

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

December 26, 2025

[REDACTED], DIRECTOR OF RISK  
WOODS SERVICES, INC.

RE: BEECHWOOD CENTER 3  
587 BEECHWOOD CIRCLE  
LANGHORNE, PA, 19047  
LICENSE/COC#: 12965

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *BEECHWOOD CENTER 3* License #: *12965* License Expiration: *11/01/2025*  
 Address: *587 BEECHWOOD CIRCLE, LANGHORNE, PA 19047*  
 County: *BUCKS* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *WOODS SERVICES, INC.*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-1* Date: *09/07/1984* Issued By: *COPA L & I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *12* Waking Staff: *9*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *10/30/2025*

**Inspection Dates and Department Representative**

10/30/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *8* Residents Served: *6*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *0*

**Number of Residents Who:**

Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *2*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *6* Have Physical Disability: *6*

**Inspections / Reviews**

**10/30/2025 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/27/2025*

**12/04/2025 - POC Submission**

Submitted By: [REDACTED] Date Submitted: *12/18/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/09/2025*

Inspections / Reviews *(continued)*

12/10/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/18/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/20/2025

12/26/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/18/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

17 - Record Confidentiality

1. 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 10/30/2025, at 9:45 AM, multiple empty medication packs, with personal information of several residents, were observed in the medication room trash can.

Plan of Correction

Accept (█ - 12/10/2025)

All medication packs with personal information were immediately checked on 10/30/25 and any materials containing resident information were removed and properly destroyed using a cross-cut shredder by PCHA of the home.

The PCHA of the home will implement mandatory use of designated confidential waste containers (locked bins) in all medication rooms for proper disposal of any materials containing resident Protected Health Information by December 17, 2025.

The PCHA of the home will conduct a mandatory in-service training for all medication certified employees on: Correct disposal procedures for medication packaging and HIPAA confidentiality requirements by December 17, 2025.

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█ - 12/26/2025)

18 - Compliance With Laws

2. Requirements

2600.

- 18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 10/30/2025 there were Carbon Monoxide detectors located in both the Mechanical Room, where the natural gas heating unit is located, and the Boiler Room, where the natural gas water heater is located, however, both detectors were installed within 6 feet of the fuel burning source. According to the CARE FACILITY CARBON MONOXIDE ALARMS STANDARDS ACT - ENACTMENT Act of Jun. 23, 2016, Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

Plan of Correction

Accept (█ - 12/10/2025)

A team member from maintenance immediately relocated both carbon monoxide detectors to compliant positions at least 15 feet from the respective fuel-burning appliances while maintaining proximity for effective detection on 11/2/2025.

Maintenance will conduct a monthly check to ensure all carbon Monoxide detectors are within the right range by December 17, 2025.

Licensee's Proposed Overall Completion Date: 12/17/2025

18 - Compliance With Laws (continued)

Implemented ( ) - 12/26/2025

44g - Telephone Number

3. Requirements

2600.

44.g. The telephone number of the Department’s personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is not posted in a conspicuous and public place in the home.

Repeat violation: 11/5/24

Plan of Correction

Accept ( ) - 12/10/2025

The telephone numbers of the department’s personal care home regional office and local ombudsman was posted immediately on the entry/exit wall at the residence in a conspicuous and publicly visible location on 10/30/25 by the PCHA. The Personal Care Home Administrator (PCHA) is responsible for maintaining all posted documents. A verification checklist to ensure all postings remains posted in a visible location has been added to the monthly environmental checklist completed by the PCHA to prevent future compliance issues starting 12/1/25. The Director of Community Residences will complete training with the PCHA by 12/31/2025 to ensure that all required postings are properly documented in the monthly environmental checklist.

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented ( ) - 12/26/2025

65g - Annual Training Content

4. 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 emergency preparedness procedures and recognition and response to crises and emergency situations during training year 7/1/2024 to 6/30/2025.

65g - Annual Training Content (continued)

**Plan of Correction**

Accept (█ - 12/10/2025)

Staff Person A will complete all required training in emergency preparedness procedures and recognition and response to crises and emergency situations by 12/17/2025. Staff Person A will also receive training from the PCHA on the importance of completing all annual trainings by 12/17/2025.

The PCHA will receive training from the Residential Director on properly tracking and monitoring all mandatory staff training requirements alerts sent by the HR department, by 12/17/2025. This training will include instruction on monitoring staff training compliance.

The Residential Director will add a monthly reminder to the Supervisors' meeting agenda to ensure all supervisors verify that their staff are up to date and in compliance with all training requirements starting December 18, 2025 meeting agenda.

Licensee's Proposed Overall Completion Date: 12/18/2025

Implemented (█ - 12/26/2025)

85a - Sanitary Conditions

**5. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On 10/30/2025 at 9:37 AM, there was a notable amount of old, dried-up urine on the toilet bowl and floor of the bathroom shared by resident's 1 and 2.

**Plan of Correction**

Accept (█ - 12/10/2025)

The bathroom was thoroughly cleaned and sanitized using appropriate disinfectant by the residential staff on 10/30/25.

The PCHA of the home will revise and update the employee task assignment schedule by December 17, 2025. The assignment schedule will include bathroom cleaning protocols to ensure:

- Resident bathrooms are cleaned and sanitized at minimum once per shift daily
- Additional spot-cleaning is performed as needed
- Evening rounds are conducted to check all bathrooms before the end of each shift
- Each cleaning is documented on the bathroom checklist

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█ - 12/26/2025)

103d - Storing Food Off Floor

**6. Requirements**

2600.

103.d. Food shall be stored off the floor.

**Description of Violation**

On 10/30/2025 at 9:30 AM, Boost Nutritional Drinks, Pepsi, Root Beer and bottled water was stored on the floor in the medication room.

103d - Storing Food Off Floor (continued)

Plan of Correction

Accept (█) - 12/04/2025)

The PCHA of the home Immediately relocated all nutritional drink boxes from the floor to a proper storage location on 10/30/25. The PCHA of the home will conduct training for all staff on proper food storage requirements by 12/17/2025. PCHA will Review proper storage procedures during monthly staff meetings starting 12/1/25. All employees will be trained on emphasizing on the importance and the reasons for elevated storage for all food items by the PCHA of the home by 12/17/25.

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█) - 12/26/2025)

103e - Left Overs

7. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated bag of eggs in the freezer.

Plan of Correction

Accept (█) - 12/10/2025)

The unlabeled item was immediately discarded by the residential staff upon discovery to prevent any potential food safety issues on 10/30/2025. All staff will be retrained on proper food storage procedures, including the requirement to label and date all food items upon opening or receipt by the PCHA of the home by 12/17/2025. This retraining will emphasize compliance with DHS and health department standards. December 17, 2025, staff will complete a weekly food inventory check during routine food shopping. This check will include verifying that all items in storage are properly labeled and dated. Any noncompliant items will be removed and reported to the supervisor.

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█) - 12/26/2025)

103g - Storing Food

8. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The Canadian Bacon in the refrigerator, and the pizza in the freezer, was opened and unsealed.

Plan of Correction

Accept (█) - 12/10/2025)

The unsealed food items were immediately discarded by the residential staff upon discovery on 10/30/2025. All staff will be retrained on proper food storage procedures, including proper sealing and storage for all food items from the PCHA of the home by 12/17/2025. This retraining will emphasize compliance with DHS and health department standards. December 17, 2025, staff will complete a weekly food inventory check during routine food shopping. This check will include verifying that all items in storage are properly labeled and dated. Any noncompliant items will be removed and reported to the supervisor.

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█) - 12/26/2025)

184b - Labeling OTC/CAM

9. Requirements

2600.

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

Description of Violation

On 10/30/2025, a package of Collagenase ointment was in the medication cart and was not labeled with a resident's name.

Plan of Correction

Accept (█) - 12/10/2025)

Collagenase ointment was immediately removed from the medication cart and reordered by nursing on 10/30/2025. The PCHA of the home will conduct a mandatory training for staff by 12/31/25 to include: resident-owned OTC medications and CAM products that must be labeled with resident's name, Unlabeled items that must not be stored in medication carts, and the Procedure for handling unlabeled medications discovered during shift. OTC meds will be added to the Medication weekly audit checklist completed by the PCHA starting December 17, 2025.

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█) - 12/26/2025)

185a - Implement Storage Procedures

10. 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 3 is prescribed █

On 10/30/2025 these medication(s) were not available in the home.

Plan of Correction

Accept (█) - 12/10/2025)

█ were immediately reordered by nursing on 10/30/25 for Resident 3. The PCHA of the home will Revise the medication weekly check management procedures to include: Weekly review of PRN medication inventory levels by nursing beginning December 17, 2025

Licensee's Proposed Overall Completion Date: 12/17/2025

Implemented (█) - 12/26/2025)

227g -Support Plan Signatures

11. Requirements

2600.

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

Description of Violation

Resident 3's support plan, dated █ was not signed by the assessor.

Plan of Correction

Accept (█) - 12/10/2025)

On 10/30/25, the assessor was notified of the missed signature and the error was corrected while the surveyor was on site. The corrected plan was provided to the surveyor by the Director of Care Coordination on 10/30/25 as evidence of corrective action.

The Director of Care Coordination met with the assigned Care Coordinator on 10/30/25 to review the proper

**227g -Support Plan Signatures (continued)**

completion of the Residential Assessment and Support Plan. The applicable 2600 regulations were reviewed in detail and the importance of obtaining applicable signatures was stressed. Scenarios and reviews of RASP's were utilized as teaching tools and performance improvement measures to help this team member improve their understanding of the information that should be included in the RASP. Steps for obtaining signatures were reviewed as follows:

*Step 1 Care Coordinator completes the RASP with input from the residential staff and treatment team.*

*Step 2 The RASP is reviewed at the Rehabilitative Support Plan (RSP) meeting with the participant and treatment team.*

*Step 3 Signatures are obtained on the RASP at the time of the meeting.*

*If the RASP is a significant change or does not coincide with a treatment team meeting, the Care Coordinator will obtain signatures when meeting with staff members and the participant upon completion of the document in the home within 5 calendar days of the assessment. On 12/9/25 a complete audit of Beechwood Center 3 RASPs was completed to ensure that all current plans are assigned by the assessor. Quarterly audits will be completed by the Director of Care Coordination and the Care Coordinators of a sampling of resident records for thoroughness starting 10/30/25. The audit goal is to reach a minimum of 20% of the records annually and will be under the responsibility of the Director of Care Coordination.*

**Licensee's Proposed Overall Completion Date: 12/09/2025**

**Implemented (█ - 12/26/2025)**