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

June 26, 2025

HIDDEN MEADOWS OPCO LLC

WHITE OAK HEALTHCARE REIT

RE: HIDDEN MEADOWS ON THE RIDGE
THE LAURELS
340 FARMERS LANE
SELLERSVILLE, PA, 18960
LICENSE/COC#: 14524

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/16/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HIDDEN MEADOWS ON THE RIDGE THE LAURELS* **License #**: *14524* **License Expiration**: *07/20/2025*

Address: *340 FARMERS LANE, SELLERSVILLE, PA 18960*

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

Administrator

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

Legal Entity

Name: *HIDDEN MEADOWS OPCO LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/05/2014* **Issued By**: *West Rockhill Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *82* **Waking Staff**: *62*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *04/16/2025*

Inspection Dates and Department Representative

04/16/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *41*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Whole Home* **Capacity**: *50* **Residents Served**: *41*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *41*

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

Have Mobility Need: *41* **Have Physical Disability**: *0*

Inspections / Reviews

04/16/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/18/2025*

05/27/2025 - POC Submission

Submitted By: **Date Submitted**: *06/20/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/01/2025*

Inspections / Reviews *(continued)*

06/02/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/23/2025*

06/26/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2025*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

42b - Abuse

1. 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

The whole home is secured dementia care unit. On [redacted] at approximately 2:45pm, Resident [redacted] was observed in the common area of the home eating a snack. The home had a change of shift at 3:00 P.M. Resident [redacted] was not accounted for during this change. At 4:07pm, the home received a call from Grandview Hospital informing that Resident #[redacted] was in the emergency department confused and in no apparent distress. The hospital staff concluded the resident had walked in. Resident [redacted] was not evaluated by the hospital or the home. The home's Memory Care Director and Administrator went to the hospital to retrieve resident [redacted], who returned to the home willingly and with no apparent injury. Resident #[redacted] was wearing sneakers, a light colored long sleeve shirt, a blue fleece vest, glasses, and dark colored pants. Resident #[redacted] did not remember the event but did remember working at Grandview Hospital for many years and where it is located. The home believes Resident #[redacted] left behind Staff Member A through the main entrance and proceeded through the parking lot to a left onto the access road, two lanes with a speed limit of 35 mph, flanked by a sidewalk on the left hand side that has fencing around an embankment and a grassy side area without a sidewalk to the right lined with trees and fencing. Resident [redacted] walked up a gradual hill on the access road and passed an active construction site building residential homes on the left hand side for a distance of approximately 0.4 miles to Grandview Hospital. The weather was a high off 77 degrees Fahrenheit and a low of 46 degrees on this date.

Staff Member A, who is a third party contracted hospice worker, exited the home at approximately 3:08pm using the main entrance, swinging the door wide open, and not looking for a resident following them. The main entrance off the unit has a magnetic lock that requires a code to exit and opens to the lobby with offices, a restroom, and reception desk that does not always have a receptionist present. Staff Member A first started working in this home on [redacted] and did not receive an orientation.

The home has an elopement policy that details it will hold elopement drills on each shift every month. The home did not complete any elopement drills in February 2025 but did conduct a drill on 3/13/25 during the first shift.

The home placed Resident [redacted] on 30 minute checks starting [redacted] at 4:40pm for 72 hours, and then moved to hourly checks from [redacted] to [redacted] at 12:00am. On [redacted], the 30 minute checks were missed from 12:30P to 2:30P; on [redacted] the 30 minute checks were missed from 12:00A to 7:00A.

Plan of Correction **Accept [redacted] 05/27/2025)**

Immediately after learning of the staff person involved, Director of Memory care provided education to staff person A. Education stressed be aware of [redacted] surroundings near memory care doors, making sure no residents are nearby and making sure the door locks each time entering and exiting the locked door.

42b Abuse (continued)

Director of facilities replaced current keypads for the memory care front door to assist in new policies for codes. Director of facilities immediately change the current code to a new code. Each month, Director of facilities will change the memory care door to a new code.

Executive Director along with Director of Memory care created an orientation packet for all outside agencies such a hospice or home health to sign off on the required 1 day within 40 hours. Each staff will sign off on the Employee Orientation checklist.

Executive Director reviewed the elopement with all staff on 4/22/2025 and reviewed with QA committee on 4/24/25.

Memory Care Director or Designee will make sure elopement drills are occurring monthly on each shift on required elopement forms. Executive Director will review each drill to make sure there were no issues, or if another drill needs to occur.

During quarterly QA meetings, Executive Director will review monthly elopement drills conducted on all 3 shifts. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented - 06/26/2025)

65a - FS Orientation 1st Day

2. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was , did not receive orientation on the following topics:

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.

4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

65a FS Orientation 1st Day *(continued)*

Plan of Correction ***Accept (- 06/02/2025)***

Executive Director along with Director of Memory care created an orientation packet for all outside agencies such a hospice or home health to sign off on the required 1st day orientation has been completed. Each agency staff will sign off on the Employee Orientation checklist.

Memory Care Director or designee will monitor any new outside providers and have them review and sign orientation sheets. Business office Director will keep signed orientation sheets together in a separate binder locked in BOD office,

Memory Care Director faxed each outside provider or agencies a copy of our complete orientation packet and instructed to have all new staff sign off on the training prior to 1st day entering Hidden Meadows on the Ridge.

Executive Director will keep copies of these complete orientation signature pages to show compliance for each agency employee have been training using the supplied orientation packet.

During monthly QA, Executive Director will review current agencies in the building and work with Director of Memory Care to audit employees to ensure orientation has been given and signed off.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented 06/26/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed 40th scheduled work hour on . However, this staff person did not complete training in the following topics:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
4. Reporting of reportable incidents and conditions.

Plan of Correction ***Accept - 05/27/2025)***

Executive Director along with Director of Memory care created an orientation packet for all outside agencies such a

65b - Rights/Abuse 40 Hours (continued)

hospice or home health to sign off on the required 40-hour orientation has been completed. Each agency staff will sign off on the Employee Orientation checklist.

Memory Care Director faxed each outside provider or agencies a copy of our complete orientation packet and instructed to have all new staff sign off on the training prior to 1st day entering Hidden Meadows on the Ridge.

Executive Director will keep copies of these complete orientation signature pages to show compliance for each agency employee have been training using the supplied orientation packet.

During monthly QA, Executive Director will review current agencies in the building and work with Director of Memory Care to audit employees to ensure orientation has been given and signed off.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented [redacted] - 06/26/2025)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Repeat Violation: [redacted]

Plan of Correction ***Directed [redacted] - 06/02/2025)***

Health and Wellness Director was educated by Executive Director following the inspection on April 17, 2025, on requirements of having a medical evaluation completed at least annually.

All current residents' charts will be reviewed by Executive Director or Director of Memory Care to make sure medical evaluations are completed appropriately and accurately on an annual basis.

Audit tool was used 5/27-5/29 by Executive Director to compare current medical evaluation from previous years to make sure there within the approved timeframe. Moving forward Executive Director or Director of Memory Care will do monthly audits
or until substantial compliance achieved.

During quarterly QA meetings, Health and Wellness Director will review residents that are coming up for their annual medical appointment. Dates will be reviewed to make sure they fall within the calendar year. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 07/24/2025

Directed Plan of Correction: *Only the overall completion date has been directed to 6/22/25. By this date, the home should be able to demonstrate substantial compliance with the above plan of correction.*

141b1 - Annual Medical Evaluation *(continued)*

Directed Completion Date: *06/22/2025*

Implemented (- 06/26/2025)

231b - Medical Evaluation

5. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on however, the resident's medical evaluation was completed on and did not indicate the resident's need for a secured dementia care unit.

Plan of Correction ***Directed (- 06/02/2025)***

Health and Wellness Director was educated by Executive Director following the inspection on April 17, 2025, on requirements of having a medical evaluation completed 60 days prior to admission.

All current residents' charts will be audited by Executive Director or Designee by 5-30-25 to make sure medical evaluations are completed appropriately and accurately within 60 days of admission including .

Health and Wellness Director or designee will continue to audit all residents charts each month to make sure medical evaluations are completed accurately and within the approved timeframe. Audits will continue for 2 months or until substantial compliance achieved.

During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure, all required forms such as the medical evaluation have been completed. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 07/24/2025

Directed Plan of Correction: *Only the overall completion date has been directed to 6/22/25. By this date, the home should be able to demonstrate substantial compliance with the above plan of correction.*

Directed Completion Date: *06/22/2025*

Implemented 06/26/2025)

231c - Preadmission Screening

6. 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 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the Resident written

231c - Preadmission Screening (continued)

cognitive preadmission screening was completed on [redacted] however the cognitive screening does not have the date it was completed.

Plan of Correction ***Directed ([redacted] - 06/02/2025)***

Health and Wellness Director updated the date of preadmission screening for resident [redacted] Executive Director reviewed for compliance.

All current residents' charts will be audited by Executive Director or Director of Memory Care by 5-30-25 to make sure
prescreens are completed appropriately and accurately. If there are any prescreens that are not complete, the Director of Health and Wellness will be instructed to complete missing sections.

Executive Director will audit all new residents required paperwork including the prescreen to make sure all sections have been completed. Audits will continue for 2 months or until substantial compliance achieved.

Executive Director provided a 1:1 in-service for Wellness Director on making sure the prescreen is completed entirely including signature and date.

During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure, all required forms such as the prescreen have been completed. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 07/24/2025

Directed Plan of Correction: *Only the overall completion date has been directed to 6/22/25. By this date, the home should be able to demonstrate substantial compliance with the above plan of correction.*

Directed Completion Date: *06/22/2025*

Implemented [redacted] 06/26/2025)