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

May 7, 2026

[redacted], QUALITY IMPROVEMENT COORDINATOR
ELWYN OF PENNSYLVANIA AND DELAWARE
[redacted]

RE: ELWYN - SPRING HAVEN
111 ELWYN ROAD
ELWYN, PA, 19063
LICENSE/COC#: 12304

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/13/2026 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: *ELWYN - SPRING HAVEN* **License #**: *12304* **License Expiration**: *01/15/2027*

Address: *111 ELWYN ROAD, ELWYN, PA 19063*

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

Administrator

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

Legal Entity

Name: *ELWYN OF PENNSYLVANIA AND DELAWARE*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-3 SP* **Date**: *01/02/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *7* **Waking Staff**: *5*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/13/2026*

Inspection Dates and Department Representative

03/13/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *7*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older**: *4*

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

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

Inspections / Reviews

03/13/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/09/2026*

04/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/18/2026*

Inspections / Reviews *(continued)*

04/24/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/04/2026*

05/07/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/05/2026*

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

131f - Fire Extinguisher Inspection

1. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home's vehicle does not have a tag showing the date of the annual inspection by a fire safety expert.

Plan of Correction ***Accept (- 04/13/2026)***

Fire Extinguisher – Immediate action was taken on 3/13/26, the fire extinguisher was removed from the vehicle by the Unit Director. On 3/26/26, during the staff meeting, the designated staff member and staff were re-educated about the regulations for having an annual inspection if you have a fire extinguisher, by the Unit Director. Moving forward, no fire extinguisher will be kept in any vehicles and designated staff will conduct a monthly vehicle inspection to ensure that there is no fire extinguisher in the vehicle and no extra items that are not listed under the 55 Pa Code Chapter 2600 regulations starting 4/15/26. The supervisor will review the form monthly, during the monthly meeting with staff, to ensure that the task is complete starting on 4/29/26.

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented (- 05/07/2026)

183e - Storing Medications

2. 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

On 03/13/2026, blister card belonging to resident #1 was observed punctured and taped over at slot

Plan of Correction ***Accept (- 04/13/2026)***

Storing Medications – On 3/13/26, the identified was discarded, and a new pill was re-ordered from the pharmacy by the Unit Director. On 3/17/26, the Nurse Case Manager completed an audit of all medications, to ensure that they were packed safely in the bubble pack with no punctures or tape. On 3/26/26, staff were re-educated on the proper storage of medications, during a staff meeting, by the Unit Director and specifically instructed that any punctured medications must be disposed of and replaced by the pharmacy. Moving forward, the NCM will complete monthly audits that start on 3/17/26, to continually identify any issues and re-training that may be needed. The Unit Director will review the audits monthly, starting the week of 4/18/26 and will address issues as identified.

Licensee's Proposed Overall Completion Date: *04/18/2026*

Implemented (- 05/07/2026)

225c - Additional Assessment

3. Requirements

2600.

225c Additional Assessment *(continued)*

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #2's most recent assessment was not dated. The resident's previous assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

On 3/16/26, the Unit Director assigned a designated staff to correct the support plan for Resident #2 to include the missing dates.
On 3/26/26, The Unit Director re educated all staff about the signatures/dates that are required on the assessment and support plan, also on the requirement that assessments must be updated not only annually but also for significant changes in condition or new admissions.
On 4/23/26, the Unit Director will complete a full audit of all current resident Resident/Support Plans (RASPs) to identify any other missing dates, signatures, or overdue assessments. The audits will be completed monthly, as well as to include residents that have significant changes in condition or if there is a new admission. On 5/1/26, the Quality Assurance Manager will conduct a quarterly audit of all resident records to ensure assessments and support plans are completed timely and on the correct standardized forms.
Auditing will end on 5 1/27.

Licensee's Proposed Overall Completion Date: *05/03/2026*

Implemented ([redacted] - 05/07/2026)

227c - Support Plan Revision

4. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #2's most recent assessment and support plan (RASP) was not dated, making it impossible to determine if the resident's support plan was completed within 30 days upon completion of the annual assessment.

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

On 3/16/26, the Unit Director assigned a designated staff to correct the assessment and support plan for Resident #2 to include the missing dates.
On 3/26/26, the Unit Director re educated all staff on the requirement that assessments and RASP's must be updated not only annually but also for significant changes in condition or new admissions.
On 4/23/26, the Unit Director will complete a full audit of all current resident assessments and Resident/Support Plans (RASPs) to identify any other missing dates, signatures, or overdue assessments. The audits will be completed monthly, as well as to include residents that have significant changes in condition or if there is a new admission.
On 5/1/26, the Quality Assurance Manager will conduct a quarterly audit of all resident records to ensure assessments and support plans are completed timely and on the correct standardized forms.
Auditing will end on 5 1/27.

Licensee's Proposed Overall Completion Date: *05/03/2026*

Implemented ([redacted] - 05/07/2026)

227g Support Plan Signatures

5. 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 #2's most recent RASP was signed by the assessor; However, no date was indicated.

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

On 3/16/26, the Unit Director assigned a designated staff to correct the assessment and support plan for Resident #2 to include the missing dates.
On 3/26/26, the Unit Director re-educated all staff on the requirement that assessments and RASP's must be updated not only annually but also for significant changes in condition or new admissions.
On 4/23/26, the Unit Director will complete a full audit of all current resident assessments and Resident/Support Plans (RASPs) to identify any other missing dates, signatures, or overdue assessments. The audits will be completed monthly, as well as to include residents that have significant changes in condition or if there is a new admission.
On 5/1/26, the Quality Assurance Manager will conduct a quarterly audit of all resident records to ensure assessments and support plans are completed timely and on the correct standardized forms.
Auditing will end on 5/1/27.

Licensee's Proposed Overall Completion Date: *05/03/2026*

Implemented ([redacted] - 05/07/2026)

251c Standardized Forms

6. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

The annual medical evaluation dated [redacted] for resident #1 and the one dated [redacted] for resident #2 were not completed on the Department's current standardized form. They were completed on an obsolete form.

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

On 3/13/26, the Unit Director destroyed all obsolete versions of the DME form to prevent future use.
On 3/26/26, the Unit Director re-educated all staff during a formal meeting on the requirement to use only current Department-standardized forms.
Residents #1 and #2 will be reassessed by their medical practitioner using the correct standardized DME form. These appointments are scheduled to be completed no later than 5/1/26. The Designated Staff/Primary Staff are responsible for coordinating these appointments and ensuring the medical practitioner completes the required "grey section" on page 2 to certify that the residents' needs can be met in a personal care home.
Effective immediately, the Unit Director will review the physical DME form prior to any scheduled PCP appointment (annual or significant change) to verify the correct version is in hand.
Post-Appointment Review: Effective immediately, the Unit Director will review every DME form within 24 hours of a completed medical appointment to ensure the practitioner properly completed all sections, including the mandatory certification section.
On 4/23/26, the Unit Director will complete a full audit of all current resident assessments to identify errors. The audits will be completed monthly, as well as to include residents that have significant changes in condition or if there is a new admission.
On 5/1/26, the Nurse Case Manager will conduct a quarterly audit of all resident assessments to ensure that all

251c - Standardized Forms (continued)

sections are appropriate in regards to PCH regulations.
Auditing will end on 5/1/27.

Licensee's Proposed Overall Completion Date: *05/03/2026*

Implemented (- 05/07/2026)