

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

September 21, 2023

[REDACTED], DIRECTOR OF OPERATIONS  
WOODS SERVICES  
[REDACTED]  
[REDACTED]

RE: BEECHWOOD CENTER 10  
588 BEECHWOOD CIRCLE  
LANGHORNE, PA, 19047  
LICENSE/COC#: 14148

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/21/2023 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: BEECHWOOD CENTER 10 License #: 14148 License Expiration: 05/02/2024  
Address: 588 BEECHWOOD CIRCLE, LANGHORNE, PA 19047  
County: BUCKS Region: SOUTHEAST

**Administrator**

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

**Legal Entity**

Name: WOODS SERVICES  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: R-4 Date: 04/08/2015 Issued By: Middletown L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 10 Waking Staff: 8

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
Reason: Incident Exit Conference Date: 06/21/2023

**Inspection Dates and Department Representative**

06/21/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: 8 Residents Served: 8

**Secured Dementia Care Unit**

In Home: No Area: Capacity: Residents Served:

**Hospice**

Current Residents: 0

**Number of Residents Who:**

Receive Supplemental Security Income: 4 Are 60 Years of Age or Older: 5  
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0  
Have Mobility Need: 2 Have Physical Disability: 7

**Inspections / Reviews**

06/21/2023 Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 07/23/2023

08/22/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/12/2023  
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 09/12/2023

Inspections / Reviews *(continued)*

09/21/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/12/2023

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan dated [REDACTED], for resident 1 indicates the resident requires assistance with eating and the presence of staff is needed for verbal cues for swallowing while eating and drinking. On [REDACTED], resident 1 was left unattended by staff in the dining area while eating.

The assessment and support plan dated [REDACTED] for resident 1 indicates that resident requires assistance with toileting and bladder management. On [REDACTED], resident1 was observed to have a strong odor of urine and resident was seated on an incontinence bed pad in a wheelchair. The pad was being used in place of more frequent toileting.

The assessment and support plan dated [REDACTED], for resident 2 indicates the resident requires assistance with toileting and turning or repositioning. On [REDACTED], the resident did not receive this assistance as required. Staff member A, reported that resident 2 was overheard yelling for help on from their room at approximately [REDACTED]. Staff member A was actively assisting another resident with care while staff members B and C were seated on a sofa in the common area. Neither staff person B or C responded to resident 2's calls for help despite being able to hear the resident calling out. Furthermore, staff person B and C refused to help when staff person A requested their assistance with resident 2, stating that the resident didn't actually need anything and that the resident was just trying to manipulate staff. Staff member A attended to resident 2 who was found to have been incontinent of urine while lying in bed. Resident 2 was soaked through to the bed, and also required assistance in repositioning their leg while in bed as it was hurting the resident in its current position. Staff person A provided the required care to resident 2.

Plan of Correction

Accept [REDACTED] - 08/22/2023)

Staff B and C were suspended on [REDACTED] pending investigation by a Woods Services Certified Investigator into this violation. Investigation was completed on [REDACTED] and reviewed/approved by the Woods Services Administrative Review Committee (ARC) on 7/7/23. Staff B and C were cleared by ARC to return to work on [REDACTED] 3. Staff B and C were counseled on 7/17/23 for unsatisfactory job performance with discussion including the noted violations by the Director of Community Residences. The Personal Care Home Administrator will provide monthly supervision that will include job performance to staff B and C starting 8/1/23.

On 7/24/23 a mandatory training on resident rights was held for all of the staff in Beechwood Center 10 by the Director of Community Residences. The Personal Care Home Administrator will include the topic of resident rights as a standing agenda items for all staff meetings monthly starting 8/1/23.

On 8/17/23 a mandatory training on assessments and support plans was held for all of the staff in Beechwood Center 10 by the Personal Care Home Administrator. Staff will be trained by the Personal Care Home Administrator when any changes occur to the ADL needs of the residents in the home or annually if there are no changes starting 8/1/23.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 09/21/2023)

42b - Abuse

## 2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

### Description of Violation

On [REDACTED], between the hours of [REDACTED], resident 3 was confined in a chair for three hours. The chair is a wheeled geriatric recliner that has a tray that securely attaches to the armrests and locks in place. Resident 3 is unable to unlock or remove the tray themselves and requires assistance of staff to get out. Furthermore, resident 3 does not require the specific use of a geriatric recliner chair, and is independent with transfers and ambulation. Resident 3 does require total assistance for eating and drinking but resident can sit at a regular table and chair for meals. On [REDACTED], staff member A questioned staff member B on why resident 3 had been sitting in the chair for three hours and requested assistance in removing the tray to allow resident to get up. Staff member B advised staff member A to leave the resident in the chair to prevent resident from getting up and "getting into things", thus restraining or confining the resident in the chair since the resident cannot remove the tray without help. After three hours of sitting in the chair, resident 3 had been incontinent of urine and feces. Staff member A was able to unlock the tray and remove resident 3 from the chair and provided the required care to the resident.

According to the assessment and care plan dated [REDACTED] for resident 2, the resident needs assistant with toileting and turning or repositioning their lower extremities. On [REDACTED] at approximately [REDACTED], while providing care to another resident, staff member A reported that they could hear resident 2 yelling for help in another room. Staff member A reported that while they were actively providing care to another resident, staff members B and C were seated on a sofa in the common area where they could hear resident 2 calling for help, however they did not answer or attend to resident 2. Staff member A reports that staff persons B and C said that resident 2 didn't actually need anything, that the resident was "just using you" and was only crying out because the resident is manipulative. Staff member A went to assist resident 2 and discovered that resident 2 had been incontinent of urine, was soaked through while lying in bed and required assistance with repositioning their leg from a position that was hurting them. Staff member A provided the required care to the resident.

### Plan of Correction

Accepted [REDACTED] - 08/22/2023)

Staff B and C were suspended on [REDACTED] pending investigation by a Woods Services Certified Investigator into this violation. The tray to the geriatric recliner was removed from the home by the Personal Care Home Administrator on [REDACTED]. Investigation was completed on [REDACTED] and reviewed/approved by the Woods Services Administrative Review Committee (ARC) on 7/7/23. Staff B and C were cleared by ARC to return to work on 7/17/23. Staff B and C were counseled on 7/17/23 for unsatisfactory job performance with discussion including the noted violations by the Director of Community Residences. The Personal Care Home Administrator will provide monthly supervision that will include job performance to staff B and C starting 8/1/23.

On 7/24/23 a mandatory training on resident rights was held for all of the staff in Beechwood Center 10 by the Director of Community Residences. The Personal Care Home Administrator will include the topic of resident rights as a standing agenda item for all staff meetings monthly starting 8/1/23.

On 8/17/23 a mandatory training on assessments and support plans was held for all of the staff in Beechwood Center 10 by the Personal Care Home Administrator. Staff will be trained by the Personal Care Home Administrator when any changes occur to the ADL needs of the residents in the home or annually if there are no changes starting 8/1/23.

42b - Abuse (continued)

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [redacted] - 09/21/2023)

42c - Treatment of Residents

3. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], during breakfast observation, resident 1 was observed sitting in a wheelchair with an incontinence bed pad placed underneath them on the wheelchair seat cushion. Resident 1 had a strong odor of urine. According to resident 1's support plan dated [redacted], resident 1 requires physical assistance with toileting, including transport into the restroom, transferring to the toilet, bowel and bladder management and use of incontinence briefs. Resident was left unattended, fully clothed, sitting on the incontinence pad bed pad which was visible to anyone else present. The pad is being used in place of more frequent assistance with toileting needs. The use of the pad in this manner conveys a lack of dignity for a resident with an incontinence need.

Plan of Correction

Accept [redacted] - 08/22/2023)

On 7/24/23 a mandatory training on resident rights was held for all of the staff in Beechwood Center 10 by the Director of Community Residences. The Personal Care Home Administrator will include the topic of resident rights as a standing agenda items for all staff meetings monthly starting 8/1/23.

On 8/17/23 a mandatory training on assessments and support plans was held for all of the staff in Beechwood Center 10 by the Personal Care Home Administrator. Staff will be trained by the Personal Care Home Administrator when any changes occur to the ADL needs of the residents in the home or annually if there are no changes starting 8/1/23.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [redacted] - 09/21/2023)

42p - Restraints

4. Requirements

2600.

42.p. A resident shall be free from restraints.

Description of Violation

On [redacted] during the hours of [redacted], resident 3 was confined in a geriatric wheeled reclining chair with a tray that is securely attached to the armrests for three hours to prevent mobility. Staff member A requested assistance from staff member B to remove the tray that was restricting the residents ability to get out of the chair, however staff member B refused to assist and stated that they should leave resident 3 in the chair so that they 'wouldn't get into anything'.

42p - Restraints (continued)

Plan of Correction

Accept (████ - 08/22/2023)

Staff B and C were suspended on █████ pending investigation by a Woods Services Certified Investigator into this violation. The tray to the geriatric recliner was removed from the home by the Personal Care Home Administrator on 6/6/23. Investigation was completed on █████ and reviewed/approved by the Woods Services Administrative Review Committee (ARC) on 7/7/23. Staff B and C were cleared by ARC to return to work on 7/17/23. Staff B and C were counseled on 7/17/23 for unsatisfactory job performance with discussion including the noted violations by the Director of Community Residences. The Personal Care Home Administrator will provide monthly supervision that will include job performance to staff B and C starting 8/1/23.

On 7/24/23 a mandatory training on resident rights was held for all of the staff in Beechwood Center 10 by the Director of Community Residences. The Personal Care Home Administrator will include the topic of resident rights as a standing agenda items for all staff meetings monthly starting 8/1/23.

On 8/17/23 a mandatory training on assessments and support plans was held for all of the staff in Beechwood Center 10 by the Personal Care Home Administrator. Staff will be trained by the Personal Care Home Administrator when any changes occur to the ADL needs of the residents in the home or annually if there are no changes starting 8/1/23.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (████ - 09/21/2023)

54a - Direct Care Staff

5. 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

Direct care staff person D does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept (████ - 08/22/2023)

Staff D was pulled from working overtime in Beechwood Center 10 on █████ by the Personal Care Home Administrator. An approved overtime list was created and implemented on 7/24/23 by the Director of Accreditation, Licensing and Program Development. All future staff placed on the list will be reviewed for qualifications to meet this regulation by Human Resources starting 8/17/23.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (████ - 09/21/2023)

85a - Sanitary Conditions

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On █████ at █████, in resident 3's room, there were clothes thrown on the floor appearing to be soiled, there was a pillowcase that had a brown stains visible on it and a used/soiled incontinence bed pad was present on the floor.

85a - Sanitary Conditions (continued)

Plan of Correction

Accept (████) - 08/22/2023)

On ██████ the clothes and bedding were pulled from resident 3's room by the housekeeper for laundering and replaced with clean bedding.

On 7/6/23 the Personal Care Home Administrator implemented new laundry procedures for Beechwood Center 10. In addition to the regular laundry schedule, soiled clothing bins were placed in the laundry room with the expectation that all soiled linens are washed during the shift. The Personal Care Home Administrator will monitor the home for compliance weekly when present starting 7/6/23.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (████) - 09/21/2023)

95 - Furniture and Equipment

7. Requirements

2600.

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

Description of Violation

Resident 3's room had a television lying flat on top of a dresser in a way that it could possibly fall off presenting a potential hazard to the resident.

Plan of Correction

Accept (████) - 08/22/2023)

On 6/21/23 the television was moved to a secure location.

On 6/21/23 the Personal Care Home Administrator submitted a maintenance request to mount the television.

On 6/21/23 maintenance mounted the television in resident 3's bedroom securely to the wall.

Starting 7/1/23 the Personal Care Home administrator will complete a monthly environmental review of the home to identify any potential hazards.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (████) - 09/21/2023)

202 - Prohibitions

8. Requirements

2600.

202. The following procedures are prohibited:

Description of Violation

On ██████ during the hours ██████, resident 3 was confined in a wheeled geriatric reclining chair with a tray that locks into place on the armrests. Resident 3 is unable to unlock or remove the tray from the armrests without assistance from staff. Staff person B had placed resident 3 in this chair as a means to prevent resident 3's from getting up and "getting into things" or wandering around the home. According to resident 3's support plan dated 2/8/23, resident 3 needs visual check by staff every 15 minutes for supervision of resident in the home.

Plan of Correction

Accept (████) 08/22/2023)

Staff B was suspended on ██████ pending investigation by a Woods Services Certified Investigator into this violation.

The tray to the geriatric recliner was removed from the home by the Personal Care Home Administrator on 6/6/23.

**202 Prohibitions (continued)**

Investigation was completed on [REDACTED] and reviewed/approved by the Woods Services Administrative Review Committee (ARC) on 7/7/23. Staff B was cleared by ARC to return to work on 7/17/23. Staff B was counseled on 7/17/23 for unsatisfactory job performance with discussion including the noted violations by the Director of Community Residences. The Personal Care Home Administrator will provide monthly supervision that will include job performance to staff B 8/1/23.

On 7/24/23 a mandatory training on resident rights was held for all of the staff in Beechwood Center 10 by the Director of Community Residences. The Personal Care Home Administrator will include the topic of resident rights as a standing agenda items for all staff meetings monthly starting 8/1/23.

On 8/17/23 a mandatory training on assessments and support plans was held for all of the staff in Beechwood Center 10 by the Personal Care Home Administrator. Staff will be trained by the Personal Care Home Administrator when any changes occur to the ADL needs of the residents in the home or annually if there are no changes starting 8/1/23.

**Licensee's Proposed Overall Completion Date: 08/31/2023**

**Implemented [REDACTED] - 09/21/2023)**