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

May 11, 2026

[redacted], REGIONAL DIRECTOR OF OPERATIONS - PENNSYLVANIA
COLUMBIA/WEGMAN SOUTHAMPTON,LLC
[redacted]

RE: THE PROVINCE OF SOUTHAMPTON
1160 STREET ROAD
SOUTHAMPTON, PA, 18966
LICENSE/COC#: 14538

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/23/2026, 03/24/2026 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: *THE PROVINCE OF SOUTHAMPTON* **License #**: *14538* **License Expiration**: *04/22/2026*

Address: *1160 STREET ROAD, SOUTHAMPTON, PA 18966*

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

Administrator

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

Legal Entity

Name: *COLUMBIA/WEGMAN SOUTHAMPTON,LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1*	**Date**: *09/20/2019*	**Issued By**: *Upper Southampton Township*
Type: *I-2*	**Date**: *09/20/2019*	**Issued By**: *Upper Southampton Township*
Type: *Other*	**Date**: *09/20/2019*	**Issued By**: *Upper Southampton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *143* **Waking Staff**: *107*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *03/24/2026*

Inspection Dates and Department Representative

03/23/2026 - On-Site: [redacted]

03/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *90*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *36* **Residents Served**: *30*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *90*

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

Have Mobility Need: *53* **Have Physical Disability**: *1*

Inspections / Reviews

03/23/2026 Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/19/2026*

04/21/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/10/2026*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/26/2026*

04/23/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/10/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/10/2026*

05/11/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/10/2026*

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

65f - Training Topics

1. 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 in medication self-administration and instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan during training year 2025.

Plan of Correction ***Accept ([redacted] - 04/21/2026)***

• The community was unable to correct training for staff person A for the year 2025 related to this violation due to the 2025 training year being closed.

• By 4/17/2026, the Health Care Director will train staff person A on the training topics required by 2600.65f of medication self-administration, instruction of meeting the resident needs as described in the preadmission screen, assessment tool, medical evaluation and support plan. Documentation shall be kept.

• By 4/17/2026, a review of current direct care staff training records will be conducted by the Residence Director, or Designee, to ensure all required annual training topics for 2025 have been completed. The following statement will be added to the bottom of the training record for annual training missed by staff. "Non-compliance identified during annual staff training record review completed on XXXXXXX by WHO as part of a plan of correction for survey on 3/23/2026". By 4/22/2026, the associate identified shall complete the required training. Documentation shall be kept.

• On 4/20/2026, the above findings for 2600.65f will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2026*

Implemented ([redacted] - 05/11/2026)

65g - Annual Training Content

2. 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).

65g - Annual Training Content *(continued)*

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 B received no fire safety training from a fire safety expert or a trained staff person during training year 2025.

Plan of Correction ***Accept ([redacted] - 04/21/2026)***

• The community was unable to correct training for staff person B for the year 2025 related to this violation due to the 2025 training year being closed.
• By 4/15/2026 staff person B will complete fire safety training conducted by a qualified trained staff person. Documentation shall be kept.
• On 4/14/2026, current staff training records were audited by the Residence Director or designee to ensure completion of required annual fire safety training. Associates that are out of compliance the following statement will be added to the bottom of the training record for annual training missed by staff. "Non-compliance identified during annual staff training record review completed on XXXXXXX by WHO as part of a plan of correction for survey on 3/23/2026". Documentation shall be kept.
• On 4/20/2026, the above findings for 2600.65g will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/20/2026*

Implemented ([redacted] - 05/11/2026)

82c - Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 3/23/26 at 9:42 a.m., several poisons were observed to include six tubes of Crest toothpaste and a Secret deodorant. Both manufacturers' instruction labels indicated to contact poison control if ingested and were unlocked, unattended, and accessible to resident 1. Not all the residents of the home, including resident 1, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 04/21/2026)***

• On 3/23/2026, upon notification by surveyor, the Residence Director secured the toothpaste in the residents locking cabinet.
• By 4/30/2026, Residence Director, or designee, will provide education to the Health Care Director on 2600.82c. Documentation shall be kept.
• By 5/8/2026, the Health Care Director or designee will train current staff on 2600.82c. Documentation shall be kept
• Beginning 4/20/2026, the Health Care Director, or designee shall audit 5 resident rooms for compliance with

82c Locking Poisonous Materials (continued)

2600.82c weekly for 2 weeks and then monthly for 2 months. Non compliance shall be corrected immediately. Documentation shall be kept.

• On 4/20/2026, the above findings for 2600.82c will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented ([redacted] - 05/11/2026)

103g - Storing Food

4. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 3/23/26 at 9:56 a.m., there was a bag of frozen mixed vegetables in the main kitchen walk in freezer. It was opened and unsealed.

Plan of Correction ***Accept ([redacted] - 04/23/2026)***

• On 3/23/2026, the Chef, identified the opened bag that had just been opened, the opened bag of frozen uncooked vegetables was immediately sealed.

• On 3/23/2026, All kitchen storage areas were inspected by the Chef to validate compliance with 2600.103g. No further issues were found.

• On 4/16/2026, the Residence Director educated dietary staff on the requirements of 2600.103g. Documentation shall be kept.

• Starting 4/20/2026, the Chef or designee will conduct daily audits for 2 weeks to ensure proper food storage compliance. Then twice a week for 2 weeks. Documentation shall be kept.

• On 4/20/2026, the above findings for 2600.103g will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 05/11/2026)

103i - Outdated Food

5. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 3/23/26 at 9:55 a.m., there was an unlabeled and undated bag of French fries in the main kitchen walk in freezer.

On 3/23/26 at 9:57 a.m., there were four tubs of vanilla, chocolate, and strawberry ice cream unlabeled and undated in the ice cream freezer.

Plan of Correction ***Accept ([redacted] - 04/23/2026)***

• On 3/23/2026, upon notification by the surveyor, the Chef reviewed the unlabeled/undated food items, identified that they were recently opened and therefore were immediately labeled.

103i Outdated Food (continued)

• On 3/23/2026, the Chef conducted a full inspection of all food storage areas. No additional items were identified to be out of compliance.

• On 4/16/2026, the Residence Director educated dietary staff on 103i. Documentation shall be kept.

• Starting 4/20/2026, the Chef or designee will conduct daily audits for 2 weeks to validate compliance with 2600.103i. Then twice a week for 2 more weeks. Documentation shall be kept.

• On 4/20/2026, the above findings for 2600.103i will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 05/11/2026)

105f - Labeling/Return of Clothes

6. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

On 3/23/26 at 9:38 a.m., a pile of various clothing and linens was observed in the memory care laundry room. It was unable to be determined which resident(s) these items belonged to. A sign on the wall of the laundry room read, Please only put one resident's clothes per washer/dryer we have had a lot of complaints of missing/mixed up clothes." The home does not have a way to safeguard resident laundry from loss.

Plan of Correction ***Accept ([redacted] - 04/23/2026)***

• The week of 3/30/2026, the unidentified clothing was identified, sorted and returned to residents by the Assistant Health Care Director.

• By 5/8/2026, the Health Care Director or designee will train current staff on 2600.105f. The current system for proper identification of resident laundry will be reinforced at that time. Documentation shall be kept

• Starting 4/27/2026, the Residence Director, Healthcare Director, and/or Designee, will conduct 2 weekly conversations with residents to ensure they are receiving their laundry back. This will continue for 4 weeks. Documentation will be maintained.

• On 4/20/2026, the above findings for 2600.105f will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented ([redacted] - 05/11/2026)

107d - Procedure Emergency Management Agency Submission

7. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The current home's written emergency procedures were submitted to the local emergency management agency on

107d - Procedure Emergency Management Agency Submission (continued)

02/09/2026. However, the previous home's written emergency procedures were submitted on 1/06/2025.

Plan of Correction ***Accept (- 04/21/2026)***

• Community is unable to correct this for 2025. The community did submit the required Emergency Management Submission on 2/9/2026.
• On 4/16/2026, A reminder date was set up by the Residence Director for the Maintenance Director to validate that 107d is met moving forward.
• On 4/20/2026, the above findings for 2600.107d will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/20/2026*

Implemented (- 05/11/2026)

141a - Medical Evaluation

8. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident 2's date of admission is . However, the initial medical evaluation was completed on The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction ***Accept (- 04/21/2026)***

• Community unable to correct initial medical evaluation, as we are past the timeline per 2600.141a. On 8/25/2025, Resident #2 had an updated DME completed. Updated DME will remain in the resident's file. Documentation shall be kept.
• By 4/20/2026 the Residence Director will provide education on regulation 2600.141a to the Health Care Director and Sales Managers. Documentation shall be kept.
• By 5/1/2026, an audit of current resident medical evaluations will be conducted by the Health Care Director or designee. Medical Evaluations found to be out of compliance shall have "Non-compliance identified during Resident Record audit completed on XX/XX/XXXX by who as part of a plan of correction for survey on 3/23/2026" written on the bottom of the DME. Documentation shall be kept.
• By 5/4/2026, any new resident DME found to be out of compliance will be sent to the resident's physician by the Health Care Director for review. Documentation shall be kept.
• Starting 4/20/2026, the Health Care Director, or Designee, shall audit new admissions for compliance with 2600.141a weekly for 2 weeks and then monthly. Documentation shall be kept.
• On 4/20/2026, the above findings for 2600.141a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations

141a Medical Evaluation (continued)

shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/04/2026*

Implemented (- 05/11/2026)

141b1 - Annual Medical Evaluation

9. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 3's most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted]

Plan of Correction ***Accept (- 04/23/2026)***

• Community unable to correct Resident #3 initial DME, as we are past the timeline per 2600.141b1. On [redacted] Resident #3 had an updated DME completed. Updated DME will remain in the resident's file. Documentation shall be kept.

• By 4/24/2026, an audit of current resident medical evaluations will be conducted by the Health Care Director or designee. Medical Evaluations found to be out of compliance shall have "Non compliance identified during Resident Record audit completed on XX/XX/XXXX by who as part of a plan of correction for survey on 3/23/2026" written on the bottom of the DME. Documentation shall be kept.

• Starting 4/20/2026, any new DME will be brought to stand up for the Residence Director to review before being put on the resident chart. DMEs out of compliance shall be updated in accordance with 2600.141b1. This will continue for 30 days. Documentation shall be kept.

• On 4/20/2026, the above findings for 2600.141b1 will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented (- 05/11/2026)

187b - Date/Time of Medication Admin.

10. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 4 is prescribed Lorazepam 1 mg tab. Resident 4's medication administration record does not include the initials of the staff person who administered on 3/23/2026 at 9:30 a.m.

Plan of Correction ***Accept (- 04/21/2026)***

• On 3/23/2026, staff responsible for the omission was re educated by the Health Care Director on proper MAR documentation. It was verified by the Health Care Director that the resident did receive their medications but the Med Tech forgot to initial. Documentation will be maintained.

• By 4/20/2026, The Health Care Director will conduct a MAR audit of all current residents for compliance with

187b Date/Time of Medication Admin. (continued)

2600.187b, any staff found to be omitting signing for meds will be re educated at that time and the nurse will verify the medications were given. Documentation will be maintained.

• On 4/15/2026, The Health Care Director trained current med techs on the requirements of 2600.187d. Documentation will be maintained.

• On 4/20/2026, the above findings for 2600.187b will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/20/2026*

Implemented ([redacted] - 05/11/2026)

234a - Admission Support Plan

11. 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 5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was not completed.

Plan of Correction ***Accept ([redacted] - 04/23/2026)***

• On 3/24/2026, the Health Care Director, educated the Assistance Health Care Director on the requirements of 2600.234a reiterating the importance of filing all paperwork timely.

• Starting 4/20/2026, the Residence Director shall audit any new resident record admitted into the SDCU for compliance with 2600.234a review weekly for 2 weeks and then monthly for 2 months. Documentation shall be kept.

• By 4/30/2026, the Health Care Director, or designee, shall audit current resident records for compliance with 2600.234a. Support plans found to be out of compliance shall have "Non compliance identified during Resident Record audit completed on XX/XX/XXXX by WHO as part of a plan of correction for survey on 3/23/2026" written on the bottom of the support plan. Documentation shall be kept.

• On 4/20/2026, the above findings for 2600.234a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 05/11/2026)