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

October 3, 2025

ELWYN OF PENNSYLVANIA AND DELAWARE

RE: ELWYN - FRIENDSHIP HALL
64 EAST OLD BALTIMORE PIKE
ELWYN, PA, 19063
LICENSE/COC#: 12289

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/11/2025 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: *ELWYN - FRIENDSHIP HALL* **License #**: *12289* **License Expiration**: *01/15/2026*

Address: *64 EAST OLD BALTIMORE PIKE, ELWYN, PA 19063*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ELWYN OF PENNSYLVANIA AND DELAWARE*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-1* **Date**: *11/06/1985* **Issued By**: *COPA L & I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *8* **Waking Staff**: *6*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *09/11/2025*

Inspection Dates and Department Representative

09/11/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *8*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older**: *4*
Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *8*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

09/11/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/04/2025*

10/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/03/2025*

Inspections / Reviews *(continued)*

10/03/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *10/03/2025*
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 for resident , dated , was not signed by the administrator or the administrator designee.

Plan of Correction ***Accept (- 10/01/2025)***

On September 11, the administrator signed the initial home contract and dated it immediately.
The administrator will review all initial documents a week after admission of all residents to ensure all documents are initialed or signed and dated correctly.
A Resident Admission Documentation Checklist will be implemented and completed for each new admission. This checklist will include a line item confirming that the contract has been signed by the administrator/designee.
The supervisor will check monthly during Chart Review to ensure all the information in the binder is correct and up to date.

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

Implemented - 10/03/2025)

144c1 - Smoking Area Guidelines

2. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area, temporarily out front of the building due to construction, does not have fireproof receptacles and/or ashtrays.

Repeat violation:

Plan of Correction ***Accept 10/01/2025)***

On September 11, 2025, staff placed approved fireproof ashtrays at the temporary smoking area in front of the building.
On September 12, 2025, residents resumed use of the original designated smoking area, which includes all required fire safety features (fireproof receptacles, ventilation, extinguishers, and non-flammable surfaces).
A "Temporary Smoking Area Protocol" binder was created on September 12, 2025. This binder includes: A checklist of required safety items (fireproof receptacle, fire extinguisher access, safe distance from the building, appropriate signage). A log to record dates and times when the smoking area is relocated and the safeguards are confirmed in place. Staff sign-off to verify compliance whenever a temporary smoking area is established.
All direct care staff were educated on the "Temporary Smoking Area Protocol" on September 12, 2025, including procedures for: Setting up a temporary smoking area. Identifying fire safety requirements. Reporting and correcting

144c1 Smoking Area Guidelines (continued)

deficiencies immediately.
The House Manager or designee will conduct a weekly safety check of the smoking area(s), including receptacles, fire extinguishers, and overall conditions. Any construction or maintenance impacting the smoking area will trigger an automatic review and implementation of the temporary smoking protocol by the Program Administrator or Maintenance Supervisor.

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

Implemented [redacted] - 10/03/2025)

187a - Medication Record

3. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

The prescription medication [redacted], give 1 ML, once a month, is listed on resident [redacted] current medication administration record however, this medication was discontinued on [redacted].

Plan of Correction ***Accept ([redacted] - 10/01/2025)***

On September 11, the administrator called his doctor for clarification of the injection and received the discontinuation script. The script was sent to the pharmacy for the MAR to be updated. Avatar has been updated to reflect the discontinuation of [redacted] on AL's EMAR profile by the nurse.
The nurse will review the MAR monthly to ensure all medications that are seen on the eMar are on site.
For all discontinued medications, a written discontinuation order will be required and retained in the resident's chart.
Nurses will cross reference physician orders with the MAR during each monthly review.
On September 12, 2025, all nursing staff were trained during the staff meeting:
• The importance of promptly updating discontinued medications in the MAR/eMAR.
• Procedures for verifying physician orders before MAR updates.
• Monthly audit expectations and responsibilities.

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

Implemented ([redacted] - 10/03/2025)

187b - Date/Time of Medication Admin.

4. 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 [redacted] is prescribed [redacted] and [redacted]. Resident [redacted] August 2025 medication administration record does not include the initials of the staff person who administered [redacted], and [redacted] on [redacted] at 8:00 PM.

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

Plan of Correction ***Accept (- 10/01/2025)***

On September 12, 2025, all Direct Care and Medication Administration Staff completed a refresher training on medication documentation protocols, including proper eMAR/MAR signing procedures. Training emphasized that medications must be signed off immediately at the time of administration in accordance with regulation §2600.187(b). A corrective note was entered in the resident's record regarding the missed initials to maintain an accurate clinical history.
The Staff Task Sheet has been updated to include a specific item requiring staff to verify they have completed and initialed all medication entries at the time of administration. A second staff member (usually the shift lead or supervisor) will cross-check the MAR by end of shift.
Starting September 16, 2025, the Administrator will complete weekly spot-check audits of randomly selected resident MARs to verify staff compliance. Any discrepancies will be documented and addressed through individual coaching or corrective action if needed.
Staff participated in a formal in-service training on September 12, 2025, covering: The "Five Rights" of medication administration, Real-time documentation expectations, and Consequences of incomplete records.

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

Implemented 10/03/2025)

225c - Additional Assessment

5. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident most recent assessment was completed on . Resident has had several instances of increased agitation, irritability and aggression since June 2025; however, the resident was not reassessed, and their support plan was not updated to reflect these significant changes.

Plan of Correction ***Accept - 10/01/2025)***

On Sept 12, staff were retrained/ reminded to complete resident RASP on time, even if the resident is not on-site. The updated RASP includes documentation of recent behavioral changes and identifies appropriate interventions and supports to address the residents' increased agitation and aggression. The assessment was signed by both staff and management. The "Unable to Participate" box was checked, as the resident was not on-site at the time of the assessment.
On September 12, 2025, all relevant staff were retrained on the requirements of:
• §2600.225(c)(2): The need for reassessment when a resident's condition significantly changes.
• §2600.227(a): Updating support plans in response to assessment findings.
• Training emphasized the importance of timely documentation—even if the resident is off-site—and the use of the "Unable to Participate" option when necessary.
The Supervisor or Designee will perform monthly audits of all resident files to ensure that:

225c - Additional Assessment (continued)

• Annual reassessments are completed on time.

• Any observed or reported behavioral/medical changes trigger a reassessment and support plan update within 7 days.

Behavioral Change Tracking Log has been implemented, where staff are required to document incidents of increased behavioral symptoms (e.g., aggression, agitation). Any three incidents within 30 days or any single significant episode will trigger an automatic clinical review to determine if reassessment is warranted.

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

Implemented [redacted] - 10/03/2025)