

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

December 10, 2025

[REDACTED], MANAGER OF GENERAL PARTNER
CSW ARBOUR SQUARE V HUNTINGDON VALLEY, L.P.
[REDACTED]
[REDACTED]

RE: CRESCENT FIELDS AT
HUNTINGDON VALLEY
2507 PHILMONT AVE
HUNTINGDON VALLEY, PA, 19006
LICENSE/COC#: 15005

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/06/2025, 10/07/2025 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: CRESCENT FIELDS AT HUNTINGDON VALLEY License #: 15005 License Expiration: 06/28/2026
Address: 2507 PHILMONT AVE, HUNTINGDON VALLEY, PA 19006
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: CSW ARBOUR SQUARE V HUNTINGDON VALLEY, L.P.
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 06/07/2023 Issued By: Lower Moreland Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 110 Waking Staff: 83

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint, Incident Exit Conference Date: 10/07/2025

Inspection Dates and Department Representative

10/06/2025 - On-Site: [REDACTED]
10/07/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	149	Residents Served:	81
Secured Dementia Care Unit			
In Home:	Yes	Area:	1st Floor
Capacity:	19	Residents Served:	18
Hospice			
Current Residents:	9		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	81
Diagnosed with Mental Illness:	12	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	29	Have Physical Disability:	1

Inspections / Reviews

10/06/2025 - Full
Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/06/2025

11/13/2025 - POC Submission
Submitted By: [REDACTED] Date Submitted: 12/09/2025
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 12/10/2025

Inspections / Reviews *(continued)*

12/10/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/09/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

65f - Training Topics

1. 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 during training year 2024.

Plan of Correction

Accept (█ - 11/13/2025)

The health care director trained staff person A on medication self-administration 2600.65.f. on 10/29/25.

By 10/31/25 the business office manager to audit direct care staff 2024 training files for medication self-administration. Associates in need of training, will be trained by 11/8/25 by health care director.

By 10/29/25, the administrator shall educate health care director/business office manager on regulation 2600.65f, documentation shall be kept.

Beginning 10/15/25, the administrator or designee will review all new hired direct care staff's training material for medication self-administration training in first 40 hours for 4 weeks.

To ensure consistent adherence to Regulation 2600.65f, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.65f.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

65g - Annual Training Content

2. 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 A 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 training year 2024.

65g - Annual Training Content (continued)

Staff person B did not receive training in fire safety or falls and accident prevention during training year 2024.

Plan of Correction

Accept (█ - 11/13/2025)

Both staff person A and B were trained by a fire safety expert in 2024 on 8/15/24, documentation to be submitted.

Staff Person B was trained in 2024 for falls and accident prevention on 8/15/2024, documentation to be submitted.

By 11/5/25, the Business office manager will audit all employee 2024 training files to ensure fire safety and falls, and accident prevention have been completed by all employees. Associates in need of training, will be trained by 11/15/25 maintenance director (fire expert).

By 10/30/25, the administrator shall educate business office manager on regulation 2600.65g, documentation shall be kept.

Beginning 11/5/25, the administrator or designee will review new hired direct care staff training material for medication self-administration training in first 40 hours for 4 weeks.

To ensure consistent adherence to Regulation 2600.65f, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.65f.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

105g - Lint Removal and Duct Cleaning

3. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 10/6/2025 at 10:06am, there was a thick accumulation of lint in the lint trap of one of the dryers in the secure dementia care unit. There were no clothes in the dryer at the time.

Plan of Correction

Accept (█ - 11/13/2025)

On 10/7/25, dryer lint was cleaned out immediately after finding by administrator.

On 10/30/29, the maintenance director trained all staff from SDU on 2600.105.g. Documentation shall be kept.

Beginning 11/5/25, the memory care director or designee will monitor and document lint traps for cleanliness daily, for 4 weeks to assure compliance.

To ensure consistent adherence to Regulation 2600.105g, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.105g.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

132d - Evacuation

4. Requirements

132d - Evacuation (continued)

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 7/30/2025 at 9:00 pm, the home took 14 minutes and 15 seconds to evacuate all residents to a fire safe area. The home has a maximum safe evacuation time of 12 minutes, specified in writing on 6/24/2025 by a fire safety expert.

Plan of Correction

Accept (█ - 11/13/2025)

On October 9, 2025, maintenance director reached out to █ for additional training due to the 14 minutes and 15 seconds timing written on the report. █ stated that it was a mistake, it should have been documented as 4 minutes and 14 seconds as per the instructor conducting the fire drill. A letter and corrected time were sent to the community on October 10, 2025. Documentation shall be submitted.

Beginning 10/30/25, the maintenance director or designee will monitor all evacuation times to assure they are within the designated times over the next two months. In addition, by 11/15/25, the maintenance director (Fire Expert) will in-service current associates on the importance of evacuation times 2600.132.d. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.132d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.132d.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #1's medical evaluation, dated █ indicated that the resident had no needs related to body positioning/movement. However, resident #1 uses a wheelchair and a walker.

141a 1-10 Medical Evaluation Information (continued)

Resident #2's medical evaluation, dated [REDACTED], does not indicate whether the resident's needs can be met safely in the home. The person who completed the form also did not check the boxes to indicate they were a medical professional in good standing and that the information in the form was generated based on their evaluation.

Resident #3's medical evaluation, dated [REDACTED] did not list the assistive devices, i.e. walker and wheelchair, used for assistance with transfers.

Plan of Correction

Accept ([REDACTED] - 11/13/2025)

Resident # 1's physician was contacted by health care director, on 10/10/25 updates were made to DME by health care director to reflect use of a walker and wheelchair.

Resident #2's Physician was contacted by health care director, on 10/10/25 updates were made by health care director to reflect the needs of the resident can be met safely in the home, also to confirm they are a medical professional in good standing and the information on the form was generated based on their evaluation.

Resident # 3's Physician was contacted by Health Care Director, on 10/10/25 updates were made by health care director to reflect assistive devices used for assistance with transfers.

On 10/29/25, the administrator in-serviced health care director and memory care director on 2600.141a 1-10. Documentation shall be kept.

By 11/5/25, the health care director or designee will audit resident charts for missing items on medical evaluation. Any findings to be corrected at time of audit.

Beginning 11/5/25, new residents will be audited for completed medical evaluations over the next 2 months by the health care director.

To ensure consistent adherence to Regulation 2600.141a 1-10, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.141a 1-10.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented ([REDACTED] - 12/10/2025)

162c - Menus Posted

6. 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 10/6/2025 at 10:15am, the home's menu for 5/11 to 9/27/2025 was posted. The menu for the current and following week were not posted. Menus dated for Fall-Winter 2024-2025 were posted on the first floor in the Secure Dementia Care Unit and in the 2nd-floor dining room.

Plan of Correction

Accept ([REDACTED] - 11/13/2025)

Our Head Chef posted new menus in every dining room on 10/6/25 consisting of additional 2-week period.

Our new 5-week cycle fall menu then started on 10/19/25 and was posted in all dining rooms by the Head Chef.

The administrator in-serviced the head chef and the dining room supervisor on 2600.162.c on 11/3/25, documentation shall be kept.

Beginning 11/5/25, the administrator or designee will monitor that menu are posted correctly in all dining rooms weekly for 4 weeks.

162c - Menus Posted (continued)

To ensure consistent adherence to Regulation 2600.162c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.162c.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█) - 12/10/2025

185a - Implement Storage Procedures

7. 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 #4 is prescribed .5-MG Lorazepam tablets every six hours as needed. On 10/7/2025 at approximately 9:45 am, this medication was not available in the home.

Plan of Correction

Accept (█) - 11/13/2025

On 10/7/25, the Health Care Director found resident #4 medication in a small zip lock bag in the bottom of narc drawer on the cart.

Beginning 11/1/25, the health Care Director implemented a basket to hold medications in small zip lock baggies on the cart in Narc drawer.

By 10/29, the health care director in-serviced all medication aides and nurses on 2600.185.a. Documentation shall be kept.

Beginning 11/5/25, the health care director or designee to audit carts weekly for all prn medicines for 4 weeks.

To ensure consistent adherence to Regulation 2600.185a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.185a.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█) - 12/10/2025

187a - Medication Record

8. Requirements

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

187a - Medication Record (continued)

- 10. Duration of therapy, if applicable.
- 11. Special precautions, if applicable.
- 12. Diagnosis or purpose for the medication, including pro re nata (PRN).
- 13. Date and time of medication administration.
- 14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5 is prescribed a daily injection of insulin from a Kwikpen before bedtime, with the sliding-scale dosage dependent on the resident's blood sugar. However, on 10/7/2025, resident #5's medication administration record did not contain a space to indicate the number of units given for any dates.

Plan of Correction

Accept (█ - 11/13/2025)

Health care director contacted ECP on 10/7/25 after speaking with surveyor, ECP educated the healthcare director on the process for insulin order entry to include documentation of number of units. The Healthcare Director corrected resident #5 Kwikpen order.

By 10/7/25, the Healthcare Director to audit remaining insulin orders on MARs to ensure area to properly document. Additional findings to be corrected at time of audit.

On 10/30/25, the health care director to in-service all medication aides and nurses how to document in ECP as it relates to 2600.187.a. Documentation shall be kept.

Beginning 11/5/25, the health care director or designee to audit MAR for proper documentation of units given for 4 weeks, then monthly X 2 months.

To ensure consistent adherence to Regulation 2600.187a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25 documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.187a.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

187b - Date/Time of Medication Admin.

9. 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 #6 is prescribed one .25-MG Alprazolam tablet twice a day as needed. The home's narcotic log indicates that resident #6 received this dose on 8/28/2025 at 8:25 pm, but the resident's medication administration record (MAR) does not indicate which staff person administered it. The narcotic log indicates the resident received doses on 8/29/25 at 8:59 am and 7:33 pm, but these administrations are not recorded on the MAR.

Plan of Correction

Accept (█ - 11/13/2025)

By 11/8/25, the Healthcare Director to audit remaining residents receiving narcotic medications for proper MAR documentation by comparing narcotic sign out sheets to the MAR. Any additional findings shall be corrected at time of audit.

On 10/30/25, the health care director in-serviced all medication aides and nurses on 2600.187.b for proper documentation in MAR. Documentation shall be kept

Beginning 11/5/25, the health care director or designee to audit MARs for proper documentation of narcotics given for 4 weeks, then monthly X 2 months.

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

To ensure consistent adherence to Regulation 2600.187b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.187b.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

225a - Assessment 15 Days

10. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3's initial assessment, dated █ indicated the resident is independent with bladder and bowel management. However, the resident was incontinent and wore incontinence products in the home.

Repeat Violation Date: 9/30/24 et al.

Plan of Correction

Accept (█ - 11/13/2025)

Resident # 3 no longer resides in the community, unable to correct resident's assessment/support plan.

On 10/30/25, the administrator in-serviced health care director and memory care director on 2600.225.a.

Documentation shall be kept.

By 11/5/25, the Healthcare Director or designee shall audit current residents assessments/support plans for accuracy. Beginning 11/5/25, the administrator or designee to audit assessments on all new move-ins and annual assessments over the next two months for accuracy.

To ensure consistent adherence to Regulation 2600.225a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.225a.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█ - 12/10/2025)

225c - Additional Assessment

11. 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

The assessment for resident #4, dated █ indicates the resident has no dietary needs. However, the resident's medical evaluation, also dated █, states that resident #4 requires a heart-healthy, mechanical-soft diet.

225c - Additional Assessment (continued)

Repeat Violation Date: 9/30/24 et al.

Plan of Correction

Accept (█) - 11/13/2025

On 10/7/25, resident # 4 assessment was corrected by health care director to reflect the current dietary needs. On 10/30/25, the administrator in-serviced health care director and memory care director on 2600.225.c, documentation shall be kept.

By 11/5/25, the Healthcare Director or designee shall audit current residents assessments/support plans for accuracy in comparison the DME.

Beginning 11/5/25, the administrator or designee to audit assessments on all new move-ins and annual assessments over the next two months, to assure they match the DME.

To ensure consistent adherence to Regulation 2600.225c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.225c.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█) - 12/10/2025

231c - Preadmission Screening

12. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #7 was admitted to the secure dementia care unit on █. However, the resident's written cognitive preadmission screening was completed on █ more than 72 hours prior to admission.

Repeat Violation Date: 9/30/24 et al.

Plan of Correction

Accept (█) - 11/13/2025

Resident # 7 prescreen was corrected by Memory Care Director on 10/7/25. Documented on the form that found at time of survey/ POC. Documented the prescreen as seen on day of admission by Memory Care director.

On 11/5/25, the Healthcare Director or designee shall audit remaining memory care residents prescreen forms for proper completion, any further findings to be noted at time of audit.

On 10/30/25, the administrator in-serviced health care director and memory care director on 2600.231.c, documentation shall be kept.

Beginning 11/5/25, the administrator or designee will audit all new move-ins prescreens for memory care over a 2-month period.

To ensure consistent adherence to Regulation 2600.231c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.231c.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (█) - 12/10/2025

234d - Support Plan Revision

13. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #8 was completed on [REDACTED] indicating the resident had no problem with irritability, agitation, or aggression. On [REDACTED] at 3:10 pm, resident #8 struck resident #9 on the left arm, grabbed and twisted resident #10's arm, and struck resident #11 on the back. Resident #8 was then assigned one-to-one supervision. However, resident #8 did not receive an updated support plan until [REDACTED], more than three months after the incident.

Plan of Correction

Accept ([REDACTED] - 11/13/2025)

As of 5/20/25, Resident #8's support plan was updated to reflect current behavioral needs, including interventions for agitation and aggression. All staff were informed of the revised plan and provided instruction on implementing the updated interventions. Going forward, beginning 11/5/25, any change in resident condition (behavioral, medical, or functional) will be noted by the Healthcare Director or designee's daily review of the 24 hour report, this will trigger an immediate reassessment and support plan revision within 48 hours of the change.

The Administrator and Resident Care Director reviewed all current memory care residents' files to ensure each support plan accurately reflects the resident's current condition and is updated as needed. This review was completed on 10/29/25.

On 10/30/25, the administrator in-serviced the health care director and memory care director on 2600.234.d. Documentation shall be kept.

Beginning 11/5/25, the health care director or designee to audit any new changes in condition to ensure they are noted on support plan, this audit to occur weekly over the next 4 weeks.

To ensure consistent adherence to Regulation 2600.224d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 12/31/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.224d.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented ([REDACTED] - 12/10/2025)