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

September 1, 2026

[redacted]
REMED RECOVERY CARE CENTERS LLC
[redacted]

RE: REMED RECOVERY CARE CENTERS
1152 NORTH NEW STREET
WEST CHESTER, PA, 19380
LICENSE/COC#: 10623

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2026 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: *REMED RECOVERY CARE CENTERS* **License #**: *10623* **License Expiration**: *05/26/2027*

Address: *1152 NORTH NEW STREET, WEST CHESTER, PA 19380*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *REMED RECOVERY CARE CENTERS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/22/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *14* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/02/2026*

Inspection Dates and Department Representative

06/02/2026 - 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**: *3*

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

Have Mobility Need: *7* **Have Physical Disability**: *6*

Inspections / Reviews

06/02/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/28/2026*

06/29/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/16/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/04/2026*

Inspections / Reviews *(continued)*

07/08/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/16/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/19/2026*

09/01/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/16/2026*

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 persons A and B did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan or infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration during the 2025 training year.

Repeat Violation: 6/23/25

Plan of Correction ***Accept ([redacted] - 07/08/2026)***

Updated:
Training regarding meeting the needs of the resident as described in the Preadmission Screening Form, Resident Assessment Tool, Medical Evaluation and Individual Support Plans has been scheduled for 7/15/2026, and will be led by the Clinical Specialist. This training will be held in person, and virtually via Google Meet for off-duty staff to attend, who will be compensated for their time. Staff attendance will be documented, tracked and then added to the Relias LMS to be included on all staff's training transcript.
A recording of the training, along with minutes and necessary materials will be distributed to any staff who were unable to attend on 7/15/2026 either in person or virtually, with the expectation that they will complete and sign off on training by 7/18/2026.

To prevent future lapses, this training will be conducted annually by the Clinical Specialist, or as needed based on changing clinical and support needs of residents.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)

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.

65g Annual Training Content *(continued)*

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 resident rights, The Older Adult Protective Services Act (35 P. S. § 10225.101 10225.5102), or falls and accident prevention in the 2025 training year.

Plan of Correction ***Accept ([redacted] - 06/29/2026)***

The home has an annual training curriculum and procedures in place so that all staff complete the required annual training content. The PA DHS Annual Trng Outline 2025 lists the required trainings and modules for each staff to complete annually. This additionally highlights the required training content that are covered in each of the training or module. Please see the previously attached PA DHS Annual Trng Outline 2025 and the previously attached 2026 version.

Procedure wise, the company's Training Coordinator registers all staff into all of the required trainings/modules when they are made available in the Relias LMS. They also email everyone at that time informing them that they are enrolled, the due date, and how to check their completion status in Relias. Staff also get emails 90 days, 60 days, 30 days, 1 week and then daily prior to a training's due date reminding them. Managers get a monthly report telling them which of their staff have both upcoming trainings due and overdue trainings. This report can also be manually checked with the current status at any time. The Training Coordinator also emails managers 2 weeks and 1 week prior to trainings with which of their staff are assigned to attend upcoming trainings.

Per the 2025 annual training curriculum, the training content of resident rights and the Older Adult Protective Services act, and falls and accident prevention would have been covered in the following modules: Collage Health & Safety Overview and Collage Confidentiality & Compliance Overview.

Staff A: Did not complete the Collage Health & Safety Overview or Collage Confidentiality & Compliance Overview by the 12/31/2025 due date. These trainings have since been completed on 3/2/2026 and 6/23/2026 respectively. See previously attached Staff A transcripts.

Staff B: Did not complete the Collage Health & Safety Overview or Collage Confidentiality & Compliance Overview by the 12/31/2025 due date. These trainings have since been completed on 2/25/2026. See previously attached Staff B transcripts.

Beginning 7/10/2026, the Administrator will maintain a master staff training tracker and cross reference it during the first week of each month with the Relias compliance dashboard to track upcoming trainings and to ensure they are completed by the assigned due date.

Staff re education on required annual training expectations is scheduled to occur with the Administrator on 7/10/2026.

Licensee's Proposed Overall Completion Date: *07/10/2026*

Implemented ([redacted] - 09/01/2026)

103e - Left Overs

3. Requirements

103e Left Overs *(continued)*

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 6/2/26 at 9:45am, there was a bag of unlabeled, undated pizza rolls in the kitchen freezer and a bag of unlabeled, undated cut onions in the refrigerator.

Plan of Correction ***Accept ([redacted] - 07/08/2026)***

Updated:
As noted above, the DHS Kitchen Checklist is completed daily, and will remain place ongoing (indefinitely). This is scheduled on the staffing grids daily, for direct care staff (Life Skills Trainers) to complete. Attached is a week of staffing grids, noting the completion of the checklist to be completed during each overnight shift.

The Administrator will conduct the weekly kitchen audits for the month of July 2026, each Wednesday, beginning 7/2/2026.

Licensee's Proposed Overall Completion Date: *07/10/2026*

Implemented ([redacted] - 09/01/2026)

103f Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 6/2/26 at 9:45am, there was no thermometer present in refrigerator or freezer in the kitchen area.

Plan of Correction ***Accept ([redacted] - 07/08/2026)***

Updated:
The Administrator will conduct the weekly kitchen audits for the month of July 2026, each Wednesday, beginning 7/2/2026. This will include a tracker to ensure thermometers are present in each refrigerator/freezer weekly through July, then monthly through 2026. See attached template.

Licensee's Proposed Overall Completion Date: *07/10/2026*

Implemented ([redacted] - 09/01/2026)

132a Monthly Fire Drill

5. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held in the month of October 2025.

Plan of Correction ***Directed ([redacted] - 07/08/2026)***

Updated:
All Life Skills Trainers (LST) are trained on how to conduct a fire drill. If a Health & Safety Representative is not in place, the Administrator will be responsible to schedule an LST to complete a monthly fire drill.

132a - Monthly Fire Drill (continued)

Proposed Overall Completion Date: 07/01/2026

Directed Plan of Correction (7/8/2026 - [redacted]

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall review and update the home's policies regarding fire safety, to include the requirements of 132a-j and include contingency plans for the conduct of drills when a designated person is unavailable.

Starting immediately, the administrator or designee shall review monthly fire drill logs to ensure the completion of drills.

Directed Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)

132d - Evacuation

6. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The maximum safe evacuation time specified in writing in the past year by the home's fire safety expert was 5 minutes and 0 seconds. During the fire drill held on 4/16/26 at 4:45am, the evacuation time was approximately 8 minutes.

Plan of Correction ***Accept ([redacted] - 07/08/2026)***

Updated:
The Administrator and Clinical Specialist identified 1 resident who is showing difficulty with evacuating within the home's designated time during the overnight shift/when in bed. During the week of 7/6/26, the Administrator will conduct an overnight fire drill to observe transfers, etc., to ensure that the safest and most time efficient procedures are being utilized during an evacuation. Based upon what is observed during this fire drill, the site-specific evacuation procedures will be updated.

If the resident is still unable to evacuate timely, an individual evacuation plan was created (attached). This resident's ability to evacuate within the designated timeframe will be determined based upon the staffing pattern as well as [redacted] *location at the time of the evacuation. The Case Manager or Clinical Specialist will request 1:1 staff from this resident's funder, to support safety and evacuation during the overnight shift. As noted in the attached plan, smoke-intumescent door strips will be installed on this resident's bedroom door by 7/8/2026. These strips prevent smoke inhalation by blocking smoke from entering the room.*

As noted above, all staff will be retrained on these updated evacuation procedures, for both the home and specific best practices for residents to safely evacuate as quickly as possible. This will be completed by 7/18/2026, with record of training kept.

132d - Evacuation *(continued)*

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)

132e - Fire Drill Sleeping Hours

7. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 4/16/26. The previous sleeping hours fire drill was conducted on 4/30/25.

Plan of Correction ***Directed ([redacted] - 07/08/2026)***

Updated:
All Life Skills Trainers (LST) are trained on how to conduct a fire drill. If a Health & Safety Representative is not in place, the Administrator will be responsible to schedule an LST to complete a monthly fire drill.

Proposed Overall Completion Date: 07/01/2026

Directed Plan of Correction (7/8/2026 - [redacted]

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall review and update the home's policies regarding fire safety, to include the requirements of 132a-j and include contingency plans for the conduct of drills when a designated person is unavailable.
Starting immediately, the administrator or designee shall review monthly fire drill logs to ensure the completion of drills.

Directed Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)

132h - Designated Meeting Place

8. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 4/16/26 at 4:45am, all residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept ([redacted] - 07/08/2026)***

Updated:
As noted in violation 132d, the Administrator and Clinical Specialist identified 1 resident who is showing difficulty with evacuating within the home's designated timeframe during the overnight shift/when in bed. During the week of 7/6/2026, the Administrator will conduct an overnight fire drill to observe transfers, etc., to ensure that the safest and most time efficient procedures are being utilized during an evacuation. Based upon what is observed during this fire drill, the site-specific evacuation procedures will be updated.

132h - Designated Meeting Place (continued)

If the resident is still unable to evacuate timely, an individual evacuation plan was created (previously attached). This resident's ability to evacuate within the designated timeframe will be determined based upon the staffing pattern as well as [redacted] location at the time of the evacuation. The Case Manager or Clinical Specialist will request 1:1 staffing from this resident's funder, to support safety and evacuation during the overnight shift.

As noted above, all staff will be retrained on these updated evacuation procedures, both for the home and specific best practices for residents to safely evacuate as quickly as possible. This will be completed by 7/18/2026, with record of training kept. Additionally, all staff are trained annually on fire safety and evacuation procedures.

Also, as noted above, the Administrator will review all completed fire drill forms immediately upon receipt, to ensure that the evacuation procedures are being followed. Additionally, upon completion of the fire drill form, either the Health and Safety Representative or the Administrator submit the drill form to the company's Quality Management Specialist to review and ensure evacuation procedures are being followed. This is a current process that will remain in place ongoing.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)

162c - Menus Posted

9. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 6/2/26 at 9:40am, the home's menu for the week beginning 6/6/26 was posted; however, the menu for the current week was not posted.

Plan of Correction ***Directed ([redacted] - 07/08/2026)***

Updated:
The weekly walkthroughs by the Administrator will continue on an ongoing basis.

Proposed Overall Completion Date: 07/01/2026

Directed Plan of Correction (7/8/2026 - [redacted]

Immediately, the administrator or designee shall audit for the presence of posted menus weekly for three months.

Directed Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)

184b - Labeling OTC/CAM

10. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

184b Labeling OTC/CAM *(continued)*

Description of Violation

On 6/2/26, blister cards of Ibuprofen 200mg with 5 tablets removed, Banophen 25mg with 5 tablets removed, and Chlorseptic Lozenges with instructions stating "use as instructed" were observed in the home's medication closet. They were not labeled with a resident name or room number. An interview with Staff Member C indicated that these medications were kept as house stock and could be used by residents or staff of the home.

On 6/2/26, [redacted] belonging to Resident #1 was located in the home's medication cabinet and it was not labeled with the resident's name.

Repeat Violation: 6/23/25

Plan of Correction ***Directed ([redacted] - 07/08/2026)***

Updated:
All DHS Medication Trained staff are receiving individual training regarding OTC and CAM labeling requirements along with the updated above 'house stock' OTC PRN procedures. This training is being conducted face to face on an individual basis by the home's Medication Manager. All individual trainings will be completed by 7/3/2026.

Regarding the Medication Manager's oversight of pharmacy orders, as of 6/19/2026 they began completing a physical inventory/audit of the medication room weekly. This will occur ongoing, as a new expectation of their role. The weekly Medication Monitor audit tool for OTC PRN medications (template attached) has been updated to include that a minimum of 2 to 3 blister packs of stock OTC PRN medications are available at all times, so that the medication is available for multiple residents if needed.

As of 6/25/2026 the contracted pharmacy began delivering the smaller quantity blister packs of OTC PRN medications, in accordance with the previously submitted updated procedures.

Proposed Overall Completion Date: 07/03/2026

Directed Plan of Correction (7/8/2026 - [redacted]

Starting immediately, the administrator or designee shall educate staff that any blister packs containing over the counter medication must be prescribed for a resident's use and present on the resident's medication administration record. Additionally, staff shall be educated that once a medication for a resident is removed from the blister package, that package then belongs to the resident and must be labeled in accordance with 2600.184b.

Starting immediately, the administrator or designee shall conduct weekly audits of the use and labeling of house stock OTC medications for two months. Documentation of audits shall be kept.

Directed Completion Date: *07/18/2026*

Implemented ([redacted] - 09/01/2026)