

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

April 28, 2025

[REDACTED]  
VS WALLINGFORD LLC  
[REDACTED]

RE: CHESTNUT RIDGE RETIREMENT  
LIVING  
2700 CHESTNUT PARKWAY  
CHESTER, PA, 19086  
LICENSE/COC#: 14141

[REDACTED],  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/20/2025 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: CHESTNUT RIDGE RETIREMENT LIVING License #: 14141 License Expiration: 04/04/2025  
 Address: 2700 CHESTNUT PARKWAY, CHESTER, PA 19086  
 County: DELAWARE Region: SOUTHEAST

**Administrator**

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

**Legal Entity**

Name: VS WALLINGFORD LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 05/19/1997 Issued By: PA L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 121 Waking Staff: 91

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Complaint Exit Conference Date: 03/20/2025

**Inspection Dates and Department Representative**

03/20/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 130 Residents Served: 74  
 Secured Dementia Care Unit  
 In Home: Yes Area: Memory Care Unit Capacity: 26 Residents Served: 22  
 Hospice  
 Current Residents: 5  
 Number of Residents Who:  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 73  
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 47 Have Physical Disability: 0

**Inspections / Reviews**

03/20/2025 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/25/2025

04/28/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 04/28/2025  
 Reviewer: [REDACTED] Follow-Up Type: Bypass Document Submission

Inspections / Reviews *(continued)*

04/28/2025 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/28/2025

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

Resident [redacted] was discharged from Crozer-Chester Medical Center with new prescription orders. The one of the new orders was to stop [redacted] tablet. Staff person A received the residents discharge paperwork with new orders. However the home failed to discontinue the medication until [redacted] This incident was not reported to the Department.

Repeat Violation: [redacted], et al

Plan of Correction

Accept [redacted] - 04/28/2025)

On 3/24/25, the Director's Team was re-educated on the policy and procedure for reporting abuse/neglect and incident reporting. The Director's Team was presented with a training video and was also provided with a reference guide regarding incident reporting policy and procedures. On 3/18/25, all staff were in-serviced on the policy and procedure for reporting abuse/neglect and incident reporting. Staff members were presented with a training video and also provided with a reference guide regarding incident reporting policy and procedures. Executive Director or Designee will present an Abuse/Neglect and Incident Reporting Inservice Training to staff bi-annually. The ERAC or Designee will continue to present an Abuse/Neglect and Incident Reporting training to all new hires during the Orientation process.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented [redacted] 04/28/2025)

182c - Medication Administration

2. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber’s orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident’s hand.
6. Place the medication in the resident’s hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On [redacted], resident [redacted] night time medications were observed on their nightstand the next morning by the residents family. The home did not administer the residents night time medications, who requires assistance taking medications. Staff verified the medications were not administered to the resident. Staff person A stated that staff person B did not administer the medications due to the resident refusing. Staff person B did not place the medication in the

182c Medication Administration (continued)

resident's hand, mouth, or other route as ordered by the prescriber.

Plan of Correction

Accept [REDACTED] - 04/28/2025)

Staff Person B was removed from Medication Cart immediately following the report of said incident. Medication Technicians were re educated on Medication Administration protocol on 4/24/25. All incidents, including medication removal, medication errors and medication refusal will be reviewed in Daily Stand Up Meeting. Director of Health & Wellness and Director of Memory Care will conduct random monthly medication administration observations to ensure that all procedures are being followed.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented [REDACTED] - 04/28/2025)

187b - Date/Time of Medication Admin.

3. 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 [REDACTED], at 8:00 pm, resident [REDACTED] was not administered the [REDACTED] tablet and [REDACTED]. Staff person B signed the medication record as the medication was administered.

Plan of Correction

Accept [REDACTED] - 04/28/2025)

Staff Person B was removed from Medication Cart immediately following the report of said incident. Medication Technicians were re educated on Medication Administration protocol on 4/24/25. All incidents, including medication removal, medication errors and medication refusal will be reviewed in Daily Stand Up Meeting. Director of Health & Wellness and Director of Memory Care will conduct random monthly medication administration observations to ensure that all procedures are being followed.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented [REDACTED] - 04/28/2025)

187c - Refusal of Medication

4. Requirements

2600.

187c Refusal of Medication (continued)

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted], at 8:00 pm, resident [redacted] refused to take a scheduled dose of [redacted] tablet and [redacted]. The home did not document in the resident's record and on the medication record the resident's refusal. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber.

Plan of Correction

Accept ([redacted] - 04/28/2025)

Staff Person B was removed from Medication Cart immediately following the report of said incident. Medication Technicians were re educated on Medication Administration protocol on 4/24/25. All incidents, including medication removal, medication errors and medication refusal will be reviewed in Daily Stand Up Meeting. Director of Health & Wellness and Director of Memory Care will conduct random monthly medication administration observations to ensure that all procedures are being followed.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ([redacted] - 04/28/2025)

187d - Follow Prescriber's Orders

5. Requirements

2600.  
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] was prescribed to repeat thyroid function testing in 6 weeks post discharge from hospitalization on [redacted]. However, the facility did not follow the prescribed order.

Resident [redacted] was discharged from the hospital on [redacted] with a new order to discontinue [redacted] tablet. However home continued to administer the [redacted] until [redacted].

Repeat Violation: [redacted], et al; [redacted], et al

Plan of Correction

Accept ([redacted] - 04/28/2025)

On 3/25/25, Director of Health & Wellness and Director of Memory Care reviewed all active medication orders for accuracy and compliance with prescriber's orders; audits will continue on a weekly basis for 6 weeks, biweekly for 6 weeks and monthly thereafter. Executive Director will conduct random Medication Cart audits on a monthly basis. Audit errors will be discussed daily, during Morning Stand Up meetings. Audit results will be reviewed during monthly QAPI meetings. Medication Technicians were re educated on Medication Administration protocol on 4/24/25.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ([redacted] - 04/28/2025)

188b - Medication Error Reporting

6. Requirements

188b - Medication Error Reporting (continued)

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [redacted] was discharged from Crozer-Chester Medical Center with a prescription order to stop [redacted] tablet on [redacted] and start [redacted] and [redacted] twice daily. However, resident [redacted] was administered an [redacted] tablet from [redacted] to [redacted]. The medication error was not immediately reported to the resident, the resident's designated person, and the prescriber.

Plan of Correction

Accept [redacted] - 04/28/2025)

On 3/25/25, Director of Health & Wellness and Director of Memory Care reviewed all active medication orders for accuracy and compliance with prescriber's orders; audits will continue on a weekly basis for 6 weeks, biweekly for 6 weeks and monthly thereafter. Executive Director will conduct random Medication Cart audits on a monthly basis. Audit errors will be discussed daily, during Morning Stand-Up meetings. Audit results will be reviewed during monthly QAPI meetings. Medication Technicians were re-educated on Medication Administration protocol on 4/24/25.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ([redacted] - 04/28/2025)

188c - Medication Error Documentation

7. Requirements

2600.

188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

Description of Violation

Resident [redacted] was discharged from Crozer-Chester Medical Center with a prescription order to stop [redacted] tablet on [redacted] and start [redacted] and [redacted] twice daily. However, resident [redacted] was administered an [redacted] tablet from [redacted] to [redacted]. There is no documentation of the error in the resident's record.

Plan of Correction

Accept [redacted] - 04/28/2025)

On 3/25/25, Director of Health & Wellness and Director of Memory Care reviewed all active medication orders for accuracy and compliance with prescriber's orders; audits will continue on a weekly basis for 6 weeks, biweekly for 6 weeks and monthly thereafter. Executive Director will conduct random Medication Cart audits on a monthly basis. Audit errors will be discussed daily, during Morning Stand-Up meetings. Audit results will be reviewed during monthly QAPI meetings. Medication Technicians were re-educated on Medication Administration protocol on 4/24/25.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ([redacted] 04/28/2025)