

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

February 28, 2025

[REDACTED]
WOODS SERVICES, INC.

[REDACTED]
ATTN DAWN SHAFFER
[REDACTED]

RE: BEECHWOOD CENTER 5
135 WEST RICHARDSON AVENUE
LANGHORNE, PA, 19047
LICENSE/COC#: 12967

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/30/2024 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 5 License #: 12967 License Expiration: 11/01/2025
 Address: 135 WEST RICHARDSON AVENUE, LANGHORNE, PA 19047
 County: BUCKS Region: SOUTHEAST

Administrator

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

Legal Entity

Name: WOODS SERVICES, INC.
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-3 SP Date: 10/20/1989 Issued By: Dept of Labor & Industry

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 7 Waking Staff: 5

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Incident Exit Conference Date: 12/30/2024

Inspection Dates and Department Representative

12/30/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 7 Residents Served: 7
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 3
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

12/30/2024 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/20/2025

02/04/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 02/27/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/09/2025

Inspections / Reviews *(continued)*

02/10/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/27/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/01/2025

02/28/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/27/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

42c - Treatment of Residents

1. Requirements

2600.

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

Description of Violation

Resident [redacted] was admitted to the home on [redacted] due to a traumatic brain injury. According to their most recent annual assessment and support plan, dated [redacted], resident has moderate difficulties with judgment, and may require staff prompting to assist with decision-making and maintaining socially appropriate behaviors.

However, on [redacted], during the third shift, Resident [redacted] asked Staff Person A to enter their room to observe them [redacted]. Instead of redirecting the resident, Staff Person A complied with the resident's request, entered the room, closed the door, and observed the act for approximately ten minutes before leaving the resident's room. Feeling that the incident was inappropriate, Resident [redacted] reported it to the home's clinical director on [redacted] and to their family member on [redacted].

Plan of Correction

Accept ([redacted] 02/10/2025)

On 11/29/24 staff person A was suspended pending investigation into the allegation. A PA Certified Investigator was assigned internally to investigate the report. Following conclusion of the investigation and review of the Administrative Rights Committee, based on preponderance of evidence, the allegation was not confirmed. Performance concerns regarding Staff A were identified during the course of the investigation and will be addressed formally by the Director of Community Residences following Staff A's return from suspension. Staff A returned from suspension on 1/3/25 however the date the Director is addressing the concern is unknown at this time due to a secondary suspension of Staff A in an unrelated matter. Staff A's employment was terminated on 2/5/25. The Personal Care Home Administrator re-trained staff in the home on resident rights (dignity/respect), positive behavioral interventions/safe management techniques, and reporting of changes in behaviors including the need for additional assessments of residents on 2/6/25. These topics will be included in the monthly house meeting held by the Personal Care Home Administrator starting 3/1/25.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ([redacted] 02/28/2025)

201 - Positive Interventions

2. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted] was admitted to the home on [redacted] due to a traumatic brain injury. According to their most recent annual assessment and support plan, dated [redacted], resident has moderate difficulties with judgment, and may require staff prompting to assist with decision-making and maintaining socially appropriate behaviors.

However, on [redacted] during the third shift, Resident [redacted] asked Staff Person A to enter their room to observe them [redacted]. Instead of redirecting the resident, Staff Person A complied, entered the room, closed the door, and observed the act for approximately ten minutes before leaving. By complying with the inappropriate request instead of redirecting the resident, Staff Person A failed to maintain professional boundaries and protect the resident from potentially harmful or exploitative situations.

201 Positive Interventions (continued)

Plan of Correction

Accept [REDACTED] 02/10/2025)

On 11/29/24 staff person A was suspended pending investigation into the allegation. A PA Certified Investigator was assigned internally to investigate the report. Following conclusion of the investigation and review of the Administrative Rights Committee, based on preponderance of evidence, the allegation was not confirmed. Performance concerns regarding Staff A were identified during the course of the investigation and will be addressed formally by the Director of Community Residences following Staff A's return from suspension. Staff A returned from suspension on 1/3/25 however the date the Director is addressing the concern is unknown at this time due to a secondary suspension of Staff A in an unrelated matter. Staff A's employment was terminated on 2/5/25. The Personal Care Home Administrator re trained staff in the home on resident rights (dignity/respect), positive behavioral interventions/safe management techniques, and reporting of changes in behaviors including the need for additional assessments of residents on 2/6/25. These topics will be included in the monthly house meeting held by the Personal Care Home Administrator starting 3/1/25.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented [REDACTED] - 02/28/2025)

225c - Additional Assessment

3. Requirements

2600.

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

- 1. Annually.
- 2. If the condition of the resident significantly changes prior to the annual assessment.
- 3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [REDACTED] was admitted to the home on [REDACTED] due to a traumatic brain injury. According to their most recent annual assessment and support plan, dated [REDACTED] resident has moderate difficulties with judgment, and may require staff prompting to assist with decision making and maintaining socially appropriate behaviors. However, on [REDACTED], during the third shift, Resident [REDACTED] asked Staff Person A to enter their room to observe them masturbating. Instead of redirecting the resident, Staff Person A complied, entered the room, closed the door, and observed the act for approximately ten minutes before leaving. Despite this incident, no additional assessment was completed for Resident [REDACTED] addressing the exhibited behaviors or supports to be implemented beyond the most recent annual assessment and support plan dated [REDACTED].

Plan of Correction

Accept ([REDACTED] - 02/10/2025)

Resident [REDACTED] is currently receiving psych and Cog services to address impulsivity and poor choices related to decision making. Resident [REDACTED] was evaluated on 11/26/24 and 12/3/24 with regard to these issues and they will continue to be addressed during individual sessions. At this time no additional goal areas or supports are needed. Per clinical assessment, current goal areas pertaining to emotional functioning and impulsivity address the present concerns. Should significant changes or need for additional services present, the request will be made to the funder and documented in the individual's support plan.

As of 7/1/24, behaviors were added to the incident management report and are reviewed monthly by the leadership team for any additional recommendations for assessment. Staff A's employment was terminated on 2/5/25. The Personal Care Home Administrator re trained staff in the home on resident rights (dignity/respect), positive behavioral interventions/safe management techniques, and reporting of changes in behaviors including the need for additional assessments of residents on 2/6/25. These topics will be included in the monthly house meeting held by

225c *Additional Assessment (continued)*

the Personal Care Home Administrator starting 3/1/25.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ( **02/28/2025)**