

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

June 12, 2026

[REDACTED]
SIMPSON MEADOWS
[REDACTED]
[REDACTED]

RE: SIMPSON MEADOWS
101 PLAZA DRIVE
DOWNINGTOWN, PA, 19335
LICENSE/COC#: 14118

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2026 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: SIMPSON MEADOWS	License #: 14118	License Expiration: 03/01/2027
Address: 101 PLAZA DRIVE, DOWNINGTOWN, PA 19335		
County: CHESTER	Region: SOUTHEAST	

Administrator		
Name: [REDACTED]	Phone: [REDACTED]	Email: [REDACTED]

Legal Entity		
Name: SIMPSON MEADOWS		
Address: [REDACTED]		
Phone: [REDACTED]	Email: [REDACTED]	

Certificate(s) of Occupancy		
Type: C-2 LP	Date: 09/11/1998	Issued By: COPA L&I

Staffing Hours		
Resident Support Staff: 0	Total Daily Staff: 65	Waking Staff: 49

Inspection Information		
Type: Partial	Notice: Unannounced	BHA Docket #:
Reason: Complaint, Incident	Exit Conference Date: 03/26/2026	

Inspection Dates and Department Representative		
03/26/2026 - On-Site: [REDACTED]		

Resident Demographic Data as of Inspection Dates			
General Information			
License Capacity: 81	Residents Served: 44		
Special Care Unit			
In Residence: Yes	Area: McKendree Gardens	Capacity: 18	Residents Served: 17
Hospice			
Current Residents: 9			
Number of Residents Who:			
Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 44		
Diagnosed with Mental Illness: 4	Diagnosed with Intellectual Disability: 0		
Have Mobility Need: 21	Have Physical Disability: 0		

Inspections / Reviews		
03/26/2026 Partial		
Lead Inspector: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 05/18/2026
05/20/2026 - POC Submission		
Submitted By: [REDACTED]	Date Submitted: 06/03/2026	
Reviewer: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 05/25/2026

Inspections / Reviews *(continued)*

05/26/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/03/2026

06/12/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

42b Abuse/Neglect

1. Requirements

2800.

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 7:45 p.m., as staff member A was pushing the wheelchair for resident [REDACTED] down the hallway, resident [REDACTED] began leaning to the left side. Staff member A fixed the resident with one hand and continued pushing the wheelchair with the other hand. Staff member A maneuvered the wheelchair, put the resident back in position, and kept going. When they got to resident [REDACTED]'s apartment door, resident [REDACTED] held onto the doorframe with both hands as the resident didn't want to go inside the room. Staff member A pushed the wheelchair through the doorframe and passed through. Resident [REDACTED] fell face-forward to the floor. Staff member A had both hands on the wheelchair and Staff member B was inside the apartment.

Neither of the staff members attempted to prevent the resident from falling. They sought assistance from staff member C and then called staff member D. The resident sustained a 2" bump on their forehead. The resident was not sent to the hospital due to DNR status.

Plan of Correction

Accept [REDACTED] - 05/26/2026)

Upon identification of the violation, the Administrator immediately reviewed the resident(s) involved to ensure resident rights are protected, and no ongoing risk exists. Any immediate concerns were addressed at the time of inspection.

Administrator or designee will in-service direct care staff on regulation 2800.42.b by 5/31/26. Direct Care staff will complete the training module "Preventing, Recognizing and Reporting Abuse" by 6/15/26.

The administrator or executive director will query 3 residents weekly for 90 days for any violation of 42b.

The administrator will go over one resident right at each monthly Assisted Living council meeting.

The administrator, nursing manager, or charge nurse will audit the 24-hour report for reports of abuse daily for 30 days, weekly for 30 days and monthly for 3 months. The results of the audit will be discussed at quarterly quality improvement meetings. The Quality Improvement Committee will decide if further auditing is necessary based upon three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [REDACTED] 06/12/2026)

65e Rights/Abuse 40 Hours

2. Requirements

2800.

65.e. 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.

65e Rights/Abuse 40 Hours (continued)

2. Emergency medical plan.
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.
5. Safe management techniques.
6. Core competency training that includes the following:
 - i. Person-centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Description of Violation

Staff person A completed [REDACTED] 40th scheduled work hour in September 2025. However, this staff person did not complete training in the following topics:

1. Emergency medical plan.
2. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
3. Safe management techniques.
4. Core competency training that includes the following:
 - i. Person centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference

Staff person C completed [REDACTED] 40th scheduled work hour in May 2025. However, this staff person did not complete training in the following topics:

1. Emergency medical plan.
2. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
3. Safe management techniques.
4. Core competency training that includes the following:
 - i. Person centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference

Plan of Correction

Accept [REDACTED] - 05/20/2026)

By 5/31/26, The Administrator will in service the human resource manager on regulation. 65e. The human resource manager has located. Staff member A&B's first day of training paper. The Human Resource manager will audit all communities first day of work training. All identified staff members with missing items will be in serviced and trained by 5/31/26. Starting 6/1/26, the Human resource manager will audit all new direct care staff new employee qualifications, weekly for 4 weeks, bi weekly for 4 weeks, and monthly for one month to validate sustained compliance. The results of the audit will be discussed during QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [REDACTED] - 06/12/2026)

82c Locked poisons

3. Requirements

2800.

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

Description of Violation

Sani-Hands wipes with a manufacturer's label indicating "Keep out of reach of children; if swallowed, get medical help or contact a Poison Control right away" were unlocked, unattended, and accessible to residents in the Memory Care Unit. Not all the residents of the residence, including residents in the Memory Care Unit, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction

Accept [redacted] - 05/20/2026)

On 3/26/26, the Dementia Care coordinator removed the Sani wipes. All other areas were checked in the unit, and no further instances were found. By 5/31/26, the Administrator will provide an in-service to nursing staff on the requirements of Regulation 81c. A daily environment-rounding tool will be done by the dementia care coordinator or designee to ensure compliance. Starting 6/1/26, the Administrator or Executive Director will audit all environment-rounding sheets weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for one month to validate sustained compliance. The results of the audit will be discussed during QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [redacted] - 06/12/2026)

121a Unobstructed egress

4. Requirements

2800.

121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

At 9:28 a.m. on [redacted], the Memory Care Unit's patio gate, which is used in an emergency, had a chain and a lock blocking the egress from the residence.

Plan of Correction

Accept [redacted] 05/20/2026)

The chain was removed from the courtyard gate immediately. All other routes of egress were checked for obstruction, and no further obstruction was found. The Executive Director in-serviced the communities' maintenance and housekeeping professionals on regulation 121a by 5/31/26. Starting 6/1/26 the Executive Director or administrator will audit the communities egress routes for obstruction weekly for 4 weeks, every two weeks for 4 weeks, and monthly for one month to validate sustained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [redacted] - 06/12/2026)

125a Combustible storage

5. Requirements

2800.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On [redacted] at 9:37 a.m., there was a can of [redacted] and [redacted] with a label precaution that reads "Danger: Extremely Flammable" located near heat sources and hot water heaters.

Plan of Correction

Accept [redacted] - 05/20/2026)

The flammable items were removed immediately. All other areas were checked for flammable materials, and no further obstruction was found. The Executive Director will in-service the communities' maintenance and housekeeping professionals on regulation 125a by 5/31/26. Starting on 6/1/26, the Executive Director or administrator will audit the community's boiler room for 4 weeks, every two weeks for 4 weeks, and monthly for one month to validate sustained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [redacted] 06/12/2026)

141a Medical evaluation

6. Requirements

2800.

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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

The medical evaluation for resident [redacted], dated [redacted], does not include a general physical examination. This area of the form is blank.

141a Medical evaluation (continued)

Plan of Correction

Accept [REDACTED] - 05/20/2026)

The staff development Coordinator will in-service the nurse manager, Administrator and Assisted living coordinate on violation 141a. We were unable to retroactively correct resident A DME. A new DME will be obtained for resident A by 5/3/26. By 5/31/26 the Assisted Living Coordinator will audit all residents DME's for missing boxes. Any resident that is missing a box that needs to be filled out will be given to the nurse manager to go be gone over with the provider. Starting 6/1/26 the Administrator or executive director will audit all new DME's, weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for one month to validate sustained compliance. The results of the audit will be discussed during QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [REDACTED] 06/12/2026)

187b Date/time of med admin

7. Requirements

2800.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] on in the am and off in the pm. However, on [REDACTED] and [REDACTED], the resident medication administration record does not include the initials of the staff person(s) who took them off.

Resident [REDACTED] is prescribed [REDACTED] concentrate 100 mg/5 ml once a day. However, on [REDACTED] at 6:00 a.m., the resident medication administration record does not include the initials of the staff person who administered it.

Resident [REDACTED] is prescribed [REDACTED] three times a day. However, on [REDACTED] and [REDACTED] at 9:30 p.m., the resident medication administration record does not include the initials of the staff person(s) who administered it.

Plan of Correction

Accept [REDACTED] - 05/20/2026)

Upon identification of the medication error, the resident was immediately assessed for adverse effects, and the prescribing physician and resident representative were notified.

All medication trained staff will be in-serviced by 5/31/26 on proper medication administration, Identification of medication errors and what constitutes as an error, Immediate response, documentation, and notification requirements per § 2800.187.

Starting 6/1/26, medication administration audits will be conducted by the Nurse Manager or designee weekly for one month, bi-weekly for one month, and then monthly to confirm maintained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [REDACTED] - 06/12/2026)

187d Follow prescriber's orders

8. Requirements

2800.

187d Follow prescriber's orders (continued)

187.d. The residence shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] on Tuesdays and Fridays between 3:00 p.m. and 11:00 p.m. However, this medication was not administered to resident [redacted] on [redacted], and it was signed by staff member D as administered.

Plan of Correction

Accept [redacted] 05/26/2026)

There was no opportunity to correct this situation immediately.
Rearrangement of resident 2 shower schedule was made so it would coincide with [redacted] treatment plan.
The Nurse Manager will complete a review of all medication errors within the last 3 months by 5/31/26 to identify any trends.
The Nurse manager will in-service all medication trained staff on 2800.187.d by 5/31/26.
Starting 6/1/26, Medication administration audits will be conducted by the Nurse Manager or designee weekly for one month, bi-weekly for one month, and then monthly to confirm maintained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [redacted] - 06/12/2026)

233c Key-locking devices

9. Requirements

2800.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the residence's locking mechanism are not conspicuously posted near the patio door in the special care unit.

Plan of Correction

Accept [redacted] - 05/20/2026)

The directions for operating the patio door were posted immediately. All other doors were checked for compliance no more instances were found. The Executive Director will in-service the communities' maintenance professionals on regulation 233c by 5/31/26. Starting on 6/1/26, the Dementia care coordinator or designee will audit the locking doors for 4 weeks, every two weeks for 4 weeks, and monthly for one month to validate sustained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [redacted] - 06/12/2026)