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

January 30, 2026

[redacted]
ARDEN COURTS WARMINSTER OF HATBORO PA LLC
[redacted]

RE: ARDEN COURTS (WARMINSTER)
779 WEST COUNTY LINE ROAD
HATBORO, PA, 19040
LICENSE/COC#: 12996

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/30/2025 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: *ARDEN COURTS (WARMINSTER)* **License #**: *12996* **License Expiration**: *06/14/2026*

Address: *779 WEST COUNTY LINE ROAD, HATBORO, PA 19040*

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

Administrator

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

Legal Entity

Name: *ARDEN COURTS WARMINSTER OF HATBORO PA LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/05/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/30/2025*

Inspection Dates and Department Representative

09/30/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *60* **Residents Served**: *38*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *38*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *38*

Have Physical Disability: *0*

Inspections / Reviews

09/30/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2025*

11/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/14/2025*

Inspections / Reviews *(continued)*

11/17/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/29/2025*

01/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

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 home utilizes the "SafelyYou" fall monitoring system. On [redacted], this system recorded Staff Member B observing Resident [redacted] lying in Resident [redacted]s bed, appearing asleep. The staff member entered the room after receiving a complaint from Resident [redacted] observed resident [redacted] in the bed, and attempted to wake the resident. Staff Member B waved for Resident [redacted] to enter [redacted] room. Staff Member B then tilted the pillow and shook Resident [redacted]s head while attempting to arouse them. After several attempts, Resident [redacted] awoke and appeared agitated. Staff Member B, standing nearby, picked up a blanket and used it to swat Resident [redacted] who reacted by attempting to swat at Staff Member B with their hand. After resident [redacted] stood up, Staff Member B then grabbed the resident's arms and physically restrained them against the wall, holding both of their hands and continuing to physically restrain the resident while the resident struggled to release from their grasp. After briefly releasing Resident [redacted] the resident moved around the room, at which point Staff Member B again grabbed and restrained Resident [redacted] when [redacted] approached the staff. Staff Member B used a wheelchair that was present in the room to forcefully push Resident [redacted] toward the door. The staff member was able to push Resident [redacted] toward the wall and out of the room, during which time Resident [redacted] fell to the floor on their bottom. While Resident [redacted] remained on the floor in the doorway, Staff Member B stood over the resident and was seen making a kicking motion. Resident [redacted] returned kicks. Resident [redacted] scooted on [redacted] bottom into the hallway while Staff Member B remained standing in the room with their hands on their hips, then closed the door, leaving Resident [redacted] on the ground in the hallway.

Repeat Violation Date: [redacted] et al

Plan of Correction ***Accept ([redacted] - 11/17/2025)***

1. Staff member B was suspending pending investigation and ultimately terminated effective 9/29/2025. Resident 1 was assessed and noted with redness and swelling on [redacted] right knee. Xray completed and no injury was found.
2. On 9/26/25 residents on Staff Member B's assignment received a skin assessment by the nurse to ensure no additional signs of abuse were found.
3. The Resident Services Coordinator/designee will educate direct care staff (nurses, medication technicians and resident aids) on "Resident Protection" policy. Target date of completion for education is 11/20/25.
4. Executive Director/designee will audit staff interactions with residents 1x/week for 4 weeks to ensure residents rights are being followed starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/30/2026)

65a - FS Orientation 1st Day

2. Requirements

2600.

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

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 Member B, whose first day of work was [redacted], 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.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

1. Staff Member B is no longer employed at the community

2. Executive Director will audit current staff member files to ensure orientation on general fire safety and emergency preparedness was completed. Any identified employees missing training will be trained on general fire safety and emergency preparedness by 11/20/25

3. Executive Director educated the Administrative Services Coordinator on regulation 65a requirements of Orientation on day 1 of hire on 11/10/25

4. Executive Director/designee will audit new hire staff 1x/week for 4 weeks to ensure general fire safety and emergency preparedness training is completed on day 1 of employment starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] 01/30/2026)

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.

65b - Rights/Abuse 40 Hours *(continued)*

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 Member B completed [redacted] 40th scheduled work hour on approximately [redacted]; however, this staff person did not complete training in the following topics: Emergency Medical Plan

Plan of Correction ***Accept[redacted] - 11/17/2025)***

1. Staff Member B is no longer employed at the community
2. Executive Director will audit current staff member files to ensure orientation on general fire safety and emergency preparedness was completed. Any identified employees missing training will be trained on the Medical Emergency Plan by 11/20/25
3. Executive Director educated Administrative Services Coordinator on regulation "65a – Rights/Abuse 40 Hours" on 11/10/25
4. Executive Director/designee will audit new hire staff 1x/week for 4 weeks to ensure the Emergency Medical Plan training is completed within 40 hours of employment starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/30/2026)

183e - Storing Medications

4. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] the following medication cards were observed to have a punctured blister foil with the medication still present in the spot- exposing it to contamination or improper sanitation:

- [redacted]
- [redacted]
- [redacted]

Repeat Violation Date: [redacted] et al

Plan of Correction ***Accept[redacted] - 11/17/2025)***

1. Medications with punctured blisters for residents [redacted] and [redacted] were disposed of due to possible contamination or improper sanitation.
2. Resident Services Coordinator/designee audited current resident medications to ensure medications were stored correctly on 9/30/25.
3. Resident Services Coordinator/designee will educate Nurses and Medication Technicians on "Medication and Treatment Guidelines" policy by 11/20/25
4. Resident Services Coordinator/designee will audit medication storage 1x/week for 4 weeks to ensure resident medication is stored properly starting on the week of 11/3/25. Findings will be submitted to the QAPI committee

183e Storing Medications (continued)

meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] 01/30/2026)

184b - Labeling OTC/CAM

5. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], a package of [redacted] and a [redacted] were found in the medication cart and were not labeled with a resident's name.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

1. Medications [redacted] and [redacted] that were located in the medication cart without a resident name were disposed of.
2. Resident Services Coordinator/designee audited current resident medications were reviewed to ensure each is labeled with a resident name when stored in the medication cart.
3. Resident Services Coordinator will educate Nurses and Medication Technicians on "Medication and Treatment Guidelines" policy by 11/20/25
4. Resident Services Coordinator/designee will audit medication storage 1x/week for 4 weeks to ensure resident medication is stored and labeled properly starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/30/2026)

201 - Positive Interventions

6. Requirements

2600.
201. Safe Management Technique [redacted] home shall use positive interventions to modify or eliminate a behavior that endangers the resident [redacted] or others. Positive interventions include improving communications, reinforcing appropriate beha direction, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On [redacted] Resident [redacted] was sleeping in Resident [redacted]s bed. Staff member B responded by attempting to awake the resident by shaking the pillow under their head roughly until the resident roused. When the resident sat up in bed, the staff member used a blanket to swat Resident [redacted] who reacted by attempting to swat at Staff Member B with their hand. After resident [redacted] arose, Staff Member B then grabbed Resident [redacted]s arms and physically restrained them against the wall, holding both of their hands and continuing to physically restrain the resident while the resident struggled to release from their grasp. After briefly releasing Resident [redacted] the resident moved around the room, at which point Staff Member B again grabbed and restrained Resident [redacted] when [redacted] approached the staff. Staff Member B used a

201 Positive Interventions (continued)

wheelchair that was present in the room to forcefully push Resident [redacted] toward the door. The staff member was able to push Resident [redacted] toward the wall and out of the room, during which time Resident [redacted] fell to the floor on their bottom. While Resident [redacted] remained on the floor in the doorway, Staff Member B stood over the resident and was seen kicking or attempting to kick the resident with their foot. Resident [redacted] returned kicks, while seated on the floor, toward Staff Member B. Resident [redacted] still on the floor, scooted on [redacted] bottom into the hallway while Staff Member B remained standing in the room with their hands on their hips, then closed the door, leaving Resident [redacted] on the ground in the hallway.

Staff Member B did not use positive interventions to modify or eliminate a behavior that endangers the resident themselves or others.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

1. Staff member B was suspending pending investigation and ultimately terminated effective 9/29/2025. Resident 1 was assessed and noted with redness and swelling on [redacted] right knee. Xray completed and no injury was found.

2. On 9/26/25 residents on Staff Member B's assignment received a skin assessment by the nurse to ensure no additional signs of abuse were found.

3. Resident Services Coordinator/designee will educate direct care staff (nurse, medication technician and resident aids) will be educated on "Increased Behavior Monitoring" policy by 11/20/25

4. Executive Director/designee will audit staff interactions with residents 1x/week for 4 weeks to ensure positive interventions are being used starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] 01/30/2026)

202 - Prohibitions

7. Requirements

2600.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.

202 - Prohibitions *(continued)*

6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move [redacted] arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompti[redacted] escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [redacted] Staff Member B grabbed Resident [redacted]s arms and physically restrained them against the wall, holding both of their hands and continuing to physically restrain the resident while the resident struggled to release from their grasp. After briefly releasing the resident, the resident moved around the room; Staff Member B again grabbed and restrained Resident [redacted] in the same manner when the resident approached the staff. Staff Member B used a wheelchair that was present in the room to forcefully push Resident [redacted] toward the door and out of the room.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

1. Staff member B was suspending pending investigation and ultimately terminated effective 9/29/2025. Resident 1 was assessed and noted with redness and swelling on [redacted] right knee. Xray completed and no injury was found.
2. On 9/26/25 residents on Staff Member B's assignment received a skin assessment by the nurse to ensure no additional signs of abuse were found.
3. Resident Services Coordinator/designee will educate direct care staff (nurse, medication technician and resident aids) on regulation 202 – Prohibitions by 11/20/25
4. Executive Director/designee will audit staff interactions with residents 1x/week for 4 weeks to ensure positive interventions are being used starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/30/2026)

231b - Medical Evaluation

8. 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 [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation was completed on [redacted]

Plan of Correction ***Accept [redacted] - 11/17/2025)***

1. Resident [redacted] medical evaluation was unable to be corrected as it is outside of the required timeline
2. Executive Director reviewed current resident medical evaluation on move in for compliance on 11/6/25. Any identified residents outside of the required timeline were unable to be fixed due to the time requirements of completion.

231b Medical Evaluation (continued)

3. Executive Director educated the Memory Care Advisor on regulation 231b Medical Evaluations on 11/7/25

4. Executive Director/designee will audit new resident move ins 1x/week for 4 weeks to ensure the medical evaluation is completed timely starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/30/2026)

252 - Record Content

9. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [redacted] record does not include a photograph of the resident that is no more than 2 years old..

252 - Record Content *(continued)*

Plan of Correction ***Accept [redacted] - 11/17/2025)***

1. Resident[redacted] photo was retaken on 9/30/25 and placed in the resident chart

2. Executive Director reviewed current resident photos on 11/5/25 to ensure they are no more than 2 years old.

3. Executive Director educated the Resident Services Coordinator and Life Enrichment Coordinator on regulation 252 – Resident Content on 11/6/25

4. Executive Director/designee will audit 5 resident photos 1x/week for 4 weeks to ensure the photos are no more than 2 years old starting on the week of 11/3/25. Findings will be submitted to the QAPI committee meeting on 11/28/25 for review and recommendations. The Executive Director will be responsible for submitting and reviewing the findings.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/30/2026)