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

March 20, 2026

[redacted] AREA GENERAL MANAGER
VS WALLINGFORD LLC
2700 CHESTNUT PARKWAY
CHESTER, PA, 19013

RE: CHESTNUT RIDGE RETIREMENT LIVING
2700 CHESTNUT PARKWAY
CHESTER, PA, 19086
LICENSE/COC#: 14141

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/17/2025, 11/18/2025, 11/19/2025 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: *CHESTNUT RIDGE RETIREMENT LIVING* **License #**: *14141* **License Expiration**: *01/30/2026*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA 19086*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *VS WALLINGFORD LLC*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA, 19013*

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

Certificate(s) of Occupancy

Type: *C-2 LP*	**Date**: *10/19/1998*	**Issued By**: *Commonwealth of Pennsylvania, L&I*
Type: *Other*	**Date**: *10/19/1998*	**Issued By**: *Commonwealth of Pennsylvania, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *11/19/2025*

Inspection Dates and Department Representative

11/17/2025 - On-Site: [redacted]

11/18/2025 - On-Site: [redacted]

11/19/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *65*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Bridges/Life Stories* **Capacity**: *50* **Residents Served**: *18*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *65*

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

Have Mobility Need: *35* **Have Physical Disability**: *0*

Inspections / Reviews

11/17/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/27/2025*

01/08/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/14/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/14/2026*

03/20/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/14/2026*

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

42c - Treatment of Residents

1. Requirements

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

Description of Violation

On 10/09/25, resident #1 had an accident while trying to make it to the bathroom. Staff person A responded to the resident's call bell and repeatedly cursed out loud saying "you made a [redacted] mess" and "I don't want to clean up this [redacted] mess". Staff person A then told the resident to "get the [redacted] out of here". When the resident tried to explain that they were experiencing diarrhea, staff person A said something along the lines of "get the [redacted] out of here and leave me alone".

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Short Term Actions
Immediate Response and Re-Education of Staff
Action Plan: To immediately address inappropriate behavior and reinforce standards of professionalism and respect.
Steps:
Staff Person A immediately suspended and upon investigation Staff Person A was terminated. Executive Operations Officer spoke to resident and family and apologized for the behavior and resident did share [redacted] was fine. Resident no longer resides in community due to personal reasons not relating to incident.

Executive Operations Officer hosted staff meeting on 11.21.2025 and 12.1.2025 discussing violation 42c and proper techniques/ professionalism, resident rights, dignity, and communication skills
Responsible Party: Executive Operations Officer
Completed on: 11.21.2025 & 12.1.2025

Action Plan: To prevent recurrence and improve staff understanding of behavior expectations.
Steps:
Implement a Monthly training program on resident rights, dignity, and communication skills for care staff for 3 months.
Responsible Party: Resident Wellness Director or Designee
Time line: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

60a - Staff/Support Plan

2. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 10/23/25 the Home's Leadership Team held a Town Hall in the Employee Lounge. One of the topics covered was "Answering call bells within 10 minutes".

- *On 11/03/25, between 21:01 and 21:42 (9:01 PM to 9:42 PM) resident #2 waited 41 minutes for staff to respond to the call bell,*

60a - Staff/Support Plan (continued)

- *On 11/16/25, between 06:16 and 06:55 (6:16 AM to 6:55 AM) resident #3 waited 39 minutes for staff to respond to the call bell,*
- *On 11/17/25, between 21:04 and 22:05 (9:04 PM to 10:05 PM) resident #2 waited 61 minutes for staff to respond to the call bell.*

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Short Term Actions
EOO purchased more walkies to ensure communication with all departments throughout the community. Front desk is monitoring call bell activity and announcing call bells ringing every few minutes on the walkie to ensure staff are aware and responding. This will be the practice until a new call bell system is installed in the first quarter of 2026 which will provide more alert options and reporting features.

Executive Operations Officer hosted staff meeting on 11.21.2025 and 12.1.2025 discussing call bell response rate and expectations.
Responsible Party: Executive Operations Officer
Completed on: 11.21.2025 & 12.1.2025

Action Plan: To share call bell response time reports and expectations with the wellness team
Steps:
Implement a Monthly staff meeting on the response rates for call bells
Responsible Party: Resident Wellness Director or Designee
Timeline: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

81b - Resident Personal Equipment

3. 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

On 11/17/25, the following bedside mobility device issues were found:

Resident #4 has a bedside mobility device on their bed. This device is not securely attached to the bed frame. The device has an uncovered opening measuring 12 inches by 6 inches. This does not adhere to the FDA guidelines which states "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."

Resident #5 has a bedside mobility device that is not attached to the bed frame but uses a wood plank that slides under the resident's mattress. Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstance.

81b - Resident Personal Equipment (continued)

Resident #6 has a bedside mobility device that is not attached to the bed frame and was loose. Bedside mobility devices that are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Immediate Inspection and Correction of Devices
Action Plan: Ensure bedside mobility devices are secure and compliant with FDA guidelines.
Steps:
Conduct immediate inspection of all bedside mobility devices in the facility to ensure compliance.
Secure all devices properly to the bed frame as per regulatory and FDA guidelines.
Replace any devices that cannot be made compliant immediately/speak to residents and Families
Responsible Party: Safety and Maintenance Engineer or Designee
Timeline: Completed on 11.20.2025

Staff Training on Device Safety
Action Plan: Train staff on correct installation and inspection of mobility devices.
Steps:
Executive Operations Officer hosted staff meeting on 11.21.2025 and 12.1.2025 discussing current enablers in the building. Executive Operations officer shared the regulations
Responsible Party: Executive Operations Officer or Designee
Timeline: Completed on 11.21.2025 and 12.1.2025

Long Term Actions
Regular Device Safety Audits
action Plan: Maintain long-term compliance and safety regarding mobility devices.
Steps:
Implement Monthly audits of all resident mobility devices.
Utilize a checklist to ensure all devices are secure and within compliance guidelines.
Address issues found in audits promptly to prevent future violations.
Responsible Party: Safety and Maintenance Engineer or Designee
Timeline: Monthly for 90 days.

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented (- 03/20/2026)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 11/17/25, soiled sheets were observed in a bag inside resident #7's bedroom. The residents' room had a foul odor due to these items.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Immediate Cleaning and Sanitization
Action Plan: Ensure immediate remediation of unsanitary conditions in resident #7's room.
Steps:
Removed the soiled sheets from resident #7's room immediately and ensure proper disposal.
Thoroughly cleaned and sanitized the area to eliminate any foul odors.
Re-assess the room to confirm the removal of unsanitary conditions.
Responsible Party: Housekeeping Staff
Timeline: Completed on 11.17.25

Staff Training on Sanitary Protocols
Action Plan: Reinforce training for staff regarding the maintenance of sanitary conditions.
Steps:
Conduct a training session for housekeeping and caregiving staff on proper sanitary procedures.
Review the importance of immediate reporting of unsanitary conditions by any staff member.
Provide written guidelines and checklists for maintaining sanitary conditions in resident rooms.
Responsible Party: Executive Operations Officer or Designee
Timeline: Completed on 11.21.2025 & 12.1.2025

Long term audit
Action Plan: Introduce a protocol for weekly room inspections to catch and address sanitary issues proactively.
Steps:
Develop a checklist for weekly random room inspections for 3 rooms focusing on identifying unsanitary conditions.
Ensure any deviations noted during inspection are logged and addressed immediately.
Responsible Party: Housekeeping Director or designee
Timeline: Weekly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented (- 03/20/2026)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #6 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Provide Immediate Lighting to Resident #6
Action Plan: To ensure Resident #6 has immediate access to a bedside light source as required by regulation.
Steps:
Provided a bedside lamp for Resident #6 that can be easily turned on or off while in bed.

101j7 - Lighting/Operable Lamp (continued)

Installed the lamp in Resident #6's bedroom, ensuring it is operable and within reach of the resident.
Verify that the lighting solution meets the standard requirements as per regulation 2600.101.j.
Responsible Party: Safety and Maintenance Engineer
Timeline Completed on 11.17.2025

Staff Training on Compliance Requirements
Action Plan: To ensure all staff are aware of the regulatory requirements regarding resident room lighting.
Steps:
Conduct a training session to review Pennsylvania regulation 2600.101.j concerning bedroom lighting requirements.
Responsible Party: Executive Operations Officer or designee
Timeline: Completed on 11.21.2025 & 12.1.2025

Long Term Actions
Routine Lighting Inspection Protocol
Action Plan: To establish a routine inspection protocol to ensure continued compliance with bedroom lighting requirements.
Steps:
Develop a checklist for Weekly routine inspections of 3 random residents' bedrooms focusing on lighting.
Keep records of inspection results and corrective actions taken if any issues are found.
Responsible Party: Safety and Maintenance Engineer or Designee
Timeline: Weekly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

132f - Alternate Exit Routes

6. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Stair Towers 1 and 2 were the only exit routes used during the fire drills held on 06/29/25, 07/31/25, 08/25/25 and 09/17/25.

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Short Term Actions
Fire Drill Route Expansion
Action Plan: Introduce alternative exit routes for fire drills to ensure all possible exits are used effectively.
Steps:
Executive Operations Officer spoke to Michael Fury (Fire Safety Specialist) and advised of the violations. Fire safety specialist sent a letter confirming different exits being used. Executive Operations Officer emphasized the importance of using different exit stair towers going forward.
Responsible Party: Executive Operations Officer
Timeline: completed on 11.21.2025

2. Staff Training on Evacuation Routes

132f - Alternate Exit Routes (continued)

Action Plan: Ensure all staff members are aware of and trained on all available evacuation routes.
Steps:
Conduct training sessions focused on the identified exit routes.
Responsible Party: Executive Operations Officer
Timeline: Completed on 12.1.2025

Long Term Actions
Regular Review and Monitoring
Action Plan: Regularly review fire drill stair tower to include different exit routes.
Steps: Safety and Maintenance Engineer or designee will audit Fire drill by Fire Safety Solutions to ensure new exit routes are being used.
Responsible Party: Safety and Maintenance Engineer or Designee
Timeline: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented (- 03/20/2026)

183e - Storing Medications

7. 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

Resident #8's Folic Acid 1 MG Tab blister pack had a puncture on the back of tablet #6.

Resident #9 is prescribed Ozempic 8MG/3ML (2 MG Dose) - Inject 2 MG subcutaneously once weekly on Monday. The storage instructions for this medication states to discard pen after 56 days. An opening date was not indicated on the pen.

Resident #5's Stimulant LX Tab 50 MG/8.6 MG blister pack had punctures on the back of tablets #2, #4 and #5.

Repeat Violation: 07/24/25 et. al., 11/25/24 et. al.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Inspect and Correct Medication Packaging
Action Plan: Ensure all medications are properly sealed and stored according to manufacturer instructions.
Steps:
Inspect all medication packs for integrity, specifically checking for punctures or damage.
Repack or replace any medications found with compromised packaging.
Responsible Party: Executive Operations Officer or Designee
Timeline: Completed 11.18.2025

Immediate Training Session for Staff
Action Plan: Educate staff on proper medication storage, packaging integrity, and labeling requirements.

183e - Storing Medications (continued)

Steps:
Organize a training session focusing on medication handling, emphasizing proper storage conditions and labeling requirements.
Responsible Party: Executive Operations Officer and Senior Wellness and Operations Specialist
Timeline: Completed on 11.24.2025

Long Term Actions
Regular Audits
Action Plan: Maintain consistent oversight of medication management to prevent future violations.
Steps:
Executive Operations Officer created new cart check audit. Weekly audit for chosen residents schedule for all medication storage areas.
Utilize a checklist based on regulatory compliance guidelines for thoroughness.
Responsible Party: Resident Wellness Director or Designee
Timeline: Weekly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

185a - Implement Storage Procedures

8. 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 #10 is prescribed Lorazepam Con 2MG/ML - Give 0.25 ML (0.5 MG) by mouth / sublingually every 4 hours as needed. On 11/18/25 this medication was not available in the home.

Repeat Violation: 10/20/25, 07/24/25 et. al, 11/25/24 et. al.

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Short Term Actions
Medication Availability Restoration
Action Plan: Ensure immediate availability of Lorazepam for Resident #10.
Steps:
Primary care discontinued Lorazepam order for Resident #10 due to resident not needing PRN.
Responsible Party: Executive Operations Officer or designee
Timeline: 11.18.2025

Staff Training on Medication Management
Action Plan: Train staff on procedures for ensuring medication availability and proper management.
Steps:
Develop and conduct a mandatory training session covering medication inventory management and order procedures.
Include role-play scenarios for emergency medication request processes.
Responsible Party: Executive Operations Officer and Senior Wellness and Operations Specialist

185a - Implement Storage Procedures (continued)

Timeline: Completed on 11.24.2025

Long Term Actions
Medication Audit
Action Plan: Prevent future medication availability issues through proactive audits.
Steps:
Executive Operations Officer created new medication cart audit schedule.
Weekly medication cart audit based on med cart audit schedule.
Utilize a checklist based on regulatory compliance guidelines for thoroughness.
Responsible Party: Resident Wellness Director or Designee
Timeline: Weekly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

187a - Medication Record

9. 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.
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 #9 is prescribed insulin based on a sliding scale: Before Meals if BS 150-200=1U, 201-250=2U, 251-300=3U, 301-350=4U. 351-400=5U, Greater than 400 = 6U and call MD. However, resident #9's November 2025 medication administration record does not provide an area to document the amount of units administered.

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Short Term Actions
1. Review and Update Medication Administration Record (MAR)
Action Plan: Ensure MAR contains all required fields for documentation of insulin administration.
Steps:
Review the current MAR format to identify missing fields necessary for documenting sliding scale insulin administration.
Consulted with a pharmacist to verify required information for insulin administration is correctly documented.

187a - Medication Record (continued)

Revised the MAR to include a field for recording administered insulin units based on the sliding scale.
Responsible Party: Executive Operations Officer or designee
Timeline: Completed 11.19.2025

Staff Training on Updated MAR
Action Plan: Educate staff on the importance of complete and accurate documentation for medication administration.
Steps:
Develop training materials focusing on the updated MAR requirements, especially for sliding scale insulin.
Conduct a training session for all medication administration staff covering the revision of the MAR and the criticalness of proper documentation.
Responsible Party: Executive Operations Officer and Senior Wellness and Operations Specialist
Timeline: Completed on 11.24.2025

Long Term Actions
Medication Audit/MAR audits
Action Plan: Prevent future medication availability issues through proactive audits.
Steps:
Executive Operations Officer created new cart check audit.
Weekly audit for chosen residents based off schedule for all medication storage areas and MAR audits.
Utilize a checklist based on regulatory compliance guidelines for thoroughness.
Responsible Party: Resident Wellness Director or Designee
Timeline: Weekly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

On 11/16/25, resident #4 was prescribed Azithromycin Tab 250 MG - Take two tablets by mouth on day one then take 1 tablet by mouth daily days two through five. However, resident #4 was administered only 1 250 MG tablet on 11/18/25 in the 8:00 AM time slot because the medication was not available on 11/17/25. The resident never received the "starting dose" of two 250 MG tablets.

Repeat Violation: 07/24/25 et. al, 03/20/25, 11/25/24 et. al.

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Short Term Actions
Re-evaluate Medication Management System
Action Plan: Ensure immediate availability of prescribed medications according to instructions.
Steps:
Compared physicians order vs med available

187d - Follow Prescriber's Orders (continued)

Identified the cause of the delay in obtaining Azithromycin for resident #4.
Implement immediate corrective measures to prevent future occurrences.
Executive Operations officer reported to DHS for missed dose. Primary care was notified
Responsible Party: Executive Operations Officer
Time line: Completed 11.18.2025

Staff Training on Medication Protocols
Action Plan: Increase staff compliance with medication administration protocols.
Steps:
Schedule an immediate training session for all nursing staff on medication protocols and the importance of following prescriber instructions.
Responsible Party: Executive Operations Officer and Senior Wellness and Operations Specialist
Time line: Completed on 11.24.2025

Long Term Actions
Medication Audit
Action Plan: Prevent future medication availability issues through proactive audits.
Steps:
Executive Operations Officer created new medication cart audit schedule.
Weekly medication cart audit based on med cart audit schedule.
Utilize a checklist based on regulatory compliance guidelines for thoroughness.
Responsible Party: Resident Wellness Director or Designee
Time line: Weekly for 90 day

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)

227d - Support Plan Medical/Dental

11. 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

Resident #4 uses a bedside mobility device; however this device is not listed in resident #4's Resident Assessment and Support Plan (RASP) dated [redacted]

Resident #6 uses a bedside mobility device; however this device is not listed in resident #6's RASP dated [redacted]

The Bureau of Human Services Licensing strongly recommends that Personal Care Homes and Assisted Living Residences consider all available alternatives before implementing the use of Bedside Mobility Devices. When such devices are in use, the resident's support plan must reflect:

- *The specific need for the device,*

227d - Support Plan Medical/Dental (continued)

- *The intended Use,*
- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*
- *If a cover is required to meet FDA guidelines.*

Repeat Violation: 08/21/25.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Immediate RASP Update
Action Plan: Include all currently used bedside mobility devices in each resident's support plan.
Steps:
Conducted an immediate review of Resident #4 and Resident #6's current use of bedside mobility devices.
Updated the Resident Assessment and Support Plans (RASPs) for both residents to include the devices, stating the specific need, intended use, risks, and resident's ability to use the device safely.
Ensure identification of the specific device and any necessity for a cover per FDA guidelines.
Communicated updates with the direct care team and residents involved.
Responsible Party: Executive Operations Officer or designee
Time line: Completed on 11/24/2025

Staff Training on RASP Requirements
Action Plan: Educate LPN and Directors about the requirements for documenting mobility devices in residents' support plans.
Steps:
Develop a training module that outlines the necessary documentation for mobility devices in RASPs as per PA Code 2600.227.d.
Schedule a mandatory training session for all staff members involved in resident care planning.
Conduct the training and provide materials that staff can refer to for clarification.
Responsible Party: Executive Operations Officer
Time line: Completed on 11.20.2025

Immediate Quality Assurance Check
Action Plan: Verify compliance with documentation standards for all residents' support plans regarding mobility devices.
Steps:
Conduct an audit of all current residents' RASPs of residents with medical/mobility devices to ensure mobility devices are properly documented.
Correct any deficiencies found immediately during the audit process.
Document findings and corrective actions taken.
Report audit results to the facility management team for oversight.
Responsible Party: Resident Wellness Director or Designee
Time line: Completed on 11.24.2025

Long Term Actions
Ongoing Monitoring and Quality Assurance

227d - Support Plan Medical/Dental (continued)

Action Plan: Sustain compliance through regular monitoring and quality assurance practices.
Steps:
Establish a regular Chart Audit of RASP monthly to ensure all aspects of compliance are reviewed
Develop checklists or tools for use in audits to ensure all aspects of compliance are reviewed.
Responsible Party: Resident Wellness Director or Designee
Time line: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented (- 03/20/2026)

231b - Medical Evaluation

12. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's medical evaluation was completed on [redacted] Further, resident #2's medical evaluation does not indicate the resident requires dementia - related care in a secured area.

Repeat Violation: 02/20/25 et. al.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Immediate Medical Evaluation Compliance
Action Plan: Ensure resident #2 receives a proper medical evaluation with documented need for secured dementia care.
Steps:
Coordinated with a physician to immediately conduct a comprehensive medical evaluation for resident #2.
Ensure all evaluations are documented on the form provided by the Department, specifying the need for secure dementia care.
Review and verify the content of the medical evaluation for compliance with 2600.231.b requirements.
Responsible Party: Resident Wellness Director or Designee
Time line: Completed on 12/12/2025

Action Plan: Prevent future admission of residents without completed medical evaluations and necessary documentation.
Steps:
Conduct a meeting with the admissions and medical team to review current protocols.
Implement an admission checklist to ensure all documentation requirements are met, including the need for secure dementia care.
Responsible Party: Executive Operations Officer or Designee
Time line: Completed on 11.20.2025

231b - Medical Evaluation (continued)

Long Term Actions
Regular Compliance Audits
Action Plan: Establish a sustainable process to regularly verify compliance with medical evaluation requirements.
Steps:
Develop a Monthly audit schedule to review recent admissions to the SDCU to ensure compliance.
Assign a compliance officer to perform audits on resident records for documentation accuracy.
Document findings of audits and address any non-compliance immediately.
Responsible Party: Resident Wellness Director or Designee
Time line: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented (- 03/20/2026)

231c - Preadmission Screening

13. 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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, a written cognitive preadmission screening was not completed.

Repeat Violation: 02/20/25 et. al.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Complete Preadmission Screenings
Resident #2 was moved to SDCU that was transitioning into a Lifebridges instead of a Life stories (SDCU). Prescreen completed on 11.20.2025

Staff Training on Preadmission Requirements
Action Plan: Educate LPN and Marketers on the importance and process of completing the cognitive preadmission screenings within 72 hours prior to SDCU admission.
Steps:
Organize a mandatory training session for all relevant staff, emphasizing the requirements of code 2600.231.c.
Responsible Party: Executive Operations Officer or designee
Time line: Complete on 11.20.2025

Long Term Actions
Implement a Quality Assurance Monitoring System
Action Plan: Establish an ongoing system to monitor compliance with preadmission screening requirements.
Steps:
Memory care director or designee will audit new admissions to a SCDU Prescreen Monthly
Responsible Party: Memory Care Director

231c - Preadmission Screening (continued)

Time line: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented (- 03/20/2026)

234a - Admission Support Plan

14. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's support plan was completed on [redacted]

Repeat Violation: 02/20/25 et. al, 11/25/24 et. al.

Plan of Correction ***Accept (- 01/08/2026)***

Short Term Actions
Verification and Immediate Support Plan Development
Resident #2 was moved to SDCU that was transitioning into a Lifebridges instead of a Life stories (SDCU).
Assessment completed on 11.19.2025

Staff Training on Timely Support Plan Documentation
Action Plan: To educate LPN and Memory Care Director on the importance and procedure of timely support plan documentation.
Steps:
Schedule a training session focusing on compliance with PA regulation code 2600.234.a.
Provide written guidelines on developing and documenting support plans effectively.
Conduct post-training assessments to ensure understanding and retention.
Responsible Party: Executive Operations Officer or designee
Time line: Complete on 11.20.2025

Quality Assurance Quick Audit
Action Plan: To perform a quick audit to check compliance with support plan requirements.
Steps:
Conduct an audit of all memory care resident files to check compliance with 72-hour support plan documentation policy.
Generate an immediate report listing compliant and non-compliant cases.
Responsible Party: Memory Care Director or designee
Time line: Complete by 12.27.2025

Long Term Actions
Implement a Systematic Documentation Review Process
Action Plan: To prevent future violations by regularly reviewing resident admissions and support plan documentation.
Steps:

234a - Admission Support Plan (continued)

Memory Care or designee to review new admissions to SDU to ensure compliance.
Regularly update the checklist and process based on feedback and any new regulatory guidance.
Responsible Party: Memory care Director or Designee
Time line: Monthly for 90 days

Licensee's Proposed Overall Completion Date: *12/27/2025*

Implemented ([redacted] - 03/20/2026)