Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

May 2, 2025

[redacted], CEO
CHANDLER HALL HEALTH SERVICES INC
99 BARCLAY STREET
NEWTOWN, PA, 18940

RE: CHANDLER HALL HEALTH SERVICES, INC. - HICKS
99 BARCLAY STREET
NEWTOWN, PA, 18940
LICENSE/COC#: 12987

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/06/2025 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: *CHANDLER HALL HEALTH SERVICES, INC. - HICKS* **License #**: *12987* **License Expiration**: *02/28/2026*

Address: *99 BARCLAY STREET, NEWTOWN, PA 18940*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *CHANDLER HALL HEALTH SERVICES INC*

Address: *99 BARCLAY STREET, NEWTOWN, PA, 18940*

Phone: **Email**:

of Occupancy

Type: *C-2 LP* **Date**: *09/29/1986* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *03/06/2025*

Inspection Dates and Department Representative

03/06/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *22*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *36* **Residents Served**: *22*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *22*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *22* **Have Physical Disability**: *0*

Inspections / Reviews

03/06/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/05/2025*

04/04/2025 - POC Submission

Submitted By: **Date Submitted**: *04/30/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/01/2025*

Inspections / Reviews *(continued)*

05/02/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *04/30/2025*

Reviewer: [redacted]

Follow-Up Type: *Not Required*

65g - Annual Training Content

1. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2024.

Plan of Correction ***Accept (- 04/04/2025)***

Staff person A has been trained in emergency preparedness procedures and recognition and response to crises. The Director of Facilities will create an online training session by 4/30/25 to accommodate all staff and to ensure all direct care and ancillary staff receive the required training. This training will be assigned to all new hires and all current staff on an annual basis. Department Heads of Ancillary Staff will be educated by 4/30/25 by the PCHA on ensuring that all relevant training in this chapter takes place on an annual basis. The PCHA will then audit 60 days prior to the end of the training year to ensure that all staff has completed the training and follow up with those who did not until all staff are in compliance.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (- 05/02/2025)

103c - Food Protected

2. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 3/6/2025, at 10:25 a.m., there was an uncovered, unsealed bag of herbs stored in the walk-in refrigerator.

Plan of Correction ***Accept (- 04/04/2025)***

The unsealed bag of herbs was placed in a sealed container, labelled, and dated at the time of the inspection. Culinary staff has been educated on ensuring all food is protected from contamination during storage, preparation, transportation, and service. All herbs will be kept in plastic bags in their individual shipping containers and will be labelled and dated at time of delivery. The Culinary Director or designee will monitor all food to ensure it is protected from contamination twice a week for two weeks and then weekly for two months.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (- 05/02/2025)

103i - Outdated Food

3. Requirements

103i - Outdated Food *(continued)*

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 3/6/2025, at 10:22 a.m., there was a tray of peeled bananas, and a black trash bag said to contain loaves of bread, in the walk-in freezer; both were unlabeled and undated.

Plan of Correction ***Accept (█ - 04/04/2025)***

The bananas and bread were disposed of at the time of inspection. Staff was educated on not using outdated or spoiled food and that all food should be labelled and dated prior to storage. The Culinary Director or designee will monitor all food to ensure that it is a. not outdated or spoiled and b. that all food is labelled and dated twice a week for two weeks and then weekly for two months.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (█ - 05/02/2025)

132h - Designated Meeting Place

4. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

All residents in the home did not evacuate to a designated meeting place away from the building or within the fire-safe area during the following fire drills:

- *on 9/20/2024 at 4:33 a.m.,16 out of 22 residents in the home evacuated.*
- *on 11/20/2024 at 7:26 p.m.,9 out of 18 residents in the home evacuated.*

Plan of Correction ***Accept (█ - 04/04/2025)***

The residents that were not evacuated during these drills were on hospice, but did not meet the requirements to stay in place during the drills. The vendor that completed the drills has been made aware of the requirements needed to allow hospice residents to remain in place during a fire drill and that all others must evacuate to a fire-safe area. Personal Care Staff will be retrained by the PCHA or designee on the evacuation of hospice residents during a fire drill by 4/30/25. The Director of Facilities will review the fire drill reports on a monthly basis for proper evacuation and schedule additional fire drills if needed to remain in compliance for the next 6 months. Fire drill evacuation numbers will be reported at QAPI meetings.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (█ - 05/02/2025)

183d - Prescription Current

5. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current *(continued)*

Description of Violation

On 3/6/2025, Guaifenesin Oral Solution and Milk of Magnesia, both prescribed for individual 1, were in the home's medication cart; however, these medications are not listed on resident 1's current medication orders.

Repeat violation: 2/15/2024

Plan of Correction ***Accept (█ - 04/04/2025)***

Resident previously had orders for both medications but they had been discontinued. Both items were removed from the medication cart at the time of the inspection. A cart audit was completed to ensure that only current medications were on hand. All staff will be inserviced on the removal of all medications, OTC, sample and CAM that do not have a current physician's order by the Clinical Manager or designee by 4/30/25. A weekly cart audit will be completed by the Clinical Manager or designee to ensure there are no medications on the cart without a current order for 1 month and will continue on a bi-weekly basis for the next 3 months.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (█ - 05/02/2025)

183e - Storing Medications

6. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 3/6/2025:

- *an Insulin Glargine Pen prescribed to resident 2 was in the medication cart with no open date indicated. According to the manufacturer's instructions an opened insulin glargine pen should be disposed of after 28 days.*
- *Olopatadine .1% eye drops prescribed to resident 3 were in the medication cart with an open date of 12/20/2024. According to the manufacturer's instructions unused Olopatadine .1% eye drops should be discarded 4 weeks after opening the bottle.*
- *Latanoprost solution .005% eye drops prescribed to resident 3 were in the medication cart with an open date of 12/20/2024. According to the manufacturer's instructions unused Latanoprost solution .005% eye drops should be discarded 6 weeks after opening the bottle.*

Plan of Correction ***Accept (█ - 04/04/2025)***

All medications were evaluated at the time of inspection to determine whether they met manufacturer's instructions regarding expiration dates. Those that did not meet the requirements were replaced and all medications were labelled according to manufacturer's instructions. All staff administering medications will be inserviced by the Clinical Manager or designee on storage requirements by 4/30/25. A weekly cart audit will be completed by the Clinical Manager or designee to ensure that all medications are labeled accordingly and discarded upon expiration date weekly for 1 month and on a bi-weekly basis for the next 3 months.

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (- 05/02/2025)

185a - Implement Storage Procedures

7. 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 Acetaminophen 325 mg tab, 2 tablets orally every 6 hours as needed. On 3/6/2025, at 1:55 p.m., this medication was not available in the home.

Plan of Correction ***Accept (- 04/04/2025)***

Resident 2's medications are provided through the family instead of through the facility-preferred vendor. Staff had reached out to the family for the medication but had not yet been received. Medication Administration Staff will be inserviced by 4/30/25 on the procedures for obtaining medications on a timely basis. Staff will be instructed to inform the nurse of any medications that are within three doses of running out. The nurse will then inform the family they will be making arrangements for the facility pharmacy to provide a week's worth of the medication until it is provided by the family. Medications provided by outside providers will be reviewed on a weekly basis by the Clinical Manager or designee for 3 weeks and then monthly for 3 months to ensure that all are available in the home.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented (- 05/02/2025)

231c - Preadmission Screening

8. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 4 was admitted to the Secure Dementia Care Unit (SDCU) on However, resident 4's written cognitive preadmission screening was not completed as of .

Repeat violation: 2/15/2024

Plan of Correction ***Accept (- 04/04/2025)***

The preadmission screening for Resident 4 was completed at the time of the inspection. All preadmission screening forms for current residents of the SDU were reviewed to ensure that all cognitive preadmission screens had been completed and documented. All staff involved in the admission process will be inserviced by 4/30/25 to ensure that the cognitive preadmission screen has been completed and documented within 72 hours prior to admission to the SDU. The Memory Care Coordinator will verify this documentation on the day of admission. The PCHA will review all admissions to the SDU on a monthly basis for 3 months to ensure that the cognitive preadmission screening was completed and documented within 72 hours prior to admission.

Licensee's Proposed Overall Completion Date: *04/30/2025*

231c - Preadmission Screening *(continued)*

Implemented (- 05/02/2025)