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

April 30, 2026

[redacted], CEO
CHANDLER HALL HEALTH SERVICES INC
99 BARCLAY STREET
NEWTOWN, PA, 18940

RE: CHANDLER HALL HEALTH SERVICES, INC. - HICKS
99 BARCLAY STREET
NEWTOWN, PA, 18940
LICENSE/COC#: 12987

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/02/2026 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CHANDLER HALL HEALTH SERVICES, INC. - HICKS* **License #**: *12987* **License Expiration**: *02/28/2026*

Address: *99 BARCLAY STREET, NEWTOWN, PA 18940*

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

Administrator

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

Legal Entity

Name: *CHANDLER HALL HEALTH SERVICES INC*

Address: *99 BARCLAY STREET, NEWTOWN, PA, 18940*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/29/1986* **Issued By**: *L & I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/02/2026*

Inspection Dates and Department Representative

02/02/2026 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *22*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *36* **Residents Served**: *22*

Hospice

Current Residents: *3*

Number of Residents Who:

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

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

02/02/2026 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/23/2026*

02/25/2026 - POC Submission

Submitted By: **Date Submitted**: *04/03/2026*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/23/2026*

Inspections / Reviews *(continued)*

03/24/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/27/2026*

03/25/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/28/2026*

03/31/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/03/2026*

04/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2026*

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

28e - Death of a Resident

1. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101— 10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on [redacted] Resident #1's personal belongings were removed from [redacted] room on [redacted] however, the refund was not issued until [redacted] in the amount of $876.00.

Plan of Correction ***Accept ([redacted] - 02/24/2026)***

The CFO will be in-serviced by The Administrator on 2/24/2026 on the Death of a Resident and the refund process.

The CFO will conduct an audit of all residents discharged and or expired in the past year, 2025.

This audit will begin the week of 2/23/26 and will conclude the week of 3/23/26, to verify all refunds have been issued timely.

Any residents that did not receive their refund timely will have an addendum placed in their file to acknowledge that the refund was not issued in accordance with the Elder Care Payment Restitution Act.

The CFO will audit all discharges weekly beginning the week of 2/23/26 and concluding the week of 3/23/26, to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented ([redacted] - 03/24/2026)

65f - Training Topics

2. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training on the following topics for 2025 training year:

- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Direct care staff person B did not receive training on the following topics for 2025 training year:

65f Training Topics (continued)

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction ***Accept (█ - 02/25/2026)***

On 2/20/2026 Staff person A received training in care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.
The administrator will complete an audit of all staff in order to identify any others who need this required training. This audit will begin the week of 2/23/26, and will conclude the week of 3/23/26, with all staff trained on this topic.
On 2/20/2026, staff person received training on Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan & Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.
The administrator will complete an audit of all staff in order to identify any others who need this required training. This audit will begin the week of 2/23/26, and will conclude the week of 3/23/26, with all staff trained on these topics.
The administrator will audit all trainings from the previous year to ensure all current staff has received proper training on all required topics. This audit will begin the week of 2/23/2026 and will conclude the week of 3/23/2026.
On 3/3/26 the administrator will review the current years training plan to ensure training on these required topics are planned for all staff.
The administrator will update the training plan as needed to ensure all required topics are planned.

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented (█ - 03/24/2026)

65g - Annual Training Content

3. 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 A and B did not receive training in the following topics during 2025 training year:

- *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*

65g - Annual Training Content (continued)

safety expert.

- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*

Repeat Violation: 3/6/2025

Plan of Correction ***Accept (- 02/25/2026)***

The Administrator/Designee will conduct an audit of all staff members who have not received fire safety and emergency preparedness training during the 2025 training year, including staff persons A & B. These staff members will have an addendum placed in their training record to acknowledge that they did not receive the training in fire safety and emergency preparedness training during the 2025 training year.
A fire safety training will be set up by 3/23/26. All staff, including staff persons A & B, will receive training in these two topics by 3/23/26 by a fire safety expert.
As this is an annual training, the administrator will put it on the calendar for next year to ensure that training in fire safety and emergency preparedness is completed annually.

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented (- 03/24/2026)

91 - Telephone Numbers

4. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident #2's bedroom in room

Plan of Correction ***Accept (- 02/25/2026)***

On 2/3/26 The Administrator placed the emergency telephone numbers on the telephone in resident #2's bedroom.
The administrator/designee will complete an audit of all telephones beginning the week of 2/23/2026 with a completion date of 3/23/2026 to ensure that the emergency numbers are available by each telephone with an outside line.
The administrator in-serviced the memory care coordinator as well as the resident care coordinator on the Emergency Telephone Numbers on 2/20/2026
Beginning the week of 2/23/2026, the Administrator/designee will complete a weekly audit of all new admissions. If the new admissions have a phone with an outside line, the emergency telephone numbers will be placed on or by the phone. This weekly audit will begin the week of 2/23/2026 with a completion date of 3/23/2026

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented (- 03/24/2026)

95 - Furniture and Equipment

5. Requirements

95 - Furniture and Equipment *(continued)*

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

Description of Violation

On 2/2/2026, at approximately 9:40 am, the commercial dryer in the laundry room is not operable. According to staff, the commercial dryer has not been operable for a couple of weeks.

On 2/2/2026, at approximately 9:58 am, the carbon monoxide detector in the main kitchen was hanging off the ceiling.

Plan of Correction ***Accept (- 02/25/2026)***

On 2/2/2026 the carbon monoxide detector in the main kitchen was properly placed on the ceiling.
On 2/2/2026 The administrator and previous Maintenance director completed an immediate audit of all carbon monoxide detectors to ensure that they were in place properly.
Beginning the week of 2/23/2026 the maintenance director/designee will complete a weekly audit of the carbon monoxide detectors to ensure compliance with this regulation. This weekly audit will begin the week of 2/22/26 with a conclusion date of 3/23/2026.
Following the completion of the weekly audit, the maintenance director/designee will conduct a monthly audit of all carbon monoxide detectors from 4/2026-10/2026, to ensure on-going compliance.
The Commercial dryer in the laundry room that is not operable has been replaced some time ago and will be removed. This dryer will be disposed of by 2/27/2026.
A monthly audit will be conducted by the maintenance director/designee to ensure that all furniture and equipment are in good repair, clean and free of hazards for the next 6 months to ensure on going compliance. This audit will begin 3/2026-9/2026. Any discrepancies will be documented and reviewed internally for correction.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented (- 03/24/2026)

185a - Implement Storage Procedures

6. 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 insulin lispro injection as per a sliding scale of 201-250=2 units, 251-300= 4 units, 301-350=6 units, and 351-400=8 units subcutaneously four times a day for diabetes.

On 1/3/2026, at approximately 8:26 am, the glucometer reading 120. However, 123 was documented on the medication administration record.

On 1/1/2026, at approximately 11:32 am, the glucometer reading was 119. However, 118 was documented on the medication administration record.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (- 02/25/2026)***

The Administrator in-serviced the Resident Care Coordinator and all med-techs on 2/20/2026 on Implementing Storage Procedures.
Beginning 2/23/26 the Resident Care Coordinator/med-tech will audit all glucometer readings daily to ensure accuracy. This daily audit will begin 2/23/26 and will conclude 3/23/26.
The Administrator/designee will conduct random weekly audits beginning the week of 2/23/26 with a conclusion date of 3/23/26.
Following the completion of the daily and weekly audits, the Resident care Coordinator will conduct monthly audits of glucometer documentation. These monthly audits will go on for 6 months beginning 4/2026 and ending 10/2026.

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented (- 03/24/2026)

191 - Resident Right to Refuse

7. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #4, admitted has not been educated about the resident's right to refuse medication if the resident believes that there may be a medication error.
Resident #5, admitted , has not been educated about the resident's right to refuse medication if the resident believes that there may be a medication error.
The home could not provide signed documentation.

Plan of Correction ***Accept (- 02/25/2026)***

Resident #5 does have the right to refuse in agreement. This will be submitted with all documentation.
Resident #4 has the right in agreement, POA signed it. This resident was a respite and is no longer a resident at Chandler Hall Health Services. This Documentation will be submitted as well.
The Administrator in-serviced the Director of Admissions on Resident right to refuse on 2/23/2026.
The Director of admissions conducted an audit on 2/20/2026 for all current residents, in order to identify other residents who are missing this right in their agreement. Any residents missing this right will get educated on the right to refuse and will sign an addendum saying so.
This audit will begin 2/23/2026, with a conclusion date of 3/23/2026.
Beginning the week of 2/22/2026, the Administrator/designee will conduct a weekly audit on all new admissions to ensure on going compliance. This weekly audit will begin the week of 2/22/2026 and will conclude the week of 3/22/26.
Following the completion of the weekly audit, The Personal Care Home Administrator will audit all resident to home contracts of new admissions for the next 6 months to ensure that all residents have been educated about the right to refuse medication if the resident believes that there may be a medication error. This will begin from 3/2026-9/2026.

191 - Resident Right to Refuse (continued)

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented (█ - 03/24/2026)

233a - Lock Approval

8. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the keypad and electronic card operated systems used on the exit doors from the SDCU.

Plan of Correction ***Accept (█ - 02/25/2026)***

The previous Director of facilities was unable to locate the Lock Approval letter.
The Administrator in-serviced the New Director of Facilities,█ on the Lock Approval on 2/20/2026
The Administrator/The New Director of Facilities reached out to Excel the lock company and are awaiting a response.
In conjunction with reaching out to Excel, the administrator/director of facilities will also be reaching out to The Department of Labor and Industry, the Department of Health as well as the local building authority for a copy of the written approval letter for the key-locking devices.
If we are unable to obtain a copy of the written approval, we will have the local building authority re-inspect the Locking system for approval by the week of 3/23/2026.

Licensee's Proposed Overall Completion Date: *03/23/2026*

Implemented (█ - 04/30/2026)