



Pennsylvania Department of Human Services

Emailing date: August 1, 2025

██████████
██████████
470 Manor Operating, LLC
490 Manor Avenue
Downingtown, Pennsylvania 19335

RE: St. Martha Villa for Independent &
Retirement Living
License #: 141080

Dear ██████████:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on May 7 and 8, 2025, and the corrections you have made in the July 14, 2025 inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary



Pennsylvania
Department of Human Services

Sent via e-mail sforde@chg.org
July 29, 2025

[REDACTED]
[REDACTED]
470 Manor Operating, LLC
490 Manor Avenue
Downingtown, Pennsylvania 19335

RE: St. Martha Villa for Independent &
Retirement Living
License #: 14108

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on June 25, 2025 and July 23, 2025 of the above facility, we have determined that your submitted plan of correction for the May 7 and 8, 2025 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Mia Johnson

Mia Johnson
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING* License #: 14108 License Expiration: 06/27/2025

Address: 490 MANOR AVENUE, DOWNINGTOWN, PA 19335

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: 470 MANOR OPERATING LLC

Address: 490 MANOR AVENUE, DOWNINGTOWN, PA, 19335

Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 07/24/2021

Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 105

Waking Staff: 79

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Provisional

Exit Conference Date: 05/08/2025

Inspection Dates and Department Representative

05/07/2025 - On-Site: [REDACTED]

05/08/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 135

Residents Served: 56

Secured Dementia Care Unit

In Home: Yes

Area: Carlson

Capacity:

Residents Served: 25

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 56

Diagnosed with Mental Illness: 1

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 49

Have Physical Disability: 0

Inspections / Reviews

05/07/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/08/2025*

06/25/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *06/26/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/26/2025*

06/26/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *06/26/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *06/30/2025*

07/23/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *06/26/2025*
Reviewer: [REDACTED] Follow-Up Type: *Exception*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 5/7/2025 the home's copy of 55 Pa. Code 2600, was not posted in a conspicuous and public place in the home.

Plan of Correction

Accepted (redacted) - 06/25/2025)

- 1. Administrator added a copy of the current license and regulations to our department notebook on display while surveyors were still in the building 5/8/2025.
- 2. Administrator checked to ensure all documents were present and on display in a public area as of 5/8/2025.
- 3. Administrator or designee educated receptionist and Wellness nurse regarding the importance of keeping this information updated for resident's viewing on or before 6/30/2025.
- 4. Administrator or designee will complete a weekly audit of ensuring the appropriate information is displayed for resident's viewing. The audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (redacted) - 07/23/2025)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). The home did not have an influenza poster anywhere.

Plan of Correction

Accepted (redacted) - 06/25/2025)

- 1. Administrator posted Influenza information in several public areas of the personal care home on 5/8/25.
- 2. Administrator checked and ensured all influenza information was displayed properly on 5/8/25.
- 3. Administrator or designee educated Clinical Director and Wellness nurse on the importance of keeping this influenza information posted all year long on or before 6/30/25.
- 4. Administrator or designee will complete a weekly audit ensuring this information continues to be displayed in designated areas. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (redacted) - 07/23/2025)

23a - Activities of Daily Living Assistance

3. 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] 2025, for resident 1 indicates the resident requires assistance with personal hygiene. On 5/8/2025, the resident did not receive this assistance as required.

Plan of Correction

Accept [REDACTED] 06/25/2025)

1. Clinical Director confirmed personal hygiene assistance for resident 1 was received immediately after it became known on 6/8/25.
2. Clinical Director and clinical team rounded rooms on personal care to ensure residents had assistance with ADL's 6/9/25.
3. Clinical Director or designee educated the Med Tech's and PCA's on the importance of ensuring every resident on personal care received ADL assistance on or before 6/30/25.
4. Clinical Director or designee will complete a weekly audit to ensure residents are receiving appropriate ADL assistance. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

25b - Contract Signatures

4. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract dated [REDACTED]/2024, for resident 2 was not signed by the resident.

The resident-home contract dated [REDACTED]/2024 for resident 3 was not signed by the resident.

Plan of Correction

Accept [REDACTED] 06/26/2025)

1. Administrator reviewed contracts for residents 2 & 3 received priority and were completed with all required signatures on or before 5/12/25.
2. Administrator reviewed Contracts from 1/1/25 to ensure all required signatures were present on 5/16/25. All contracts were current. Administrator and Admissions Director will review current resident contracts dated prior to January 1, 2025, by 6/30/25 to ensure required signatures are present.
3. Administrator or designee educated Admissions Director on the requirements and importance of obtaining correct signatures at the time of signing on or before 6/30/25.
4. Administrator or designee will complete a weekly audit of all new contracts to ensure all required signatures are present. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

25b - Contract Signatures *(continued)*

Licensee's Proposed Overall Completion Date: 06/30/2025

41e - Signed Statement

5. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident 3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept [REDACTED] - 06/26/2025)

1. Admission Director reviewed Contracts for residents 2 & 3 and a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures was obtained on or before 5/16/25.

2. Admissions Director reviewed Contracts were from 1/1/25 to present to ensure residents received and signed acknowledgment that they received a copy of the resident rights and complaint procedures on or before 5/16/25. All contracts were current. Administrator and Admission Director will review current resident contracts dated prior to 1/1/25 to ensure resident rights and complaint procedures were provided and a signed acknowledgement was obtained on or before 6/30/25.

3. Administrator or designee educated Admission Director on the requirements and importance of all resident's reviewing and signing a statement acknowledging receipt of a copy of the resident rights and complaint procedure on or before 6/30/25.

4. Administrator or designee will complete a weekly audit of all new contracts to ensure there is a signed statement acknowledging that the resident received a copy of the resident rights and complaint procedures. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [REDACTED] - 07/23/2025)

54a - Direct Care Staff

6. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

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

54a - Direct Care Staff (continued)

Plan of Correction

Accept ([REDACTED] - 06/26/2025)

1. Clinical Director removed Staff person A was immediately off the schedule and was given instructions on how to obtain the correct documents needed to return to work on 5/9/25.
2. Administrator reviewed employee files for the last 90 days to ensure all had education documentation on or before on or before 5/16/25. Human Resource Director will review current employee files dated prior to the last 90 days to ensure education documentation is present on or before 6/30/25.
3. Administrator or designee educated HR Director of this regulation and importance of having proper education documentation on or before date of hire on or before 6/30/25.
4. HR Director or designee will complete a weekly audit to ensure proper documentation is obtained for all new hires. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/23/2025)

63a - First Aid/CPR Training

7. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 4/23/2025, from 6:00 pm until 4/24/2025 at 7:00 am, 56 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

On 4/24/2025, from 6:00 pm until 4/25/2025 at 8:00 am, 56 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

On 4/25/2025, from 11:00 pm until 4/26/2025 at 3:00 pm, 56 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

On 4/27/2025, from 7:00 am until 3:00 pm, 56 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

On 4/27/2025, from 11:00 pm until 4/28/2025 at 8:00 am, 56 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

Plan of Correction

Accept ([REDACTED] 06/25/2025)

1. Administrator Immediately following the survey, adjusted staff schedules to ensure at least one staff person for every 50 residents was CPR certified 5/16/25.
2. Administrator reviewed current staff records to ensure CPR certifications were up to date and identified staff needed to continue compliance. Additional staff members are currently enrolled in CPR classes to ensure continued compliance as of 6/30/25.
3. Administrator or designee educated HR Director and Scheduler regarding this regulation and the importance of always having enough certified staff in the building on or before 6/30/25.

63a - First Aid/CPR Training (continued)

4. HR Director or designee will complete an audit of all incoming new staff to ensure continued compliance. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [REDACTED] - 07/23/2025)

65d - Initial Direct Care Training**8. Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
 - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [REDACTED]/2023, began providing unsupervised ADL services on 6/6/2023. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Direct care staff person B, hired on [REDACTED] 2024, began providing unsupervised ADL services on 12/17/2024. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until 5/7/2025.

Repeat Violation: 4/29/2024, et al

Plan of Correction

Accept [REDACTED] - 06/25/2025)

1. Administrator ensured Staff person A & B immediately took the Direct Care Staff training course and passed the

65d - Initial Direct Care Training (continued)

competency test as of May 9, 2025

2. Administrator reviewed pertinent staff records to ensure this certificate was present in their records on or before May 16, 2025.

3. Administrator or designee educated Clinical Director and HR Director regarding this regulation and the importance of having this completed and provide certificate before hire date on or before June 30,2025.

4. HR Director or designee will complete an audit of all incoming new direct care staff to ensure this certificate is completed and present before hire date. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (████) - 07/23/2025)

65f - Training Topics

9. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training during training year 2024.

Direct care staff person C did not receive training in medication self-administration training during training year 2024.

Direct care staff person D did not receive training in medication self-administration training during training year 2024.

Direct care staff person E did not receive training in medication self-administration training during training year 2024.

Repeat Violation: 4/29/2024, et al

Plan of Correction

Accepted (████) 06/25/2025)

1. Administrator ensured Staff persons A,C,D, & E completed medication self-administration training as of May 16,2025.

2. Administrator reviewed staff records to ensure medication self-administration training is on the staff training schedule for 2025 on or before May 16, 2025.

3. Administrator or designee educated Clinical Director regarding this regulation and the importance of having this training completed yearly on or before June 30, 2025.

4. Clinical Director or designee will complete an audit of new staff to ensure they are on the list to receive this training according to the Staff Training Plan. This audit will be conducted once a week for a month. The audit

65f - Training Topics (continued)

results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [redacted] - 07/23/2025)

65g - Annual Training Content

10. 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 D did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2024.

Staff person E did not receive training in 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 during training year 2024.

Staff person F did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year 2024.

Repeat Violation: 4/29/24, et al

Plan of Correction

Accept [redacted] 06/25/2025)

1. Clinical Director provided Staff persons D, E, & F emergency preparedness training following survey on or before May 16, 2025
2. Administrator reviewed Staff records to ensure emergency preparedness training was on the staff training plan for the current year on or before May 16, 2025.
3. Administrator or designee educated HR Director regarding this regulation and the importance of having this training completed yearly on or before June 30, 2025.
4. HR Director or designee will complete an audit of new staff to ensure they are on the list to receive this training according to the Staff Training Plan. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

65g - Annual Training Content (*continued*)

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [REDACTED] - 07/23/2025)

66b - Training Plan Content

11. Requirements

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include dates, times and locations of the trainings.

Repeat Violation: 4/29/2024, et al

Plan of Correction

Accept [REDACTED] 06/25/2025)

1. Administrator ensure the Training Plans in question were corrected on or before May 16, 2025.
2. Administrator review Previous training plans to ensure pertinent information was documented on or before May 16, 2025.
3. Administrator or designee educated Clinical Director and HR Director regarding this regulation and the importance of having the pertinent information on all training documents on or before June 30, 2025.
4. Clinical Director or designee will complete an audit of all new trainings to ensure documentation is correct. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [REDACTED] - 07/23/2025)

82c - Locking Poisonous Materials

12. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 5/8/2025, the Memory Care laundry room was left unlocked with Laundry detergent bottles that state to "if ingested to seek medical attention immediately" on the floor next to the washing machine. Not all the residents of the home, including residents in memory care, have been assessed capable of recognizing and using poisons safely.

Repeat violation: 7/31/2024, et al, 4/29/2024, et al

Plan of Correction

Accept [REDACTED] - 06/25/2025)

1. Administrator ensured Memory Care laundry room door lock was immediately changed so that it cannot be left unlocked in the future on May 9, 2025.
2. Administrator ensured other doors and cabinets were checked to verify they were locked on memory care. If a

82c - Locking Poisonous Materials (continued)

lock was needed, a locked was provided on or before May 16, 2025.

3. Administrator or designee educated housekeeping staff regarding the importance of keeping poisonous materials locked up on before May 30, 2025.

4. Administrator or designee will complete an audit to ensure all doors remain locked on memory care. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [redacted] - 07/23/2025)

85a - Sanitary Conditions

13. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/8/2025, resident 1's bathroom had feces on the floor and in and around the toilet area. The feces was brown in color and had an odor.

Repeat Violation: 7/31/2024, et al, 4/29/2024, et al

Plan of Correction

Accept [redacted] /25/2025)

1. Housekeeping Director ensured Resident 1's bathroom was immediately cleaned and sanitized on or before May 9, 2025.

2. Administrator reviewed all other bathrooms to ensure sanitary conditions were present on or before May 16, 2025.

3. Administrator or designee educated Housekeeping Director regarding the importance of keeping sanitary conditions on or before June 30, 2025.

4. Administrator or designee will complete an audit to ensure sanitary conditions in the bathrooms are being maintained. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [redacted] - 07/23/2025)

92 - Windows

14. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 5/8/2025, in the personal care 2nd floor lounge area near stairwell 261 window screens are torn.

On 5/8/2025, in the personal care 3rd floor lounge area window screens are torn.

92 - Windows (continued)

Repeat violation 7/31/2024, et al

Plan of Correction

Accept [redacted] - 06/25/2025)

1. Director of Maintenance ensured Personal Care 2nd and 3rd floor lounge area screens were immediately repaired on or before May 16, 2025
2. Administrator checked other screens were for holes or tears and repairs were made on or before May 16, 2025.
3. Administrator or designee educated Director of Maintenance regarding this regulation and the importance of making sure screens are in good repair on or before June 30, 2025.
4. Administrator or designee will complete and audit to ensure screens are in good repair. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [redacted] - 07/23/2025)

95 - Furniture and Equipment

15. Requirements

2600.

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

Description of Violation

On 5/8/2025, there was a reclining chair in the memory care unit television area, the cushion had a wet spot with a stain and a wet area underneath of the chair.

Repeat Violation: 4/29/2024, et al

Plan of Correction

Accept [redacted] - 06/25/2025)

1. Administrator ensured the chair in question was immediately cleaned and floor was immediately cleaned on May 8, 2025.
2. Administrator checked Furniture on all floors were checked to make sure they were in good repair, clean and free of hazards as of May 30, 2025
3. Administrator or designee educated Director of Housekeeping and the Director of Maintenance on this regulation and the importance of making sure the furniture and equipment are in good repair, clean and free of hazards on or before June 30, 2025.
4. Administrator or designee will complete an audit to ensure furniture and equipment are in good repair, clean and free of hazards. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [redacted] - 07/23/2025)

103g - Storing Food

16. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/8/2025, the ice cream containers located in the ice cream freezer were opened and unsealed.

Repeat Violation 7/31/2024, et al, 4/29/2024, et al

Plan of Correction

Accept [REDACTED] - 06/25/2025)

1. Administrator ensured Ice cream container lids were immediately closed on May 8, 2025 while surveyors were present in the facility.
2. Administrator change to ice cream to individualized cups to avoid this issue in the future on or before May 30, 2025.
3. Administrator or designee educated Dietary Supervisor on the importance of keeping these lids closed. Ice cream cups ordered and will be introduced as soon as containers are empty on or before June 30, 2025.
4. Administrator or designee will complete an audit to ensure lids on ice cream containers are closed. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [REDACTED] - 07/23/2025)

162c - Menus Posted**17. Requirements**

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 5/7/2025, the home's menu for the week of 5/5/2025 and 5/12/2025 were not posted in the Memory Care Unit.

Repeat Violation: 4/29/2024, et al

Plan of Correction

Accept [REDACTED] - 06/25/2025)

1. Menus were immediately placed on memory care unit while surveyors were still in the building on May 9, 2025.
2. Menus were checked throughout PC and memory care to ensure all menus were correct and posted.
3. Administrator or designee educated Dietary Supervisor on the importance of keeping these menus current and posted in all designated areas.
4. Administrator or designee will complete and audit to ensure menus are current and posted. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

183b - Meds and Syringes Locked**18. Requirements**

- 2600.

183b - Meds and Syringes Locked (continued)

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/8/2025, there was a gray pill observed on the floor behind the chair in room 45.

Plan of Correction

Accepted [REDACTED] - 06/25/2025)

- 1. Clinical Director ensured pill was immediately removed from room and discarded appropriately on May 8, 2025 while the surveyor was in the building.*
- 2. Administrator ensured all other rooms were checked and for any loose medications that may have fallen on the floor on or before May 16, 2025.*
- 3. Clinical Director or designee educated clinical staff regarding making sure residents are watched when they are taking the medications and floors are regularly checked for any loose medications that may have fallen on or before June 30, 2025.*
- 4. Clinical Director or designee will complete an audit to ensure staff are watching residents during medication administration and floors are being checked regularly. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.*

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented [REDACTED] - 07/23/2025)

183d - Prescription Current**19. Requirements**

2600.

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

Description of Violation

On 5/8/2025, resident 4 had Preparation H, Eye drops, Nasal Spray on their end table. These medications were not listed on resident 4's medication administration record.

On 5/8/2025, resident 5 had Cortizone cream, Tylenol PM and Vapor Drops in the medicine cabinet. These medications were not listed on resident 5's medication administration record.

On 5/8/2025, resident 6 had Ammonium Lactate, Bayer Aspirin, sweet oil, eye drops in their medicine cabinet. These medications were not listed on resident 6's medication administration record.

Plan of Correction

Accepted [REDACTED] - 06/25/2025)

- 1. Clinical director ensured Residents 4, 5, 6 all OTC medications were removed from the rooms May 8, 2025.*
- 2. The administrator completed a sweep of resident's rooms to ensure OTC medications were removed from any rooms that had them on or before May 16, 2025.*
- 3. Administrator or designee educated Clinical Director regarding this regulation and the importance of removing any OTC medication that does not have a doctor's order.*
- 4. Administrator or designee will complete a room audit to ensure compliance with this regulation. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.*

183d - Prescription Current (continued)

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (████) - 07/23/2025)

191 - Resident Right to Refuse

20. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 2, admitted █████ 2024, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 3, admitted █████/2024, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept (████) - 06/25/2025)

1. Administrator ensured Residents 2 & 3 were given information on the right to refuse medication immediately following the survey on or before May 16 2025.
2. Administrator reviewed Documentation to ensure residents have been educated on the right to refuse medication on or before June 5, 2025.
3. Administrator or designee educated Admission Director on this regulation and the importance of making sure residents are given this education on the right to refuse medication on admission on or before June 30, 2025.
5. The administrator will complete a random audit education of residents' right to refuse medication. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 6/30/25.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (████) /23/2025)

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

July 25, 2025

[REDACTED]
470 MANOR OPERATING LLC
490 MANOR AVENUE
DOWNTOWN, PA, 19335

RE: ST. MARTHA VILLA FOR
INDEPENDENT & RETIREMENT
LIVING
490 MANOR AVENUE
DOWNTOWN, PA, 19335
LICENSE/COC#: 14108

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/14/2025 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: ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING License #: 14108 License Expiration: 06/27/2025

Address: 490 MANOR AVENUE, DOWNINGTOWN, PA 19335

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: 470 MANOR OPERATING LLC

Address: 490 MANOR AVENUE, DOWNINGTOWN, PA, 19335

Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 07/24/2021

Issued By: COPA L & I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 87

Waking Staff: 65

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Monitoring

Exit Conference Date: 07/14/2025

Inspection Dates and Department Representative

07/14/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 135

Residents Served: 53

Secured Dementia Care Unit

In Home: Yes

Area: Carlson

Capacity: 35

Residents Served: 22

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 53

Diagnosed with Mental Illness: 4

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 34

Have Physical Disability: 0

Inspections / Reviews

07/14/2025 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/02/2025

Inspections / Reviews (*continued*)

07/25/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/25/2025

Reviewer: [REDACTED]

Follow-Up Type: *Bypass Document Submission*

07/25/2025 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/25/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract Addendum to Personal Care Admission Agreement for Memory Support Service dated 5/23/2025 for resident 1, was not signed by the administrator, administrator designee, and/or payer.

Plan of Correction

Accept [redacted] - 07/25/2025)

- 1. Administrator reviewed contract for resident 1 on 7/14/25, signed, and returned copy of signed signature page to surveyor before she left the building on 7/14/25.
- 2. Administrator reviewed all memory care resident's contracts to ensure all signatures were present on 7/24/25.
- 3. Administrator education Admission Director on the importance of having all parties' signatures present on contracts.
- 4. Administrator or designee will audit new contracts to ensure facility and resident's signatures are present until 8/1/25

Licensee's Proposed Overall Completion Date: 08/01/2025

Implemented [redacted] - 07/25/2025)