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

October 2, 2025

[redacted], EXECUTIVE DIRECTOR-PINE RUN VILLAGE
PINE RUN VILLAGE, INC.
[redacted]

RE: PINE RUN LAKEVIEW
2425 LOWER STATE ROAD
DOYLESTOWN, PA, 18901
LICENSE/COC#: 15036

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/25/2025, 08/25/2025 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: *PINE RUN LAKEVIEW* **License #**: *15036* **License Expiration**: *08/24/2026*

Address: *2425 LOWER STATE ROAD, DOYLESTOWN, PA 18901*

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *PINE RUN VILLAGE, INC.*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/25/2023* **Issued By**: *Township of Doylestown*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *94* **Waking Staff**: *71*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *08/26/2025*

Inspection Dates and Department Representative

08/25/2025 - On-Site: [redacted]

08/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *107* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Arbor* **Capacity**: *13* **Residents Served**: *13*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

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

Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

08/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/15/2025*

09/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/02/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/27/2025*

Inspections / Reviews *(continued)*

09/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/02/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/02/2025*

10/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/02/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The laptop screen, empty medication packets, and report sheets containing the residents' information were left unlocked, unattended, and available on the second floor medication station by staff member A at 10:00 a.m. on 8/26/2025.

Plan of Correction ***Accept (- 09/22/2025)***

• Staff member was re-educated, reiterating privacy policies as it relates to PHI and the consequences of non-compliance.

• All nurses and med techs will receive re-education on the importance of maintaining Resident confidentiality in accordance with regulation 17 by 9/22/25.

• All staff are re-educated on HIPPA privacy and confidentiality annually through RELIAS platform.

• Policy review and distribution of policies will be reviewed to clarify procedures for securing MAR's, med carts, and any PHI by RSM.

• RSM will complete an unannounced weekly audit to ensure med carts are locked, laptops are closed, PHI is not being left in open view and medication packets are disposed of in shredder. Weekly audit starts 9/2/25 and ends 9/30/25.

• RSM will audit monthly for the next 3 months.

•Results of random auditing will be reviewed with Administrator weekly until 9/30/25 and monthly thereafter.

• All violations will be forwarded to Quality Management for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented (- 10/02/2025)

28f - Resident's Funds and 30-day Refund

2. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

On resident 1 was discharged from the home. The home did not provide the resident a refund until

On resident 2 was discharged from the home. The home did not provide the resident a refund until

Plan of Correction ***Accept (- 09/22/2025)***

• All residents who discharge /expire from Personal Care, refunds will be identified and processed within 7-10

28f - Resident's Funds and 30-day Refund (continued)

business days by the Billing Office Coordinator.

• If there's a credit showing on date of service, the account will be adjusted, refund will be submitted through the AP system, and the family will be called.

• The Billing Office Coordinator will be responsible for sending their direct manager an email when a resident discharges /expires from Personal Care as well to ensure the refund is completed timely.

• We have not had any discharges or deaths since our inspection. Any discharges and deaths from 9/15/25 forward will adhere to the requirements above, ensuring refunds are provided within 30 days.

• All violations will be forwarded to Quality Management for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented (- 10/02/2025)

65g - Annual Training Content

3. 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 B, with date of hire [redacted] did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the training year of 2024.

Plan of Correction ***Accept (- 09/26/2025)***

• All staff will receive in-person fire training by 12/30/25 and annually thereafter.

• Fire Safey Expert Michael Fure is scheduled on 9/24/25. Anyone not able to participate in this training will be trained by [redacted] who have their fire training certificates.

• Monthly fire drills are utilized to review fire safety with all who participated once the drill is complete.

• 10 dates will be offered to all staff on all shifts for staff who did not participate in monthly drills and in-person training. Sign-in sheets will be kept proving in-person training sessions by [redacted] have been completed by 12/30/25.

• Sign-in sheet will be submitted from [redacted] 9/24/25 in-person training session.

• All violations will be forwarded to Quality Management for review and recommendations.

65g - Annual Training Content (continued)

• Attached are the Fire Drill sign in sheets from 1/17,1/24, 2/7, 3/27, 4/17, 5/28, 6/24, 7/16, and 8/30 with the staff who have received in-person Fire Safety training by our Fire Safety Expert after the completion of each fire drill.

• 10 additional dates will be offered to staff who were not working during 2025 drills to receive the required annual in-person fire safety training, ensuring all staff have received in-person fire training for year 2025.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented ([redacted] - 10/02/2025)

131f - Fire Extinguisher Inspection

4. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the commercial laundry has not been inspected by a fire safety expert since January 2024.

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

• Location for all fire extinguishers have been identified and inspected by [redacted] on 8/29/25. There is a total of 26 fire extinguishers.

• Keystone Fire Company provided a new fire extinguisher tag for our Commercial laundry room extinguisher on 9/4/25.

• As of 9/4/25, All fire extinguishers have been identified and are in compliance with 131(f) regulation.

• The next inspection of fire extinguishers is due January 2026. Once the fire company provides updated tags or replaces the fire extinguishers as needed, Maintenance tech [redacted] will ensure ALL fire extinguishers have updated tags for 2026 and are inspected monthly for compliance.

• Maintenance Tech will complete monthly audit for the next 3 months to ensure fire extinguishers are inspected monthly as required.

• All violations will be forwarded to Quality Management for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented ([redacted] - 10/02/2025)

132c - Fire Drill Records

5. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 7/16/25 does not include the time.

132c - Fire Drill Records (continued)

The fire drill records for the drills conducted on 8/31/24, 9/25/24, 10/28/24, 11/21/24, 12/11/24, 1/17/25, 1/24/25, 2/7/25, 3/27/25, 4/17/25, 5/28/25, 6/24/25, and 7/16/25 do not include the exit route(s) used.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

• Please find the attached fire drill log from 8/31/24 through 7/16/25 showing in column 4 the exit routes used during our fire drills.

• PCHA will review fire drill log after every fire drill to ensure all required information (time and exit routes) are documented accurately beginning with August 2025 fire drill.
• A new fire drill sign in sheet and fire drill log will be utilized starting with the August fire drill.

Licensee's Proposed Overall Completion Date: *09/24/2025*

Implemented ([redacted] - 10/02/2025)

132e - Fire Drill Sleeping Hours

6. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 1/17/2025 at 3:27 am.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

• In 2025 Lakeview had 2 sleeping hour fire drills:
• January 17, 2025, at 3:57am - attached is the sign in sheet
• July 16, 2025, at 11:55pm - attached is the sign in sheet

•Documentation from our 11-7 7/16/25 Fire Drill is attached proving a fire drill was completed during sleeping hours.
• 2 sleeping hour drills will be scheduled every year. In 2026 our sleeping hour drills will be in the months of January and July.
• These drills will be recorded on the fire drill log and sign in sheets starting September 2025.
• PCHA will ensure all information is documented correctly on the log and sign in sheet after every drill starting in August of 2025.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented ([redacted] - 10/02/2025)

171b4 - Staff Training

7. Requirements

2600.

171b4 - Staff Training *(continued)*

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff persons C and D transport residents to doctors' appointments. However, staff persons C and D have not completed the initial new hire direct care staff person training.

Plan of Correction ***Accept (- 09/22/2025)***

- [redacted] *will be Lakeview's driver effective 9/22/25.*
- [redacted] *will receive Lakeview orientation, fire training, departmental orientation and complete the DHS Care Giver Course by 9/22/25.*
- [redacted] *will be responsible to complete all Direct care staff annual education as required.*
- *All violations will be forwarded to Quality Management for review and recommendations.*

Licensee's Proposed Overall Completion Date: *09/22/2025*

Implemented (- 10/02/2025)

183b - Meds and Syringes Locked

8. Requirements

2600.

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 8/26/2025 at 10:15 a.m., staff member A left the medication carts for the 2nd floor unlocked, unattended, and accessible.

On 8/26/2025 at 10:20 a.m., staff member A left a medicine cup with two pills on top of the medication cart between medication passes unlocked, unattended, and accessible.

Plan of Correction ***Accept (- 09/26/2025)***

- *Staff member [redacted] was re-educated on proper medication handling and storage procedures by RSM on 9/17/25.*
- *All Licensed staff will receive re-education on Regulation 183(b), emphasizing all medications must remain locked and secured at all times unless actively being administered by 9/22/25.*

- *RSM will conduct weekly audit for the next 4 weeks to ensure compliance with medication security protocols are being upheld (week of 9/9, 9/12, 9/19, 9/24).*
- *Audits will continue on a monthly basis (October 30, 2025, November 29, 2025, December 30, 2025).*
- *All violations will be forwarded to Quality Management for review and recommendations.*

Licensee's Proposed Overall Completion Date: *09/24/2025*

183b - Meds and Syringes Locked *(continued)*

Implemented ([redacted] - 10/02/2025)

185a - Implement Storage Procedures

9. 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 3 is prescribed blood glucose monitoring one time a day. On 8/24/2025 at 4:17 a.m., the glucometer reads 195, but it was documented as 198.

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

• Upon the discovery, the discrepancy between the Accu-Chek reading and MAR was investigated.
• The MAR entry was identified as a documentation error and the staff member was counseled on accurate transcribing practices on 8/26/25 by RSM.
• A corrected entry was made with proper documentation on 8/26/25 by RSM.
• Re-education will be provided to all nurses and med techs by 9/22/25 to ensure proper understanding of PSL policies and DHS regulations are understood.
• Staff are to report any malfunctions immediately to RSM or PCHA.
• RSM will conduct an audit 3 x's per week for 1 month beginning 9/1/25. Audit ends 9/30/25.
• Audit results will be reviewed with Administrator.
• All violations will be forwarded to Quality Management for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented ([redacted] - 10/02/2025)

187b - Date/Time of Medication Admin.

10. 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

Resident 4 is prescribed Tramadol 50 mg. Resident 4's medication administration record does not include the initials of the staff person who administered it on 8/6/2025 and 8/25/2025 at midday.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

• Re-education session on proper medication administration procedures and timely documentation will be provided to all med techs and nurses by 9/22/25.
• A Medication Administration Documentation Check list must be completed by every nurse / med tech at the end of their shift and be submitted to the RSM for review beginning 9/22/25.

• RSM will review MAR's daily for the next 30 days (daily starting 9/1/25 - 9/30/25).
• Weekly audits of MAR's will continue monthly by RSM (October 30, November 29, December 30).

187b - Date/Time of Medication Admin. (continued)

- *Audit results will be reviewed with Administrator every Friday starting 9/5 through 12/19).*
- *All violations will be forwarded to Quality Management for review and recommendations.*

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented ([redacted] - 10/02/2025)

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident 4 is prescribed Warfarin Sodium 2 mg. However, this medication was not administered to the resident from 8/15/2025 to 8/18/2025 at 6:00 p.m.

Resident 4 is prescribed Augmentin Oral Tablet 500-125 mg. However, this medication was not administered to the resident on 8/10/2025 at 10:00 p.m.

Resident 4 is prescribed Benzonate 100 mg. However, this medication was not administered to the resident on 8/25/2025 at midday.

Resident 4 is prescribed Tylenol Extra Strength 500 mg. However, this medication was not administered to the resident on 8/25/2025 at midday.

Resident 4 is prescribed IPRAT-ALBUT 0.5-3 ml. However, this medication was not administered to the resident on 8/10/2025, on 8/18/2025 at 9:00 p.m., or on 8/18/2025 at 6:30 a.m.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

- *Immediately upon discovery, the MAR for identified Resident was reviewed by RSM.*
- *The staff involved were re-educated on the requirement that all administered medications must be documented in both the MAR and when applicable, the controlled substance log (re-education completed 9/22/25).*
- *A review was conducted to ensure there were no adverse effects for the Resident by RSM and physician on 8/27/25.*
- *All med-passing staff will receive re-education on proper documentation practices for medication administration, the importance of accurately completing the MAR in accordance with prescriber directions, the requirement to document, both in the MAR and controlled substance log by 9/22/25.*

- *RSM will audit MAR's and controlled substance logs weekly for the next 4 weeks (Week of 9/1, 9/8, 9/15, 9/22).*
- *RSM will audit MAR's and controlled substance logs monthly (October 30, November 29, December 30).*
- *Audit results will be reviewed with Administrator (9/6, 9/12, 9/19, 9/26, 10/30, 11/29 and 12/30).*
- *All violations will be forwarded to Quality Management for review and recommendations.*

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 10/02/2025)

234a - Admission Support Plan

12. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

• Audit of all current Arbor Residents 72-hour RASP was completed on 9/5/25.
• Correction - update to [redacted] RASP was completed on 9/4/25.
• Moving forward, Admission's Coordinator will complete a 72-hour and 30-update RASP timely for all new admissions and transfers to The Arbor.

• PCHA will audit weekly to ensure 72-hour RASPS are completed as required (week of 9/1, 9/8, 9/15, 9/22, 9/29, 10/6, 10/13, 10/20, 10/27, 11/3,11/10, 11/17, 11/24, 12/1, 12/8, 12/15 and 12/22).
• All violations will be forwarded to Quality Management for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Implemented ([redacted] - 10/02/2025)