and 30-day Refund

2. Requirements

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #2 was discharged on [REDACTED]/2025. The home did not provide the required refund until 04/16/2025.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions – The AED was re-educated by the Executive Director on 7/7/2026 on DHS regulation 2600.25.f to ensure that residents refunds will be reimbursed within 30 days of discharge.

Additional corrective actions – The AED will audit residents accounts who have discharged within the last quarter, by 7/31/2026, to ensure that refunds have been issued within 30-days of discharge. Any account found not to be compliance will have documentation of deficiency added to the resident's record, noting POC 6/2/26.

Ongoing quality assurance actions- The AED will audit 5% sample of discharged residents records each month as part of the quality assurance process to ensure all refunds have been issued, with the first 5% sample being

28f - Resident's Funds and 30-day Refund (continued)

completed by August 31, 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 08/07/2026

Evidence of Completion

See attached.

Implemented [REDACTED] - 08/25/2026)

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 A did not receive training in medication self-administration training during training year 2025.

Repeated Violation - 02/12/2025, et al.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions – Staff member A completed the medication self-administration training on 1/21/2026 for 2026. We are unable to have Staff member A complete the medication self-administration training for the 2025 calendar year as this training period has closed.

Additional corrective actions – the executive director re-educated the AED on 7/7/2026, on DHS regulation 2600.65.f to ensure that all Direct Care employees complete the medication self-administration training and the list of all required annual trainings, as outlined in the annual training plan. All current employee files will be audited by July 31, 2026 by the AED to ensure that all employees have completed the Medication self-administration training and other training topics as required pre reg 2600.65.f.

Ongoing quality assurance actions- The AED will audit 5% sample of all staff records each month as part of the quality assurance process to ensure all required training is complete and recorded, with the first 5% sample being completed by July 31, 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 08/07/2026

65f - Training Topics (continued)

Evidence of Completion

See attached.

Implemented [REDACTED] - 08/25/2026)

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation*On 06/02/26, at 9:55 am, resident #3's bathroom toilet had a brown substance on the toilet seat and inside the bowl.**On 06/02/26, at 10:00 am, the memory care common area bathroom toilet had a brown substance on the side of the bowl.**Repeated Violation - 02/12/2025, et al.***Plan of Correction****Accept** [REDACTED] - 07/21/2026)*Immediate corrective actions – On 6/2/26, prior to the Licensing Representatives departure, the toilets in both resident's #3 bathroom and the common area bathroom in memory care were cleaned.**Additional corrective actions – The Department Directors and the Maintenance team will be re-educated by the Executive Director and the AED by 7/13/2026 on DHS regulation 2600.85a to ensure that sanitary conditions are maintained. The Maintenance Director will audit the community by 7/17/26 to ensure that the community meets sanitary conditions. The Maintenance Director will complete walk through 2x weekly for 4 weeks to ensure that sanitary conditions are maintained. Audits will be completed by 8/7/2026.**The Maintenance Director is responsible for sustained compliance.**Ongoing Quality Assurance Actions –. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026***Licensee's Proposed Overall Completion Date: 08/07/2026****Evidence of Completion**

See attached.

Implemented [REDACTED] - 08/25/2026)

101j7 - Lighting/Operable Lamp

5. 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 #4 does not have access to a source of light that can be turned on/off at bedside.***Plan of Correction****Accept** [REDACTED] - 07/21/2026)*Immediate corrective actions – On 6/2/26, during the inspection, the lamp in residents #4's room was plugged in.**Additional corrective actions – The Department Directors and the Maintenance team will be re-educated by the Executive Director and the AED by 7/13/2026 on DHS regulation 2600.101.j7 to ensure that an operable lamp or other source of lighting can be turned on at resident's bedside. The Maintenance Director will audit the community*

101j7 - Lighting/Operable Lamp (continued)

by 7/13/26 to ensure that the room has an operable lamp or other source of light at the bedside. The Maintenance Director will complete an audit 2x weekly for 4 weeks to ensure that bedside lighting is operable. Audits will be completed by 8/7/2026.

The Maintenance Director is responsible for sustained compliance.

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 08/07/2026

Evidence of Completion

See attached.

Implemented [REDACTED] - 08/25/2026)

103i - Outdated Food**6. Requirements**

2600.

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

Description of Violation

There were 3 packs of unlabeled, undated waffles in the walk-in freezer.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions – On 6/2/26, prior to the Licensing Representative's departure, the waffles were discarded. On 6/12/26, the Dining Director and cooks were in-serviced on DHS reg. 2600.130.i by the executive Director.

Additional corrective actions – The Dining Director was re-educated by the Executive Director on 7/7/2026 on DHS regulation 2600.130.i to ensure that foods are labeled and dated or they may not be used. The Dining Director will audit inventory by 7/13/26 to ensure that all inventory is dated, not spoiled nor cans dented. The Dining Director will complete audits 2x weekly for 4 weeks to ensure that there is no spoiled inventory. Audits will be completed by 8/7/2026.

The Dining Director is responsible for sustained compliance.

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 08/07/2026

Evidence of Completion

See attached.

Implemented [REDACTED] - 08/25/2026)

171b5 - First Aid Kit**7. Requirements**

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

171b5 - First Aid Kit (continued)

Description of Violation

The first aid kit in the van does not include antiseptic. The alcohol wipes in the kit expired on 09/22.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions – On 6/2/26, prior to the Licensing Representative's departure, the alcohol wipes were replaced. On 7/8/2026, antiseptic wipes were added to the first aid kit by the Life Enrichment Director.

Additional corrective actions – All Department Directors will be re-educated by the Executive Director and the AED by 7/13/2026 on DHS regulation 2600.171.b5 to ensure that the vehicle has a first aid kit with the continents as specified in 2600.96. The Resident Life Director and/ or Resident Care Director will audit all first aid kits by 7/13/26 to ensure that they have all continents as specified. The Resident Life Director or Resident Care Director will check first aid kits weekly for 4 weeks to ensure that first aid kits are properly stocked. Audits will be completed by 8/7/2026.

The Resident Care Director is responsible for sustained compliance

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026

Licensee's Proposed Overall Completion Date: 08/07/2026

Evidence of Completion

Implemented [REDACTED] - 08/25/2026)

See attached.

181f - Record of Medication

8. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 06/02/26, resident #5's record did not include a current list of medications. The list in the resident's record did not include Vitamin B12.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate Corrective Actions – on 6/3/26 The Resident Care Director reviewed and compared the residents' current list of prescribed medications to the actual medications that the resident has in her apartment. Resident #5 was educated by the RCD on 6/3/26 that the community must have prescribers' orders for all Cam and OTC for each resident that self-administers medications.

Additional Corrective Actions - The Resident Care Director and Med Techs will be re-educated by 7/15/26 by the Executive Director and the AED on DHS regulations 2600.181.f to ensure that the residents record has a list of prescriptions, OTC medications, and CAM medications for each resident who self-administers their medications. The Resident Care Director will complete a self-med assessment for all self-medicators by 7/24/2026, to ensure that the residents record lists all prescriptions, OTC medications, and CAM medications. The RCD and Wellness Nurse will complete quarterly Self-med assessments to ensure continued compliance beginning September 2026.

RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions –. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 07/24/2026

181f - Record of Medication (*continued*)**Evidence of Completion****Implemented** [REDACTED] - 08/25/2026)*See attached.*

185a - Implement Storage Procedures

9. 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 #6 is prescribed glucose checks 3 times a day with meals at 8:00 am, 12:00 pm, and 5:00 pm. On 05/18/26, at 8:36 am, the glucometer had a reading of 98, and the medication administration record was blank.***Plan of Correction****Accept** [REDACTED] - 07/21/2026)*Immediate Corrective Actions -**The Resident Care Director, AED and Med Techs will be re-educated by 7/15/26 by the Executive Director on DHS regulations 2600.185.a regarding the use of glucometers and documenting the readings according to HSL policy and processes.**Additional Corrective Actions - The RCD will audit all glucometers by 7/16/26 to ensure that all readings and documentation have been completed per prescribers' orders. Then the RCD will audit Glucometers 2 x weekly x 4 weeks to ensure that the Med Tech and nurses are completing blood sugar checks and documenting according to prescribers' orders. Audits will be completed by 8/7/2026.**RCD is responsible for sustained compliance.**Ongoing Quality Assurance Actions – The RCD and Wellness Nurse will review glucometer readings each month to ensure that the readings are being recorded accurately beginning August 1, 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.***Licensee's Proposed Overall Completion Date: 08/07/2026****Evidence of Completion****Implemented** [REDACTED] - 08/25/2026)*See attached.*

187b - Date/Time of Medication Admin.

10. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation*On May 22, 2026, at 9:05 pm, May 26, 2026, at 9:05 pm, May 27, 2026, at 9:05 pm, and May 31, 2026, resident #7 was administered Tramadol 50 mg. The staff signed out the narcotic sheet but failed to initial or record the date and time of administration on the medication administration record.*

187b - Date/Time of Medication Admin. (continued)

On May 31, 2026, at 8:00 am, and May 31, 2026, at 5:02 pm, resident #8 was administered APAP-COD-3 Tablet. The staff signed out the narcotic sheet but failed to initial or record the date and time of administration on the medication administration record.

Repeated Violation - 02/12/2025, et al.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions - The Resident Care Director, AED and Med Techs will be re-educated by 7/15/26 by the Executive Director on DHS regulations 2600.187.b to ensure that the medication administration is documented at the time the medication is given.

Additional Corrective Actions - The RCD will observe each Medication Technicians pass medications one time over the next 4 weeks to ensure that they are following the correct process for documenting medication. Observations will begin 7/13/26. Then the RCD will randomly observe medication administration documentation 2 x weekly x 4 weeks to ensure that the Medication Technicians are recording the administration at the time of occurrence. Audits will be completed by 8/7/2026.

RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions - The RCD and Wellness Nurse will review medication administration documentation monthly, and a daily review of the SMART Dashboard to ensure that the documentation is recorded accurately. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 - July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 08/07/2026

Evidence of Completion

Implemented [REDACTED] - 08/25/2026)

See attached.

187d - Follow Prescriber's Orders**11. Requirements**

2600.

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

Description of Violation

Resident #5 has been prescribed Clotrimazole 1% Cream to be applied as a thin layer topically to the affected area twice daily, in the morning and evening. However, this medication was not administered to resident #5 on the evening of 06/02/26 and the morning of 06/03/26 due to unavailability.

Plan of Correction

Accept [REDACTED] 07/21/2026)

Immediate corrective actions - On 6/3/26, the medication was ordered from the pharmacy prior to the Licensing Representative's departure. The Resident Care Director, AED and Med Techs will be re-educated by 7/15/26 by the Executive Director on DHS regulations 2600.187.d to ensure that the resident's medications are available and ensure that the home is following the prescriber's orders.

Additional Corrective Actions - Medication technicians will audit the med carts by 7/16//26 to ensure that all medications are available per the prescribers' orders. Additionally, the Med techs will complete a Shift Change Responsibilities checklist as a process to identify medications that need to be reordered. Then, the RCD will review

187d - Follow Prescriber's Orders (continued)

audit med cart audits weekly x 4 weeks to ensure all medications are available and on the cart. Audits will be completed by 8/7/2026.

RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions – Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026.

Licensee's Proposed Overall Completion Date: 08/07/2026

Evidence of Completion

See attached.

Implemented [REDACTED] - 08/25/2026)

12. Requirements

2600.

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

Description of Violation

Resident #5 is prescribed Metoprolol SUCC ER 100 mg: 1 tab orally daily; hold for SDP less than 100 or HR less than 60. On 6/1/26, at 9:28 am, resident #5 was administered Metoprolol 100 mg; however, resident #5's vitals were not taken.

Resident #6 is prescribed the Novolog Flex Pen inject subcutaneously three times daily with meals. If the glucose reading is less than 60, call the MD. According to the sliding scale, if the glucose reading is between 0 and 150, administer 0 units; for readings between 151 and 200, administer 2 units; for readings between 201 and 250, administer 4 units; for readings between 251 and 300, administer 6 units; for readings between 301 and 350, administer 8 units; for readings between 351 and 400, administer 10 units; and if the reading exceeds 400, call the MD. However, resident #5 did not receive the Novolog Flex Pen on 05/20/26 at 9:02 am, despite the glucometer reading of 236, which required 4 units according to the sliding scale.

On 05/18/26, at 8:00 am, resident #6's glucose reading was 411, and on 05/21/26 at 8:00 am, resident #6's glucose reading was 58. According to the physician's order the physician should have been contacted. However, the home did not provide notes documenting the contact made.

Repeated Violation - 09/22/2025, 05/07/2025, 02/12/2025, et al.

Plan of Correction

Accept [REDACTED] - 07/21/2026)

Immediate corrective actions – The Resident Care Director, AED and Med Techs will be re-educated by 7/15/26 by the Executive Director on DHS regulations 2600.187.d to ensure that the Medication Technicians are following the prescribers' orders including, taking vital signs, sliding scale, contact physician and document notification.

Additional Corrective Actions – The RCD will observe each Medication Technicians pass medications, once over the next 4 weeks to ensure that they are following the prescribers' orders. Observations will begin 7/13/26. Then the RCD will randomly observe medication administration documentation 2 x weekly x 4 weeks to ensure that the Medication Technicians are taking vital signs, following the sliding scale, contacting the physician, and documenting physician notification. Audits will be completed by 8/7/2026.

RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions – Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 2026 –July, August, and September -in October 2026

Licensee's Proposed Overall Completion Date: 08/07/2026

187d - Follow Prescriber's Orders (*continued*)**Evidence of Completion****Implemented** [REDACTED] - 08/25/2026)*See attached.*

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

September 23, 2026

[REDACTED]
CARE HSL NEWTOWN OPCO LLC
[REDACTED]
[REDACTED]

RE: THE BIRCHES AT NEWTOWN
70 DURHAM ROAD
NEWTOWN, PA, 18940
LICENSE/COC#: 14230

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/11/2026 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: THE BIRCHES AT NEWTOWN

License #: 14230

License Expiration: 09/25/2026

Address: 70 DURHAM ROAD, NEWTOWN, PA 18940

County: BUCKS

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: CARE HSL NEWTOWN OPCO LLC

Address: [REDACTED]

Certificate(s) of Occupancy

Type: I-2

Date: 06/17/2006

Issued By: Newtown Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 165

Waking Staff: 124

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Monitoring

Exit Conference Date: 08/11/2026

Inspection Dates and Department Representative

08/11/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 120

Residents Served: 106

Secured Dementia Care Unit

In Home: Yes

Area: Daybreak

Capacity: 57

Residents Served: 47

Hospice

Current Residents: 12

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 105

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 59

Have Physical Disability: 1

Inspections / Reviews

08/11/2026 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/10/2026

Inspections / Reviews (*continued*)

09/11/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/18/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/21/2026

09/23/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/18/2026

Reviewer: [REDACTED]

Follow-Up Type: Not Required

24 - Personal Hygiene

1. Requirements

2600.

24. Personal Hygiene - A home shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

1. Bathing.
2. Oral hygiene.
3. Hair grooming and shampooing.
4. Dressing, undressing and care of clothes.
5. Shaving.
6. Nail care.
7. Foot care.
8. Skin care.

Description of Violation

The assessment and support plan, dated [REDACTED]/2026, for resident # 1 indicates the resident requires assistance with bathing, oral hygiene, hair grooming and shampooing, dressing, undressing and care of clothes, shaving, nail care, foot care, skin care. On 8/11/26, the resident waited 28 minutes for assistance with oral hygiene and hair grooming.

Plan of Correction

Accept [REDACTED] - 09/11/2026)

Immediate corrective actions – Care aide provided immediate assistance to resident #1, on 8/11/26, at the time of notification of the resident's needs.

Additional corrective actions – All Directors and Direct Care Staff will be in-serviced by the Executive Director or Assistant Executive Director by 9/17/26, to ensure the residents needs are being met in a reasonable amount of time and according to the RASP. In addition, training will include a review of protocols for answering call bells to meet care needs and acknowledging call bells to end the alert.

The Resident Care Director, Memory Care Director and Wellness Supervisor will monitor the call bell system to ensure the staff is responding timely to the residents' needs.

Ongoing Quality Assurance Actions – The RCD and MCD will audit call bell reports weekly x 4 weeks to ensure timely responses. Audits will be completed by 10/9/2026. The RCD and MCD will review with the Wellness Management Team at Daily Huddle the call bell reports to ensure staff are consistently responding to call bells in a reasonable amount of time, beginning 9/14/26. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 July, August, September in October 2026.

Licensee's Proposed Overall Completion Date: 10/09/2026

Evidence of Completion

Implemented [REDACTED] - 09/23/2026)

See attached.

95 - Furniture and Equipment

2. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The stand up shower in bathroom 105 is not draining properly and overflowing to the bathroom floor causing a

95 - Furniture and Equipment (continued)

tripping hazard.

Plan of Correction

Accept [REDACTED] - 09/11/2026)

Immediate corrective actions – Housekeeping immediately cleaned up the water on the floor in the bathroom on 8/11/26, on the day of inspection.

Additional corrective actions – The Maintenance Director, Housekeeping Team will be in-serviced, on DHS regulation 2600.95 to ensure furniture and equipment are in good repair. Additionally, the Housekeeping Team and Direct Care Staff will be in-serviced by the Executive Director or Assistant Executive Director to report any drainage or leakage issues to the Maintenance Team by 9/17/26. The Maintenance Director assessed the water drainage issue and evaluated the area to determine the cause and appropriate corrective action. The drain was cleared and flushed on 9/5/26 by the Maintenance Director. The Splash guard is diverting water from the bathroom and is draining properly into the center of the shower drain.

Ongoing Quality Assurance Actions – The Maintenance Director will conduct quarterly inspections of the community to identify and address any water drainage concerns beginning October 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 July, August, September in October 2026.

Licensee's Proposed Overall Completion Date: 09/17/2026

Evidence of Completion

Implemented [REDACTED] - 09/23/2026)

See attached.

103c - Food Protected**3. Requirements**

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 8/11/26 at 9:50 A.M. there was an uncovered package of brown sugar stored in on the kitchen counter of the secured dementia care unit.

Repeat Violation: 10/22/25 et al, 1/8/26

Plan of Correction

Accept [REDACTED] 09/11/2026)

Immediate corrective actions – The brown sugar was immediately discarded by The Assistant Executive Director at the time of the inspection, on 8/11/26.

Additional Corrective Actions- The Directors and dining team will be re-educated by 9/17/26 by the Executive Director and AED on DHS regulation 2600.103.c to ensure that all food shall be protected from contamination while being stored, prepared, transported and served.

The Dining Director audited all food prep areas on 8/11/26 to ensure all food items were protected.

Ongoing Quality Assurance Actions – The Dining Director will audit food prep areas, refrigerators and freezers daily x 4 weeks to ensure that all food is protected and covered. Audits will be completed by 10/9/26. The Dining Services Director will complete a daily review of the kitchen and food storage areas, using the Daily Kitchen Checklist, beginning 9/14/26. Dining Director is responsible for sustained compliance.

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 (July, August,

103c - Food Protected (continued)

September) in October 2026.

Licensee's Proposed Overall Completion Date: 10/09/2026

Evidence of Completion

See attached.

Implemented [REDACTED] - 09/23/2026)

171b5 - First Aid Kit**4. Requirements**

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the vehicle used to transport residents does not include a thermometer.

Plan of Correction

Accept [REDACTED] - 09/11/2026)

Immediate corrective actions – On 8/18/26, prior to the inspector's departure, the thermometer was placed back into the First aid Kit by the resident Life Director.

Additional corrective actions – All Directors will be re-educated by the Executive Director or the Assistant Executive Director by 9/17/26 on DHS regulation 2600.171.b5 to ensure that the vehicle has a first aid kit with the continents as specified in 2600.96. The Resident Life Director will audit all first aid kits by 9/14/26 to ensure that they have all continents as specified.

Ongoing Quality Assurance Actions – The Resident Life Director will audit first aid kits weekly for 4 weeks to ensure that first aid kits are properly stocked. Audits will be completed by 10/9/26. The Resident Life Director will monitor First aid Kits weekly to ensure they remain fully stocked beginning 8/14/26.

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 (July, August, September) in October 2026.

Licensee's Proposed Overall Completion Date: 10/09/2026

Evidence of Completion

See attached.

Implemented [REDACTED] - 09/23/2026)

185a - Implement Storage Procedures**5. 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 is prescribed Ibuprofen 800 mg 1 tablet every 6 to 8 hours as needed. On 8/11/26 this medication(s) were not available in the home.

185a - Implement Storage Procedures (*continued*)**Plan of Correction**

Accept [REDACTED] - 09/11/2026)

Immediate Corrective Actions -

On 8/11/26 Resident #2 medication was ordered from the pharmacy by Med Tech M.C, Medication was received in house on 8/12/26.

Additional Corrective Actions - The Resident Care Director, AED and Med Techs will be re-educated by 9/17/26 by the Executive Director on DHS regulations 2600.185.a to ensure that the home implements safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. The Medication Technicians will audit Med carts by 9/14/26 to ensure that all medications are available in the home per prescribers' orders.

Ongoing Quality Assurance Actions – Then the Med Techs will audit Med carts weekly x 4 weeks to ensure that all medications are available in the home according to prescribers' orders. Wellness supervisor will review cart audits weekly to ensure completion and availability of medications. Audits will be completed by 10/9/2026.

The RCD and Wellness Nurse will review Med Carts and audits weekly beginning the week of 9/14/26. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 (July, August, September) in October 2026.

Licensee's Proposed Overall Completion Date: 10/09/2026

Evidence of Completion

Implemented [REDACTED] - 09/23/2026)

See attached.

187b - Date/Time of Medication Admin.

6. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #3 is prescribed Tramadol 50 mg 1 tablet every 8 hours as needed. Resident #3's August 2026 medication administration record does not include the initials of the staff person who administered Tramadol on 8/6/26 and 8/9/26 at 9:00 A.M.

Repeat Violation: 2/12/25, et al,

Plan of Correction

Accept [REDACTED] - 09/11/2026)

Immediate corrective actions – Resident received both doses of tramadol, on 8/6 and 8/9 as documented on the Narcotic count sheet. A note was added to the resident record to confirm that medications were given but not signed on 8/12/26, by the wellness supervisor.

Additional Corrective Actions - The Resident Care Director, AED and Med Techs will be re-educated by 9/17/26 by the Executive Director on DHS regulations 2600.187.b and the shift change responsibility, to ensure that the medication administration is documented at the time the medication is given and to ensure the dashboard has been reviewed. Additionally, The Executive Director and the Assistant Executive Director will re-educate the Resident Care Director, Wellness Supervisor, and the Memory Care Director by 9/17/26 on checking the SMART Dashboard daily to monitor the EMARs for any missed signatures.

187b - Date/Time of Medication Admin. (continued)

RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions – The RCD and Wellness Nurse will review medication administration documentation monthly to ensure that the documentation is recorded accurately. The RCD and MCD will review the SMART Dashboard daily at clinical huddle to monitor the EMARs for any missed signatures. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q3 July, August, September) in October 2026.

Licensee's Proposed Overall Completion Date: 09/17/2026

Evidence of Completion

Implemented [REDACTED] - 09/23/2026)

See attached.