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

June 4, 2026

[redacted]
BRISTOL HOUSE MEMORY CARE LLC
[redacted]

RE: BRISTOL HOUSE MEMORY CARE
2527 BRISTOL ROAD
WARRINGTON, PA, 18976
LICENSE/COC#: 14458

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/21/2025 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: *BRISTOL HOUSE MEMORY CARE* **License #**: *14458* **License Expiration**: *02/21/2026*

Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*

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

Administrator

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

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/19/2019* **Issued By**: *Warrington Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *10/21/2025*

Inspection Dates and Department Representative

10/21/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *48* **Residents Served**: *36*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *35*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *36*

Have Physical Disability: *0*

Inspections / Reviews

10/21/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/29/2025*

12/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/25/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/07/2025*

Inspections / Reviews *(continued)*

03/12/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/05/2025*

Reviewer: [redacted] **Follow Up Type:** *Bypass Document Submission*

06/04/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *03/12/2026*

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

While walking back to their apartment on [redacted], Resident [redacted] was approached by Resident [redacted] from behind. Resident [redacted] pushed the resident and then grabbed their left hand and twisted the resident's fingers, dislocating the left ring finger which required treatment at a hospital. Resident [redacted] was assessed by EMS and sent to a behavioral health unit. Resident [redacted] has a documented history of physical and verbal abuse toward staff members at the home. On [redacted], the resident became physically aggressive with a staff member and hit them in the head. On [redacted] the resident slammed a staff member's foot in a door causing injuries. On [redacted], the resident put their hands on another staff member. On [redacted] and [redacted], the resident became verbally aggressive and threatened staff members and continuously resisted care. After staff injected the resident with diabetic medications with a reusable injector, the resident would grab the injector and refuse to give it back to the staff. The local police responded to the home to assist with this resident's behaviors on [redacted] and [redacted]. Resident [redacted] support plan, dated [redacted], indicates Resident [redacted] requires moderate supervision while in the home, can be easily upset and agitated toward staff and can make decisions that are harmful to self and others.

Plan of Correction ***Accept [redacted] - 12/08/2025)***

Request removal of violation.
Resident [redacted] had never been aggressive with other residents only with staff. We as a community did what was recommended prior by DHS which was behavior modification in how Resident [redacted] was approached by staff. Up until this incident Resident [redacted] had been more cooperative with staff. But we felt that resident was not appropriate for a secure dementia community and had several failed attempts to remove [redacted] from the building and also issued a 30-day notice. However, resident [redacted] refused to get on transport to go to the BHU and police stated they could not force [redacted] to go. It was not until this incident occurred that we were able to have [redacted] removed from the building. As a community we did all that could be done under these circumstances.
1. DON immediately transferred resident to a BHU for treatment. Resident will not readmit to community.
2. Admission criteria and discharge criteria will be reviewed by ED/DON/RCC and updated to include verbiage on residents with aggressive or noncompliant behavior by 11/30/2025.
3. ED will educate DON/RCC on any new admission/discharge criteria by 11/30/2025
4. All residents will be required to have an appropriate dementia diagnosis prior to being admitted to the community.
5. All resident move in assessments will be reviewed by DON/ED/RCC prior to acceptance to community to ensure admission criteria is met beginning 11/19/2025.
6. Resident RASPS will include comprehensive plans to ensure behavior needs are met, as needed. Updates will be made as necessary.
7. Admissions and care needs will be reviewed with ED by DON at quarterly QA meeting on Jan 19,2026 meetings.

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

Implemented [redacted] - 03/12/2026)

65a - FS Orientation 1st Day

2. Requirements

2600.

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 person A, whose first day of work was [redacted], did not receive orientation on the following topics: Evacuation procedures; staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; the designated meeting place outside the building or within the fire-safe area in the event of an actual fire; smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable; the location and use of fire extinguishers; smoke detectors and fire alarms; telephone use and notification of emergency services

Staff person B, whose first day of work was [redacted] did not receive orientation on the following topics: Evacuation procedures; staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; the designated meeting place outside the building or within the fire-safe area in the event of an actual fire; smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable; the location and use of fire extinguishers; smoke detectors and fire alarms; telephone use and notification of emergency services

Plan of Correction ***Accept [redacted] 12/08/2025)***

Staff person A and Staff person B did have all the required training per regulation 65a on their first day of New Hire Orientation. Description of such training was not specific enough on the forms used to sign off on the training on day one of orientation.

Form for New Hire Orientation was revised by Executive Director to be more specific outlining all topics for regulation 65a and documented for Both Staff Persons A and B.

To prevent future violations revised new hire orientation form to be used for all new hires.

Staff person A re-educated on Evacuation procedures; staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; the designated meeting place outside the building or within the fire-safe area in the event of an actual fire; smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable; the location and use of fire extinguishers; smoke detectors and fire alarms; telephone use and notification of emergency services on 11/25/25 and documentation of training maintained in employee file.

Staff person B terminated as of 10/24/25

Executive director educated Business office Manager and business office assistant on11/25/2025 on use of revised form.

All staff training documents were audited by the Business Office Assistant and completed in 10/2025 as part of prior POC to ensure that all staff meet 65a

To prevent future violations new orientation form to be utilized to ensure regulation is met.

Business Office Manager will audit on new employee documentation after 1st day of orientation to ensure

65a - FS Orientation 1st Day (continued)

completion per state regulation

Licensee's Proposed Overall Completion Date: *12/07/2025*

Implemented [redacted] - 03/12/2026)

65e - 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person C, hired [redacted], received 0 hours of annual training in training year 2024.

Repeat Violation Date: [redacted]

Plan of Correction ***Directed [redacted] - 12/08/2025)***

1. On 10/13/2025 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 65 e to ensure compliance. Business Office Assistant, will complete audit on all staff training hours of in person/online Relias training. Audit of employee training was completed by 10/24/2025 to ensure compliance will be met by all staff by 12/31/2025.
Staff person C has completed all required training per regulation 65e for training year 2025.
2. On 10/15/2025 at All Staff meeting, Executive Director educated all staff on the yearly requirement for training and their responsibility to complete online and in person training per the Staff Annual Training Plan.
3. To prevent future violations effective 10/2025 Monthly Audit to be completed by Business Office Assistant to ensure all staff completed scheduled monthly in-person and online Relias training to ensure all staff are current with training completed according to annual training plan and per regulation 65e 12 hours of Annual Training.
Department Supervisor to be notified of any staff member out of compliance to ensure completion of Training.

Proposed Overall Completion Date: 12/07/2025

Directed Plan of Correction [redacted] - 12/8/25)

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall provide an additional 12 hours of remedial education to staff person C to make up for missed training in 2024.

Directed Completion Date: *12/24/2025*

Implemented [redacted] - 03/12/2026)

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.

131f - Fire Extinguisher Inspection *(continued)*

Description of Violation

On [redacted] the fire extinguisher located in the hallway outside of the Goldfinch medication room did not have an inspection tag present.

Repeat Violation Date: [redacted]

Plan of Correction ***Accept [redacted] - 12/08/2025)***

Violation occurred due to delay in receiving extra inspection tags for Fire Extinguishers to replace as needed and upon inspection.
On 10/22 Maintenance tech replaced inspection Inspection sticker and ED who is fire safety certified inspected fire extinguisher tag and initialed the tag.
Repeat violation from 9/2025 inspection and the following was completed.
1. On 10/13/25 Executive Director Educated Maintenance Person, Director of Nursing, Business Office Manager, Business office Assistant, Activities Director on regulation 131 f and to notify Executive Director if inspection stickers are removed.
3. To prevent further violations the Maintenance person and/or designee will provide monthly audit of fire extinguishers effective 10/2025 and monthly ongoing to ensure inspection tag is intact per regulation 131f. Monthly Inspection sheet to be retained in Fire Safety Binder.,
November inspection to be completed on 11/27/2025

Licensee's Proposed Overall Completion Date: *12/07/2025*

Implemented [redacted] 03/12/2026)

183e - Storing Medications

5. 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], one white, oblong pill was observed loose in the "Blue Jay" medication cart.

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]

Plan of Correction ***Accept [redacted] - 12/08/2025)***

1.Director of Nursing corrected on sight during inspection by disposing of blister packed medication that was found to have a punctured blister foil and removed and properly disposed of loose pill in "Blue Jay" Medcart.
2. Director of Nursing will provide education to med techs on 11/25/2025 on Regulation 183e and proper process and protocol for med cart audit.

183e - Storing Medications (continued)

3.Director of nursing/RCC/med Tech to complete weekly med cart audits for 4 weeks, and monthly thereafter. Documentation will be kept
4. Pharmacy nurse liaison will begin to provide a secondary monthly med cart audit starting 11/25/2025 for 6 months
5.DON Will review med cart audit findings and education needs Quarterly at QA meetings. Next meeting to be held on 1/19/2025

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

Implemented [redacted] - 03/12/2026)

234b - Support Plan Needs Elements

6. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident [redacted] assessment and support plan, dated [redacted], does not include an assessment of Personal Hygiene, Managing Healthcare, Securing Healthcare, Doing Laundry, or Shopping, though it is indicated that the resident requires assistance in these areas. The home did not develop a plan to meet these needs.

Repeat Violation Date: [redacted]

Plan of Correction ***Accept [redacted] - 12/08/2025)***

1. Violation Corrected at time of inspection. Director of Nursing updated resident [redacted]'s RASP to include Personal Hygiene, Managing Healthcare, Securing Healthcare, Doing Laundry, or Shopping, with a written plan to meet these needs.
2. ED educated DON/RCC on regulation 234(b) on 11/19/2025
3. RASPS will be completed by DON/RCC within 72 hours of admission as per regulation
4. DON/RCC to complete 100% audit of all RASPs by 12/5/2025
5. DON/RCC will complete a 10% audit of resident charts monthly for 6 months to ensure accuracy and completeness of RASPS. Documentation will be kept
6. Community will be upgrading to electronic health records as of 12/4/2025 under the direction of the DON. Electronic compliance documents will be department forms
7. Audits will be reviewed with ED by DON at Quarterly QA meeting on 1/19/2025

Licensee's Proposed Overall Completion Date: *12/04/2025*

Implemented ([redacted] 03/12/2026)

236 - Staff Training

7. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

236 - Staff Training *(continued)*

Description of Violation

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU) had only 2 hours of training in dementia care during the 2024 training year.

Repeat Violation Date: [redacted]

Plan of Correction ***Accept*** [redacted] ***12/02/2025)***

On 9/16/25 we had our annual licensing inspection and received this same violation for dementia care training during the 2024 training year, and the follow was put in place.

1. On 10/13/2025 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 236 Staff training and process to ensure compliance going forward.
2. On 10/15/2025 All staff educated on the yearly requirement for training and their responsibility to complete online and in person training per the Staff Annual Training Plan.
3. To prevent future violations Monthly Audit to be completed by Business Office Assistant effective 10/2025 and monthly ongoing to ensure all staff completed scheduled monthly in-person and online. Audit of employee training was completed by 10/24/2025 to ensure compliance with regulation 236. A list of staff missing training will be provided to department supervisors to ensure completion and full compliance by 12/31/2025.

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

Implemented [redacted] ***- 03/12/2026)***

252 - Record Content

8. 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.

252 Record Content *(continued)*

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]s record does not include their most recent support plan.

Plan of Correction ***Accept [redacted] - 12/08/2025)***

1. Original RASP was found by DON in filing and provided to surveyor prior to exit interview.

2. All filing was completed on 10/22/2025 by DON

2. DON/RCC/designee will ensure all filing is completed within 48 hours of receipt of any documentation

3. ED educated DON/RCC on regulation 252 on 11/19/2025

4. DON/RCC will complete 10% audit of resident charts monthly for 6 months to ensure all regulatory pieces are present. documentation will be kept

5. Audits will be reviewed with ED at quarterly QA meeting on 1/19/2025

Licensee's Proposed Overall Completion Date: *12/02/2025*

Implemented[redacted] - 03/12/2026)