

Department of Human Services  
Bureau of Human Service Licensing

September 30, 2021

[REDACTED] AUTHORIZED MEMBER  
SPRINGFIELD PCH LLC  
PO BOX 1030  
BRICK, NJ 8723

RE: SPRINGFIELD CROSSINGS  
463 WEST SPROUL ROAD  
SPRINGFIELD, PA, 19064  
LICENSE/COC#: 14651

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/19/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
Mia Johnson

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services  
Bureau of Human Service Licensing

September 8, 2021

[REDACTED] AUTHORIZED MEMBER  
SPRINGFIELD PCH LLC  
PO BOX 1030  
BRICK, NJ 8723

RE: SPRINGFIELD CROSSINGS  
463 WEST SPROUL ROAD  
SPRINGFIELD, PA, 19064  
LICENSE/COC#: 14651

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 07/19/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,  
Mia Johnson

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

**Name:** *SPRINGFIELD CROSSINGS*      **Licen e #:** *14651*      **Licen e Expiration Date:** *11/18/2021*  
**Adde :** *463 WEST SPROUL ROAD, SPRINGFIELD, PA 19064*  
**County:** *DELAWARE*      **Region:** *SOUTHEAST*

**Administrator**

**Name:** [REDACTED]      **Phone:** *6105430700*      **Email:** [REDACTED]

**Legal Entity**

**Name:** *SPRINGFIELD PCH LLC*  
**Address:** *PO BOX 1030, BRICK, NJ, 8723*  
**Phone:** *6105442200*      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** *C-2 LP*      **Date:** *07/10/2000*      **Issued By:** *Department of Labor & Industry*

**Staffing Hours**

**Resident Support Staff:** *0*      **Total Daily Staff:** *67*      **Waking Staff:** *50*

**Inspection**

**Type:** *Partial*      **Notice:** *Unannounced*      **BHA Docket #:**  
**Reason:** *Incident*      **Exit Conference Date:** *07/19/2021*

**Inspection Dates and Department Representative**

*07/19/2021 - On-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** *84*      **Residents Served:** *62*

**Secured Dementia Care Unit**

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

**Hospice**

**Current Resident :** *4*

**Number of Residents Who:**

**Receive Supplemental Security Income:** *0*      **Are 60 Years of Age or Older:** *62*  
**Diagnosed with Mental Illness:** *0*      **Diagnosed with Intellectual Disability:** *0*  
**Have Mobility Need:** *5*      **Have Physical Disability:** *0*

## Inspections / Reviews

07/19/2021 - Partial

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow-Up Date: *08/28/2021*

9/8/2021 POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *09/11/2021*

9/30/2021 - Document Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.

- 15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 7/8/21, at 10:00 am, a allegation of abuse was reported to staff person A. However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction

Accept

On 7/8/21 This executive director contacted [REDACTED] and requested a call back from the On-Call person to report abuse, this executive director never received a call back. On 7/9/21 this executive director contacted [REDACTED] again and was put into the voicemail for [REDACTED] and received no call back. On 7/10/21 this executive director contacted [REDACTED] again and was put into the voicemail for [REDACTED]. After multiple attempts to contact [REDACTED] and report the bruise of unknown origin. The Executive Director spoke to supervisor on 7/20/21. Supervisor stated that [REDACTED] was on-call on 7/8/21 and remembered my call but was unable to contact me. Per our conversation on 7/20/21 the supervisor requested a copy of the report submitted to DHS for [REDACTED] record but did not feel an Act 13 was necessary.

Going forward the community will no longer wait to receive guidance from [REDACTED] on whether or not an Act 13 is necessary. Community will attempt to contact [REDACTED] per reporting practices, in addition community will send Act 13 regardless of whether or not they reach [REDACTED].

Completion Date: 08/27/2021

Document Submission

Implemented

Completed

227d - Support Plan Medical/Dental

1. 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

The assessment for resident #1, dated 4/13/21, indicates the resident has a need for "some" assistance with transferring. The resident now requires more assistance with transferring and on palliative care. The resident's support plan, dated 4/13/21 does not document how this need will be met to provide more care when transferring.

**227d - Support Plan Medical/Dental (continued)****Plan of Correction****Accept**

- 1. Please note resident is not on palliative care, but is currently on Hospice.*
- 2. The resident was reassessed to determine residents needs for transfer. Resident support plan was updated to reflect the resident's needs for transfer.*

**Completion Date:** 07/19/2021**Document Submission****Implemented***Completed see attached*