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

March 25, 2026

BKD CLARE BRIDGE OF DUBLIN, LLC

RE: BROOKDALE DUBLIN
160 ELEPHANT ROAD
DUBLIN, PA, 18917
LICENSE/COC#: 15121

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/28/2026, 01/30/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE DUBLIN* **License #**: *15121* **License Expiration**: *12/06/2026*

Address: *160 ELEPHANT ROAD, DUBLIN, PA 18917*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *BKD CLARE BRIDGE OF DUBLIN, LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/20/1988* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *02/03/2026*

Inspection Dates and Department Representative

01/28/2026 - On-Site:

01/30/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *22*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *26* **Residents Served**: *22*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *22*

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

Have Mobility Need: *22* **Have Physical Disability**: *0*

Inspections / Reviews

01/28/2026 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/05/2026*

03/06/2026 - POC Submission

Submitted By: **Date Submitted**: *03/25/2026*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/20/2026*

Inspections / Reviews *(continued)*

03/25/2026 Document Submission

Submitted By: [redacted]

Date Submitted: *03/25/2026*

Reviewer: [redacted]

Follow Up Type: *Not Required*

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted], at approximately 11:15 am, resident [redacted] with a diagnosis of unspecified dementia, eloped from a locked, secured facility. The home has locked doors that can be accessed by entering the posted code for the front door, while the side door features a 15-second delay before it can be opened. The home had two agency staff working along with the director of nursing and staff person A, who was shadowing one of the agency staff. The director of nursing reported that they last saw resident [redacted] in the dining area around 9:30 am. Visitors arrived at the front door around 10:44 am, as noted in the visitor log. Staff person A, who let the visitors enter the home, was unaware that a resident was hanging around the door and that resident [redacted] resided in the facility. The home is not equipped with Wonder Guard. The entire home is a lock unit. Resident [redacted] eloped and was returned by the Dublin police at 11:15 am. The home was not aware resident [redacted] was missing until Dublin police brought [redacted] back to the facility. Resident [redacted] was missing for approximately 30 minutes. Per staff interviews the resident was wearing a fleece jacket and a hat. The director of nursing completed the vital signs assessment, and no injuries were reported. The temperature on that day was reported to be around 35 degrees. Per resident [redacted]s interview, the resident stated that [redacted] did not get hurt or fall and that [redacted] wanted to be outside. Resident [redacted]s support plan dated 6/18/25 indicates the resident requires 24-hour direct supervision.

On [redacted] at approximately 4:30 pm, resident [redacted] was pacing back and forth prior to the incident. Per DME dated [redacted] the resident needs supervision. Resident [redacted]s support plan reports that [redacted] requires 24-hour supervision due to a [redacted] diagnosis, is prone to wandering, and requires a secure unit. While having dinner, resident [redacted] got up after eating. Three staff members were helping in the dining area. When the alarm of the rear door rang, two staff members were running towards the door to redirect, and because of the door malfunction, resident [redacted] was able to open the second door. When the staff arrived, they saw the second door shutting. Resident [redacted] was able to get to the parking lot of the facility. Staff persons B and C were able to get the resident from the parking lot by the rear exit door and redirect [redacted] back to the community.

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

o Immediate Actions Taken
? Resident [redacted] On date of incident (01/05/2026), resident was immediately assessed by the Director of Clinical Services Specialists upon return; no injuries were identified.
? The front entrance procedure was reviewed with all on duty staff, including agency personnel on 01/06/2026. Resident [redacted]s support plan was reviewed and updated by the Clinical Services Specialist on 01/05/2026. Resident [redacted] Resident was immediately redirected back into the building and assessed; no injuries were identified. Resident [redacted]s support plan was reviewed and updated by the Health & Wellness Coordinator on 01/05/2026.
? All exit doors were tested and verified for proper function by a licensed and authorized vendor.
? Ongoing: To assist with ongoing compliance, the Executive Director, or designee, will implement the following monitoring plan: Elopement Prevention Audits, five times per week from 3/1-3/31/2026. After the first month, audits will continue once a week 4/1-5/31/2026. Audits will be available for DHS review.
Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

42b - Abuse *(continued)*

Implemented - 03/25/2026)

44f - Written Decision

2. Requirements

2600.
44.f. Within 7 days after the submission of a written complaint, the home shall give the complainant and, if applicable, the designated person, a written decision explaining the home's investigation findings and the action the home plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the ho e's investigation validates the complaint allegations, a resident who could potentially be harmed or designated person shall receive a copy of the decision, with the name of the affected resident re ved, unless contraindicated by the support plan.

Description of Violation

The home received a written complaint about resident s health decline on . The home did not provide its investigation findings and plan to resolve the complaint.

Plan of Correction ***Accept - 03/06/2026)***

o To assist with ongoing compliance, the Executive Director, or designee, will implement the following monitoring plan: Complaint Compliance Audits: Audits will verify: All written complaints logged, each complaint has a documented investigation, a written decision was issued within seven days, copies were provided to the complainant, the affected resident, and designated persons as required, and documentation is complete and filed, beginning 3/1/2026. Audits will be conducted by the Executive Director or designee, five (5) times per week 3/1-3/31/2026 and 1x/week 4/1-5/31/2026. Any missing or late written decisions will be corrected timely. All audits will be recorded in the Complaint Compliance Audit Log, including: Date and time of audit, auditor name, findings, corrective actions taken. The Executive Director, or designee, will review the log monthly, from 3/1-5/31/2026, to assist in complying with all deadlines were met and documentation is complete. Complaint Compliance Audit Log will be available for review by DHS.

- Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented - 03/25/2026)

65a - FS Orientation 1st Day

4. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

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

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

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 03/06/2026)***

o Immediate: The Executive Director reviewed all orientation records for current employees to ensure no other staff were missing required Day 1 fire safety and emergency preparedness topics on 02/08/2026. Any gaps identified were corrected immediately and documented. Audit will be available for review by DHS.
o The Executive Director will provide retraining to all supervisory staff involved in onboarding to reinforce the requirement that fire safety and emergency preparedness orientation must occur prior to the first day of resident contact 03/16/2026. The retraining will include a review of §2600.65(a) requirements, step by step expectations for Day 1 orientation, proper documentation procedures and required forms, the consequences of delayed orientation and the importance of resident safety.
o Ongoing: The Executive Director or designee will conduct monthly audits of all new hire staff files from 3/1/2026-5/31/2026 to verify that Day 1 fire safety and emergency preparedness orientation is completed and documented before the employee begins work. The Executive Director will review the checklist before scheduling any new employee for resident contact beginning 3/1/2026. Audit results will be available for DHS review.
- Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/25/2026)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.

65b Rights/Abuse 40 Hours *(continued)*

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person E completed 40th scheduled work hour on However, this staff person did not complete training in the following topics: resident rights.

Plan of Correction ***Accept (- 03/06/2026)***

o Immediate: The administrator reviewed the employee's training file, verified missing content, and ensured that the staff person received the full Resident Rights training module 02/13/2026. Documentation of completion has been added to the employee's personnel file. Audit will be available for review by DHS.
o The Executive Director will provide retraining to all supervisory staff involved in onboarding to reinforce the requirement that the full Resident Rights training module must be completed within the first 40 hours of work for all new employees; training will be completed by 03/16/2026.
o Ongoing: The Executive Director or designee will audit all new hire training files once weekly from 3/1/2026 4/30/2026, to ensure timely completion of required topics. Audits will continue monthly from 5/1/2026 7/31/2026. A hard copy log has been created to track each new employee's hire date, and training completion dates. This log will be reviewed weekly to verify no employee exceeds 40 scheduled work hours without completing all required topics from 3/1/2026 7/31/2026. Log will be available for review by DHS.
Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented - 03/25/2026)

95 - Furniture and Equipment

6. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On the rear exit door near resident s room was malfunctioning. Resident eloped out of the secured facility and into the parking lot due to the exit door malfunctioning.

Plan of Correction ***Accept - 03/06/2026)***

o Immediate: Resident was safely returned to the building, assessed for injury or distress, and monitoring was increased for the remainder of the shift on 01/21/2026.
o Training: In service will be conducted for staff working in the community on: Requirements of §2600.95 Maintenance of Building and Grounds, with emphasis on the obligation to report any malfunctioning door, alarm, or safety device immediately, elopement prevention procedures, including staff responsibilities when a door alarm activates or when a door is observed not functioning properly, proper use of the facility's secured unit door systems, including how to test alarms, identify mechanical issues, and escalate concerns to Maintenance and Administration, review of the community's elopement response protocol, including resident search procedures, documentation, and notification requirements by 03/18/2026. Documentation of training will be available for review by DHS.
o Ongoing: The Executive Director or designee will conduct secured unit door checks five times a week from

95 - Furniture and Equipment (continued)

3/1-3/31/2026 to verify: All exit doors latch properly, all alarms activate as designed, no mechanical issues or delays in door closure are present. After the first month, secured unit door checks will continue weekly from 4/1/2026-5/31/2026 and monthly from 6/1/2026-7/31/2026. All checks will be documented on the Secured Door Safety Audit Sheet and will be available for DHS review.
- Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/25/2026)

125b - Combustible Restrictions

7. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On [redacted] sensitive skin shave gel with a warning label was unlocked, unattended, and accessible to resident [redacted]s room. According to the warning label, "If the can is punctured, it might be flammable."

Plan of Correction ***Accept [redacted] - 03/06/2026)***

o Immediate: The shave gel was removed immediately on 01/28/26 and secured in the locked medication/chemical storage area by the Clinical Services Specialist. A sweep of Resident [redacted]s room and surrounding hallway was completed to ensure no other potentially hazardous items were accessible. All resident rooms on the unit were checked on 1/28/26 for unsecured chemicals, aerosols, or personal-care products with warning labels by the interim Executive Director.
o Training: education will be provided to all direct-care staff on: Requirements of §2600.125(b), emphasizing that any item labeled flammable, hazardous, or “keep out of reach of children” must be stored in a locked area at all times, identification of common household items that qualify as hazardous under DHS standards, including aerosols, cleaning products, nail polish remover, rubbing alcohol, and certain personal-care items, expectations for room-side supervision, including not leaving personal-care items unattended during ADLs and assisting with compliance that all products are secured immediately after use, procedures for reporting and removing any hazardous item found unsecured. Training will be completed by 3/20/2026. Attendance will be documented and will be available for review by DHS.
o Ongoing: The Executive Director, or designee, will complete daily room-side environmental checks five times a week from 3/1-3/31/2026, to verify no hazardous items are left accessible. After the first month, checks will be completed weekly from 4/1/2026-5/31/2026; and monthly from 6/1/2026-7/31/2026. A new Hazardous Item Storage Audit Sheet will be completed and available for review by DHS.
- Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/25/2026)

183e - Storing Medications

8. Requirements

2600.

183e - Storing Medications *(continued)*

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 s blister pack of tablets was torn on the foil at pill the pill remained inside the packaging.

Plan of Correction ***Accept 03/06/2026)***

o Immediate: The medication within the damaged blister pack was removed from the medication cart immediately on 01/28/26. An audit of all other resident blister packs was completed by the Clinical Services Specialist on 01/29/2026 to verify no additional packaging damage or compromised medications were present.
o Training: Retraining will be provided to all medication-certified staff covering: Requirements of §2600.183(e), emphasizing that medications must be protected from damage, contamination, and improper handling at all times, proper handling of blister-pack medications, including how to open packs without tearing adjacent foils and how to identify early signs of packaging stress or damage, procedures for immediately reporting any damaged, torn, or compromised packaging to the Administrator and pharmacy, reinforcement that damaged packaging cannot be used, even if the pill appears intact by 03/18/2026 by the Clinical Services Specialist or Health & Wellness Director. Attendance record will be made available for review by DHS.
Ongoing: Upon implementation of the plan of correction, the Executive Director, or designee, will conduct blister-pack integrity checks for five days weekly from 3/1-3/31/2026, to verify no packaging is torn, punctured, or compromised. After the first month, checks will continue monthly from 4/1/2026-6/30/2026. A new Blister Pack Integrity Audit Sheet will be made to document all checks. Certified Medication Techs will be in-serviced on how to handle blister packs using proper support techniques (e.g., pressing directly behind the pill, avoiding pressure on adjacent pockets) to reduce the risk of foil tearing by 03/16/2026 by the Clinical Services Specialist or Health & Wellness Director. Attendance record will be made available for review by DHS.
Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented - 03/25/2026)

185a - Implement Storage Procedures

9. 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 is prescribed ; give two tablets by mouth every 4 hours for pain or fever greater than 100.4 degrees as needed. On this medication(s) was not available in the home.

Plan of Correction ***Accept - 03/06/2026)***

o Immediate: A cart audit was completed by the Health and Wellness Director or designee for all other PRN medications for all residents to confirm full availability and adequate stock 01/29/2026 by the Clinical Service Specialist.
o Training: Re-training will be conducted for all medication-certified staff on: Requirements of §2600.185(a), emphasizing that all prescribed medications, including PRNs, must be available in the home at all times, proper inventory management, including checking PRN quantities at each shift change and documenting when supplies

185a Implement Storage Procedures (continued)

are running low, procedures for timely reordering, including when to notify pharmacy, when to notify the Administrator, and what to do if a medication is delayed, expectations for shift to shift communication, including documenting low stock alerts in the communication log and verbally reporting them during handoff by 03/18/2026 by the Clinical Services Specialist or Health & Wellness Director. Attendance record will be available for review by DHS. Ongoing: The Health & Wellness Director, or designee, will complete med cart audits to ensure PRN medications are available and fully stocked; five days weekly from 3/1 3/31/2026. After the first month, med cart audits for PRN medications will continue once weekly from 4/1/2026 5/31/2026, then monthly from 6/1/2026 7/31/2026. A PRN Medication Availability Audit Sheet will be implemented to document completion of checks and will be available for review by DHS.

Proposed target date for significant compliance: (3/20/2026)

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/25/2026)