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

January 5, 2026

[redacted]
OXFORD PERSONAL CARE LLC
[redacted]

RE: OXFORD CROSSINGS
310 EAST WINCHESTER AVENUE
LANGHORNE, PA, 19047
LICENSE/COC#: 14858

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/27/2025, 10/29/2025, 10/30/2025 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: *OXFORD CROSSINGS* **License #**: *14858* **License Expiration**: *11/14/2025*

Address: *310 EAST WINCHESTER AVENUE, LANGHORNE, PA 19047*

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

Administrator

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

Legal Entity

Name: *OXFORD PERSONAL CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *121* **Waking Staff**: *91*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *10/30/2025*

Inspection Dates and Department Representative

10/27/2025 - On-Site: [redacted]

10/29/2025 - On-Site:

10/30/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *116* **Residents Served**: *84*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Aria* **Capacity**: *27* **Residents Served**: *17*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *80*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *37* **Have Physical Disability**: *0*

Inspections / Reviews

10/27/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/14/2025*

12/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/31/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/16/2026*

Inspections / Reviews *(continued)*

01/05/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/31/2025*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted] at 9:27 am, an agent of the Department, requested access to the internal investigation file and assignment sheets. Staff person A did not provide the documents until 12:25 pm.

On [redacted], at 10:45 am, an agent of the Department, requested access to staff records. Staff person A did not provide the documents until 12:25 pm.

On [redacted], at 11:33 am, an agent of the Department, requested access to resident files. Staff person A did not provide the documents until 1:35 pm.

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

1. The administrator and the DON that was employed at the time of this survey are not with Oxford Crossing anymore
2. All remaining department heads have been educated on providing access in a timely manner to the department.
3. DHS Binder, Policy Binder, CPR Binder, Fire Drill Binder, Education Binders, have all been created and will be given the state upon their arrival.
4. The administrator will monitor the binders make sure they are kept up to date.
5. Any other information requested by the state will be given to by the administrator and/or designee to the inspectors as soon as possible.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ([redacted] - 01/05/2026)

15c - Supervision

2. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted] at 10:50 pm, resident [redacted] made a report alleging abuse involving staff persons B, C, D, and E. The staff were suspended on [redacted] and returned to work on [redacted] without an approved plan of supervision.

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

1. The administrator and the DON that was employed at the time of this survey are no long with Oxford Crossing.
2. All remaining department heads have been educated on suspension for alleged abuse and contacting the department for guidance before employees return from suspension.
3. The administrator will sign the suspension form before anyone is brought back
4. The administrator or designee will ensure compliance

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] 01/05/2026)

15c - Supervision *(continued)*

17 - Record Confidentiality

3. 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

On [redacted] at 9:36 pm, the Director of Wellness's office door was propped open and resident records were unlocked, unattended, and accessible.

On [redacted], staff interviews revealed that activities held in the secured dementia care unit are being recorded on the staff person's personal cellphone, stored on the phone and shared via "WhatsApp" with staff. The videos stored on the staff person's phone were dated August 26, 2025, to current.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The office door was immediately shut
2. The administrator and the DON that was employed at the time of this survey are no long with Oxford Crossing.
3. All staff has been educated on record confidentiality and no doors that contain residents private information will be propped open at any time.
4. All department heads will monitor areas of the community during rounds for any unauthorized record access.
5. Activity staff was brought into the Human Resources office and they deleted all the pictures off the personal cell phones immediately.
6. All staff has Ipads and all resident photos to be posted on WhatsApp will be taken with the Ipad and the Ipad left in the community at all times.
7. A policy will be implemented in reference to front line employee cell phone use
7. Administrator and Activities Director to monitor

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

42b - Abuse

4. 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

On [redacted], at 6:15 pm, resident [redacted], who resides in the home's secured dementia care unit (SDCU), exited through the window of an unlocked and unoccupied bedroom. On [redacted] resident [redacted] was asking staff about the parking lot. Staff person D showed the resident a window close to the parking lot in hopes that the resident would realize

42b Abuse (continued)

[redacted] was home. Staff person F was notified by a family member that was visiting another SDCU resident that resident [redacted] was outside walking on the street unsupervised. Staff person F located the resident outside leaning against a dumpster in the home's parking lot. Staff person F stated that resident [redacted] stated that [redacted] broke out of jail through the window. Staff person F assisted in redirecting the resident back into the building and assessed the resident's status. No apparent injury was suffered.

The resident was outside the SDCU, according to staff person, wearing a jacket, shirt jeans, hearing aids, and glasses for 10 to 15 minutes. On [redacted], resident [redacted] showed Staff person F that [redacted] was successful at exiting the SDCU through the window by bending the metal latch on the window and opening it. The window is facing a parking lot with the speed limit of 15 mph. Streets surrounding the home are Winchester Avenue and Pine Street with speeds from 30 to 40 mph. Resident [redacted]s assessment and support plan (RASP), dated [redacted], indicates the resident requires extensive supervision and is high functioning. Staff interviews report the resident has consistent exit seeking behaviors; however, the resident's RASP dated [redacted] did not include this need or a plan to meet this need.

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

1. The resident was immediately returned to the facility
2. The unlocked room was locked.
3. The administrator and DON are no longer with the community
4. An Elopement Drill was done and training done with the staff
5. Elopement Drills will be held every other month moving forward for one year
6. The Administrator and Maintenance Director will conduct and monitor the drills
7. An audit of all windows in MC was conducted and windows have been permanently locked.
8. The MC director and/or designee will do window checks during room rounds daily.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

42c - Treatment of Residents

5. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], during staff interviews resident [redacted] was referred to as "creepy."

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. Staff were trained on dignity and respect
2. The administrator will do dignity and respect training at the Town Hall monthly for three months
3. Dignity and respect training will continue to be done annually
4. Leadership will observe all staff for positive interactions with residents
5. Any negative interaction or suggestion will be subject to disciplinary action
6. Annual training will be reviewed by the administrator and/or designee monthly

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ([redacted] - 01/05/2026)

42o - Associate/Communicate

6. Requirements

2600.
42.o. A resident has the right to freely associate, organize and communicate with others privately.

Description of Violation

Resident [redacted] was told by an unknown staff person that [redacted] could not be friends with Resident [redacted].

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. Staff were trained on resident rights and boundaries
2. The residents are still friends and have confirmed that the relationship is consensual.
3. Administrator had a meeting with the residents daughter who stopped in to ask when the state was going to do something about [redacted] family members friendship and is against the relationship.
4. It was explained that residents have the right to be friends as long as it is a mutual agreement and it is.
5. The daughter was very unhappy with that answer and said [redacted] will move [redacted] family member
6. Administrator explained that as the resident has rights we will not be interfering in their relationship.
7. It is [redacted] and [redacted] family members right to move if they chose to do so
8. Administrator is monitoring to make sure that the relationship is not interfered with by the community.
9. Resident rights training will continue to be done annually
10. Annual training will be reviewed by the administrator and/or designee monthly

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

42s - Privacy

7. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted] resident [redacted] stated that their family member disclosed to them that an unknown staff person refused to assist resident [redacted] with showering because the resident was being inappropriate. During staff interview on [redacted], it was disclosed that [redacted] talked with resident [redacted] family and told them to be careful with resident [redacted].

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. Training was done on resident rights and privacy
2. Training will be done monthly in Town Hall for three months
3. Administrator or designee will do the training
4. Moving forward the resident rights and privacy training will continue to be done annually
5. Staff will look for any breach in privacy during rounds.
5. The annual training will be reviewed by the administrator and/or designee monthly

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

44b Retaliation

8. Requirements

2600.
44.b. The home shall permit and respond to oral and written complaints from any source regarding an alleged violation of resident rights, quality of care or other matter without retaliation or the threat of retaliation.

Description of Violation

A complaint was filed against the home anonymously. Staff person A asked staff who made the complaint and learned who made the complaint. Staff interviews revealed that staff person A yelled at the complainant.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The administrator that the complaint was made about is no longer with the community.
2. Training was done with staff in reference to retaliation
3. Staff may report concerns anonymously through HR and leadership will review trends regularly.
4. The current administrator did the training and knows the regulation.
5. Dignity and respect will continue to be part of annual training
5. Annual training will be reviewed by the administrator and/or designee monthly

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

65g Annual Training Content

9. 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 persons G and H did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during the 2024 training year.

Repeat violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The staff members were trained in emergency preparedness
2. A training plan was created for 2024 and 2025
3. All staff audit was conducted on annual training
4. Annual training was completed with all staff for 2024 and 2025'
5. An annual training plan will be completed every January
6. Training will be done at Town Hall monthly by the administrator and/or designee
6. Training will be uploaded into Relias for all staff
7. Annual training will be reviewed by the administrator or designee monthly

65g - Annual Training Content *(continued)*

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] 01/05/2026)

65i - Training Record

10. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include the length of the annual trainings related to their job duties for the 2024 training year.

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

1. An annual training plan was completed for 2024 and 2025 and the length of time for each training was added.
2. All records were updated
3. Staff completed the 2024 and 2025 annual training
4. Moving forward a training plan that includes length of time will be completed every January and approved by the administrator
5. The annual training plan will be reviewed by the administrator or designee monthly

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

81a - Accomodation

11. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home's procedures for bedside mobility devices does not include a periodical assessment for proper installation and maintenance and that the device remains appropriate to the resident's need.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. A full inventory of all assistive devices was implemented
2. All new mobility devices will be checked when they are brought into the community by PT
2. All mobility devices will be checked for safety monthly
3. The therapy department, nursing, or administrator will conduct the safety check
4. Any issues will be reported to the administrator and/or DON who will contact the family for a replacement

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] 01/05/2026)

81b - Resident Personal Equipment

12. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident [redacted] has a bedside mobility device on their bed. This device is not securely attached to the bedframe. The device has an uncovered opening measuring 11 ½ inches by 15 inches. This does not adhere to the FDA guidelines which state, "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place."

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

1. The device was immediately removed from the bed
2. The family was contacted and informed
3. The device was later securely attached to the bed
4. A cover was purchased and put on by the family.
5. The mobility device was inspected by the administrator
6. Ongoing the mobility devices will be checked monthly by the therapy department, DON or administrator
7. Any issues will be reported to the administrator or DON
8. Administrator or DON will reach out to the family for a solution

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

82c - Locking Poisonous Materials

13. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] at 11:30 am, the following were observed:

Micro-kill bleach bottle with germicidal bleach wipes, with a manufacturer's label indicating "If in eyes, hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first five minutes, then continue rinsing the eye. Call a poison control center or doctor for treatment advice , was unlocked, unattended, and accessible to residents in the kitchenette underneath the sink the cabinets. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Cleanslate Oxnard RTU Disinfectant Cleaner, with manufacturer's label indicating "keep out of reach of children have the product container or label with you when calling a poison control center or doctor or going for treatment. If in eyes: Hold eyes open and rinse slowly and gently with water for 15–20 minutes. Remove contact lenses if present, after the first 5 minutes, then continue rinsing. Call a poison control center or doctor for treatment advice. If on skin: Take off contaminated clothing. Rinse skin immediately with plenty of water for 15–20 minutes. Call a poison control center or doctor for treatment advice", was unlocked, unattended, and accessible to residents in the kitchenette underneath the

82c - Locking Poisonous Materials (continued)

sink the cabinets. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Labccin Advanced Hand Sanitizer, with manufacturer's label indicating "if swallowed, get medical help or contact poison control center right away", was unlocked, unattended, and accessible to residents in the kitchenette underneath the sink the cabinets. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Medline Spectrum Advance Gel Hand Sanitizer, with manufacturer's label indicating "if swallowed, get medical help or contact poison control center right away", was unlocked, unattended, and accessible to residents in the kitchenette underneath the sink the cabinets. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat violation [redacted] et al

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. All poisonous materials were moved out of the kitchenette
2. The food service director was called to the kitchen
3. All staff were in-serviced on poisonous materials
4. A lock was installed on the cabinet
5. Memory Care coordinator has implemented a rounds sheet to be completed daily.
6. All department heads doing rounds will will look for hazardous items
7. Administrator/designee will review the rounds sheets for completion
8. Round sheets will be brought to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

85a - Sanitary Conditions

14. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted], at 4:30 pm, the men's common bathroom on the first floor has one urinal and one toilet. The toilet is clogged with feces.

On [redacted], resident room [redacted] had a strong odor of urine.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The toilet was immediately flushed, cleaned and sanitized
2 The bathroom is checked and cleaned periodically by housekeeping
3. Administrator does community rounds and addresses any areas of concern right away
8. Ongoing, administrator and departments will do rounds in community and address any concerns
9. A complaint sheet was put in place for staff to address any areas of concern or report any complaints
10. Administrator or designee to monitor and address all concerns with the appropriate department head

85a - Sanitary Conditions *(continued)*

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

105g - Lint Removal and Duct Cleaning

15. 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 [redacted] at 9:31 am, there was an approximate 1-inch accumulation of lint in the lint trap of the whirlpool dryers in the second-floor laundry room. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The lint was removed immediately
2. The staff was in-serviced on removing lint from the dryer after each use
3. Housekeeping staff was in-serviced on checking the dryers and removing lint when the residents or families are doing wash.
4. Housekeeping has implemented a lint log for the dryers that is turned into the administrator
5. Ongoing the administrator or designee will monitor the dryers for lint during rounds and unannounced visits

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

141a 1-10 Medical Evaluation Information

16. 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 [redacted] medical evaluation dated [redacted] did not include page two and the home did not have the completed documentation.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The Documentation of Medical Evaluation (DME) will be corrected per plan of correction

141a 1 10 Medical Evaluation Information (continued)

2. An comprehensive audit was conducted on all DMEs
3. A tickler file was created for all DMEs
4. Monthly, the DON will review the tickler and make sure to complete any DMEs that are due
5. The administrator and/or designee will review at QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented (- 01/05/2026)

141b1 - Annual Medical Evaluation

17. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident annual medical evaluation dated did not include the home's determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept - 12/16/2025)***

1. The medical evaluation will be corrected per plan of correction
2. An comprehensive audit was conducted on all DMEs
3. A tickler file was created for all DMEs
4. Monthly, the DON will review the tickler and make sure to complete any DMEs that are due
5. The administrator and/or designee will review at QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 01/05/2026)

183b - Meds and Syringes Locked

18. 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 at 10:52 am, and were unlocked, unattended, and accessible on top of resident bathroom sink. Resident does not self administer their medications.

Repeat violation et al

Plan of Correction ***Accept - 12/16/2025)***

1. The items were immediately removed
2. Room rounds were conducted to ensure there were no more medications in resident rooms that do not self medicate

183b Meds and Syringes Locked (continued)

3. Training was completed with nursing staff on self medication administration

4. The administrator and/or designee will continue to monitor 2x weekly during room rounds for sixty days and then during routine room rounds.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

183d - Prescription Current

19. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], at 3:15 pm, [redacted] 1 tablet by mouth every 4 hours as needed prescribed to resident [redacted] was in the home's medication cart; however, the medication was discontinued on [redacted]

On [redacted], at 3:17 pm, [redacted] 1 tablet by mouth every 8 hours as needed prescribed to resident [redacted] was in the home's medication cart; however, the medication was discontinued on [redacted]

Repeat violation [redacted] et al

Plan of Correction ***Accept[redacted] - 12/16/2025)***

1. The medication was immediately removed.
2. A med cart audit was conducted, weekly and then daily for two weeks in November by an outside agency
3. Any medications that were discontinued were removed from the cart
4. Med Cart audits will be done weekly by inhouse nursing staff ongoing with no end date
5. Any medications that are discontinued will be removed within an hour of the order
6. Med Cart audits will be reviewed weekly by the administrator
7. Med Cart audits will be brought to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented[redacted] - 01/05/2026)

187a - Medication Record

20. 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.

187a - Medication Record *(continued)*

9. Administration times.
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 [redacted] is prescribed [redacted] mg give one tablet by mouth every 12 hours as needed for anxiety. Staff recorded on the resident's October's 2025 medication administration record that the medication was administered on [redacted] however the narcotic count sheet was logged for [redacted] as being administered.

Repeat violation [redacted] et al

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

1. The med tech wrote the wrong date on the narcotic sheet
2. Training was done with all med techs on medication administration
3. A narc book audit will be implemented and completed weekly on random residents
4. During the narcotic count the oncoming shift will verify the date
4. The audits will be turned into the administrator and/or designee
5. Administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

187b - Date/Time of Medication Admin.

21. 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] Resident [redacted]'s October 2025 medication administration record does not include the initials of the staff person who administered this medication on [redacted] at 9:00 pm. This medication was administered on [redacted] by staff person I according to the narcotic count sheet.

Resident [redacted] is prescribed [redacted] Resident [redacted] October 2025 medication administration record does not include the initials of the staff person who administered this medication on [redacted] at 9:00 pm. This medication was administered on [redacted] by staff person F according to the narcotic count sheet.

Resident [redacted] is prescribed [redacted]. Resident [redacted]s October 2025 medication administration record does not include the initials of the staff person who administered this medication on [redacted] at 9:00 pm. This medication was administered on [redacted] by staff person J according to the narcotic count sheet.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. Training was done with all med techs on medication administration
2. An MAR audit will be implemented and completed weekly on random residents by the DON or designee
3. The PCC dashboard will be monitored by the DON and/or designee

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

3. The audits will be turned into the administrator and/or designee for review
4. Administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

22. 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]. Resident [redacted]'s October 2025 medication administration record does not include the initials of the staff person who administered the medication on [redacted] at 5:00 pm.

Resident [redacted] is prescribed [redacted] Resident [redacted] October 2025 medication administration record does not include the initials of the staff person who administered the medication on [redacted] at 9:00 pm.

Resident [redacted] is prescribed [redacted]. Resident [redacted] October 2025 medication administration record does not include the initials of the staff person who administered the medication on [redacted] at 9:00 pm.

Resident [redacted] is prescribed [redacted]. Resident [redacted] October 2025 medication administration record does not include the initials of the staff person who administered the medication on [redacted] at 9:00 pm.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. Training was done with all med techs on medication administration
2. An MAR audit will be implemented and completed weekly on random residents
3. The audits will be turned into the administrator and/or designee for review
4. Administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] tablet by mouth at bedtime for pain. However, this medication was not administered to resident [redacted] on [redacted] at 9:00 pm. The medication administration record was initialed as administered however the narcotic log indicates 18 pills left. There are 19 pills remaining.

Repeat violation [redacted] et al

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. Training was done with all med techs on medication administration
2. An MAR audit will be implemented and completed weekly on random residents
3. An Narc book audit will be implemented and completed weekly
4. A shift to shift narcotic count will be completed by off going and on coming shifts.
5. Med techs are given observations by an in house trainer
6. The audits will be turned into the administrator and/or designee for review
7. Administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

201 - Positive Interventions

24. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted] has exhibited exit-seeking behaviors since January 2025. On [redacted] the resident pulled the fire alarm in the SDCU. On [redacted] the resident exited the home at 4:15 am and was observed in the front of the building. On [redacted] the resident was able to get into the SDCU emergency stairwell. On [redacted], at 6:00 pm, resident [redacted] was asking staff about the parking lot. Staff person D showed the resident the window closest to the parking lot. On [redacted], at approximately 6:15 pm, resident [redacted] exited the Secure Dementia Care Unit (SDCU) through the window of an unlocked, unoccupied bedroom. The home has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction ***Accept [redacted] 12/16/2025)***

1. The resident was immediately brought in
2. The unlocked room was locked.
3. The administrator and DON are no longer with the community
4. An Elopement Drill was done and training done with the staff
5. Elopement Drills will be held every other month moving forward for one year
6. The Administrator and Maintenance Director will conduct and monitor the drills
7. RASP will be updated with specific language for exit seeking behavior and staff educated on positive interventions to redirect resident if [redacted] is exit seeking.
8. Staff will be trained on how to redirect and positive interventions to use to redirect all residents

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

224a - Preadmission Screen Form

25. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted]s preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident [redacted] preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home.

Repeat violation [redacted] et al

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The prescreen was completed immediately
2. An audit was completed on all prescreens
3. Any issues found were corrected per POC
4. New admission files will have a check list that has to be completed before the admission that includes a completed pre-screen.
5. An audit will be completed monthly by the DON or designee
5. The audit will be turned into the administrator for review
6. The administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

224b - Assessment Referral

26. Requirements

2600.
224.b. An applicant whose personal care service needs cannot be met by the home shall be referred to a local appropriate assessment agency.

Description of Violation

On [redacted] the home determined that it could not meet the needs of resident [redacted] The home did not refer the applicant to a local assessment agency.

Plan of Correction ***Accept [redacted] 12/16/2025)***

1. The home determined that a resident was at a level of care that was above what the community could offer
2. The home told the hospital that they would not be able to take the resident back and [redacted] would need to find a higher level of care
3. The resident did find a community and went from the hospital to the new community
4. Moving forward the community will issue a thirty day notice to any resident that they cannot meet their level of care
5. A copy of the thirty day notice will be submitted to the department for review
6. The administrator will ensure that no resident is told they cannot return without proper notice.

224b Assessment Referral *(continued)*

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] 01/05/2026)

227d - Support Plan Medical/Dental

27. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident [redacted], dated [redacted], indicates the resident has no need for help transferring in and out of a bed or chair. However, the resident uses a bedside mobility device. The resident's assessment, dated [redacted], does not mention the device and does not include the specific need for the device, the intended use and any risks associated with such use, the resident's ability to use the device safely for its intended purpose, and an Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

The assessment for resident [redacted], dated [redacted], does not address the resident's exit seeking behaviors and hallucinations states no need. However, the home has documentation from the resident's family indicating that the resident has hallucinations. The home has documentation of resident [redacted] exit seeking behaviors occurring on [redacted] and [redacted]. The resident's support plan, dated [redacted] does not document how this need will be met.

The assessment for resident [redacted], dated [redacted], indicates behaviors are no problem. On [redacted] and [redacted] there was an incident between resident [redacted] and another resident. Resident [redacted] is the aggressor in both incidents. The resident's assessment does not address the resident's behaviors.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The RASPs will be updated
2. An audit was completed on all RASPs by consulting administrator
3. Any issues found will be corrected per POC
4. An audit will be completed monthly by the DON or designee
5. The audit will be turned into the administrator for review
6. The administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)

227g -Support Plan Signatures

28. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan.

Plan of Correction ***Accept[redacted] 12/16/2025)***

1. The RASPs will be updated
2. An audit was completed on all RASPs by consulting administrator
3. Any issues found will be corrected per POC
4. An audit will be completed monthly by the DON or designee
5. Any unsigned RASPs will be given back to the DON and considered incomplete.
5. The audit will be turned into the administrator for review
6. The administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented[redacted] - 01/05/2026)

231c - Preadmission Screening

29. 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 [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident [redacted] written cognitive preadmission screening was not completed.

Repeat violation[redacted] et al

Plan of Correction ***Accept[redacted] - 12/16/2025)***

1. The prescreen was completed immediately
2. An audit was completed on all prescreens
3. Any issues found were corrected per POC
4. No SDCU admission is allowed without the required cognitive screening
4. An audit will be completed monthly by the DON or designee
5. The audit will be turned into the administrator for review
6. The administrator will bring the audit to QA

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented[redacted] - 01/05/2026)

231e - No Objection Statement

30. Requirements

2600.

231e No Objection Statement *(continued)*

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Repeat violation [redacted] et al

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The agreement was updated immediately
2. An audit was done on all resident admission charts by the Business Office Manager
3. Any issues are being corrected
4. A new admission checklist has been implemented and electronic signatures are being implemented for better accuracy
5. The administrator and Business Office Manager will review all new admission charts for accuracy and completion

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ([redacted] - 01/05/2026)

235 - Discharge/Transfer/Closure

31. Requirements

2600.
235. Discharge - If the home initiates a discharge or transfer of a resident, or the legal entity chooses to close the home, the administrator shall give a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This requirement shall be stipulated in the resident-home contract signed prior to admission to the secured dementia care unit.

Description of Violation

The home did not provide a written 30 day notice to the designated person for resident [redacted]. On [redacted], resident [redacted] designated person learned from Lower Bucks Hospital that the home was not allowing the resident to turn. On [redacted] staff person A informed the designated person of resident #[redacted] that the home is unable to meet the needs of the resident. Staff person A also informed resident [redacted] designated person if they wanted resident [redacted] to returned to the home temporarily, until another placement is identified they would have to provide a 24/7 one to one companion at the resident's expense. On [redacted] the resident's belongings were removed from the home.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The home determined that a resident was at a level of care that was above what the community could offer
2. The home told the hospital that they would not be able to take the resident back and [redacted] would need to find a higher level of care
3. The resident did find a community and went from the hospital to the new community
4. Moving forward the community will issue a thirty day notice to any resident that they cannot meet their level of care
5. The administrator will ensure that no resident is told they cannot return without proper written notice prior to discharge.
6. A copy of any written notices will be provided to the department for review

Licensee's Proposed Overall Completion Date: *01/16/2026*

235 - Discharge/Transfer/Closure *(continued)*

Implemented [redacted] - 01/05/2026)

236 - Staff Training

32. 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).

Description of Violation

Direct care staff persons G and H, who work in the Secure Dementia Care Unit (SDCU) had no documented hours of training in dementia care during the 2024 training year. Training documentation provided did not list the length of the trainings.

Repeat violation [redacted] et al

Plan of Correction ***Accept [redacted] - 12/16/2025)***

1. The nursing staff had dementia training for 2024
2. A training plan was created for 2024 and 2025
3. All staff audit was conducted on annual training
4. Annual training was completed with all staff for 2024 and 2025'
5. An annual training plan will be completed every January
6. Training will be done at Town Hall monthly by the administrator and/or designee
6. Competency testing is included when training is completed in Relias
6. All in service training will be uploaded into Relias for all staff
7. Annual training will be reviewed by the administrator or designee monthly

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented [redacted] - 01/05/2026)