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

July 21, 2026

[redacted], COO
HSL BLANDON SUBTENANT LLC
[redacted]

RE: KEYSTONE VILLA AT FLEETWOOD
501 HOCH ROAD
BLANDON, PA, 19510
LICENSE/COC#: 22770

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/11/2026 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: *KEYSTONE VILLA AT FLEETWOOD* **License #**: *22770* **License Expiration**: *06/04/2027*

Address: *501 HOCH ROAD, BLANDON, PA 19510*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HSL BLANDON SUBTENANT LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/18/2011* **Issued By**: *Maidencreek Township*

Staffing Hours

Resident Support Staff: *38* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/11/2026*

Inspection Dates and Department Representative

06/11/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *61*

Secured Dementia Care Unit

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

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *61*

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

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

06/11/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2026*

07/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/20/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/20/2026*

Inspections / Reviews *(continued)*

07/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2026*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:32 a.m., a document containing medical information including blood glucose readings and blood pressure readings for residents #1, #2, #3, and #4 was unattended and accessible on top of the home's 3rd floor medication cart. Repeated Violation: 05/29/2025.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, the document was immediately removed from the med cart by the Executive Director.

Additional Corrective Action: Beginning 6/11, Resident Care Director trained all caregivers and medtechs on record confidentiality. This training was completed between the dates of 6/11 and 6/18.

Ongoing Quality Assurance Actions: Beginning the week of 6/15, the resident care director will perform weekly rounds for 8 weeks to ensure resident records confidentiality is being maintained. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

95 - Furniture and Equipment

2. Requirements

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

Description of Violation

At approximately 3:10 p.m., the left side fire door leading into the hallway near room 337 did not close and latch automatically and needed the intervention of staff to close securely.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: Advanced doors came to the community 6/12 and fixed the fire doors on the 3rd floor, ensuring they now latch automatically.

Additional Corrective Action: Maintenance Director and Maintenance Assistant were provided with training on 6/12 by the Executive Director related to regulation 2600.95. All doors were checked for compliance.

Ongoing Quality Assurance: During our next fire drill, the maintenance director or assistant will be responsible for

95 - Furniture and Equipment (continued)

ensuring all fire doors close properly. The maintenance director will perform daily building rounds. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

103e - Left Overs

3. Requirements

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

At approximately 2:07 p.m., there was an unlabeled undated bag containing what was identified by staff as frozen chicken cutlets in the walk-in freezer of the home.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, the chicken culets were thrown away.

Additional Corrective Action: Between 6/12 and 6/18, all cooks and the dining services directed were trained by the Executive Director on regulation #103e.

Ongoing Quality Assurance: The Dining Services Director will audit the walk-in freeze three times a week for 12 weeks to ensure all foods are labeled and sealed. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

103g - Storing Food

4. Requirements

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

Description of Violation

At approximately 2:07 p.m., a bag containing what was identified by staff as frozen chicken cutlets, was open and unsealed in the walk-in freezer of the home.
At approximately 2:10 p.m., there was an open and unsealed container of ice cream in the glass topped chest freezer located in the kitchen of the home.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, the chicken culets and ice cream were thrown away.

103g - Storing Food (continued)

Additional Corrective Action: Between 6/12 and 6/18, all cooks and the dining services directed were trained by the Executive Director on regulation #103e.

Ongoing Quality Assurance: The Dining Services Director will audit to ensure food is closed or in a sealed container three times a week for 12 weeks to ensure all foods are labeled and sealed. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 07/21/2026)

121a - Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 9:38 a.m., the dining room fire exit doors that lead to the smoking area could not open without use of excessive force which would block egress from the dining room.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: Advanced doors came to the community 6/12 and fixed the exit doors in the PC dining room so they can now be opened without force.

Additional Corrective Action: Maintenance Director and Maintenance Assistant were provided with training on 6/12 by the Executive Director related to regulation 2600.121a. All doors were checked for compliance.

Ongoing Quality Assurance: During our next fire drill, the maintenance director or assistant will be responsible for ensuring all fire doors close properly. The maintenance director will perform daily building rounds. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

131f - Fire Extinguisher Inspection

6. 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

At 9:22 a.m., the fire extinguisher in the facility transportation van did not have an attached inspection tag.

131f - Fire Extinguisher Inspection *(continued)*

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection, the tag was located on the floor next to the fire extinguisher and was placed back on the extinguisher.

Additional Corrective Action: The maintenance director and maintenance assistant were provided with training on 6/12 by the Executive Director related to regulation 131f.

Ongoing Corrective Action: The maintenance director will audit 5% of fire extinguishers monthly to ensure they are appropriately tagged. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

132h - Designated Meeting Place

7. 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

Through an interview with the resident, it was confirmed that during the fire drill conducted on 5/3/26 at 4:18 a.m., resident #1 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At 6:56pm on 6/11/26, a second shift fire drill was performed by the maintenance director and the maintenance director ensured all residents were evacuated to a designated meeting place.

Additional Corrective Action: Two day prior to inspection on 6/9/26, all staff completed our mandatory annual fire safety training with [redacted] with Fire and Safety Solutions.

Ongoing Corrective Action: The Executive Director will observe the next four fire drills to verify that all residents are evacuated to a designated meeting place. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

181c - Self-administration Assessment

8. Requirements

2600.

181c - Self-administration Assessment *(continued)*

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #5 self-administers medications to include Refresh Tears Eye drops; however, resident #5 has not been assessed by a physician, physician's assistant, or certified/registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications. The resident medical evaluation dated 5/6/26 does not indicate the resident is able to self-administer medications.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, the eye drops were removed from the residents apartment.

Additional Corrective Action: All wellness staff were trained by the Resident Care Director on 7/8 about regulation #181c.

Ongoing Corrective Action: The Resident Care Director will conduct monthly audits of 5% of resident apartments to verify that residents who are not authorized to self-administer medications do not have medications stored in their apartments. Any findings will be addressed immediately through corrective action and staff re-education, as appropriate. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

183b - Meds and Syringes Locked

9. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At approximately 2:41 p.m., a bottle of Refresh Tears eyedrops were found on an end table in the apartment belonging to resident #5. The door to the apartment was unlocked and the medication was unattended and accessible.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, the eye drops were removed from the residents apartment.

183b - Meds and Syringes Locked (continued)

Additional Corrective Action: All wellness staff were trained by the Resident Care Director on 7/8 about regulation #183b.

Ongoing Corrective Action: The Resident Care Director will conduct monthly audits of 5% of resident apartments to verify that residents who are authorized to self-administer medications have their apartment door locked or their medications secured. Any findings will be addressed immediately through corrective action and staff re-education, as appropriate. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

183e - Storing Medications

10. 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

Resident #6's Pregabalin 25 mg medication card was tampered with and had tape on the back of the card holding a tablet in place.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, the pregablain was properly disposed of.

Additional Corrective Action: A full med cart audit was completed the week of 6/29 by the resident care director and executive director. All med techs were retrained on 7/8 by the resident care director on regulation 183e.

Ongoing Corrective Action: Beginning the week of 7/6, a member of the wellness team will be completing a weekly audit to ensure all medications are properly stored. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

185a - Implement Storage Procedures

11. 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 #7's PRN Bisacodyl 10 mg and PRN Morphine Sulf 100mg/5mc 0.25 ML medications were not available in

185a Implement Storage Procedures (continued)

the home.
Repeated Violation 05/29/2025

Plan of Correction ***Accept (- 07/13/2026)***

Immediate Corrective Action: At the time of inspection on 6/11, we received an order from the physician to discontinue prn bisacodyl and morphine.

Additional Corrective Action: A full med cart audit was completed the week of 6/29 by the resident care director and executive director. All med techs were retrained on 7/8 by the resident care director on regulation 185a.

Ongoing Corrective Action: Beginning the week of July 6, 2026, a member of the Wellness Team will conduct weekly audits to verify that all ordered PRN medications are available and on hand for resident use and properly stored. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 07/21/2026)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #1's Lispro 100 Unit/ML KWIKPEN check blood sugar 4 times daily w/SSI; 0 150 2U. On 6/1/26 at 9:00 a.m., the medication administration record was transcribed incorrectly indicating resident was administered 3 units when only given 2 units.
Repeated Violation: 05/29/2025.

Plan of Correction ***Accept (- 07/13/2026)***

Immediate Corrective Action:
Upon identification of the transcription error, the Resident Care Director immediately reviewed Resident #1's medication administration record (MAR) against the physician's order to verify the correct sliding scale insulin dose. The documentation error was corrected, and the medication technician involved received immediate re education on accurately documenting medications administered and verifying documentation against physician orders prior to completing the MAR.

Additional Corrective Action: All med techs were retrained on 7/8 by the resident care director on how to understand and implement sliding scale instructions.

Ongoing Quality Assurance: Beginning the week of July 6, 2026, the Resident Care Director or resident care coordinator will conduct weekly audits of all residents receiving sliding scale insulin to verify that medication administration records accurately reflect the physician's orders and the dose administered. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure

187a - Medication Record (continued)

compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)

187d - Follow Prescriber's Orders

13. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3's orders indicate Lisinopril 5 mg tab 1 tab orally every morning for hypertension. Hold if SBP is less than 110. On 6/1/26, the medication was held when the SBP reading was 110.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

Immediate Corrective Action:
Upon identification of the deficiency, Resident #3's physician order was immediately reviewed with the medication administration record to verify the prescribed hold parameters. The medication technician involved received immediate re-education on following physician orders exactly as written, including the proper interpretation of hold parameters and ensuring medications are administered unless the specific criteria to hold the medication are met.

Additional Corrective Action: Additional Corrective Action: All med techs were retrained on 7/8 by the resident care director on how to understand parameters and prescriber instructions.

Ongoing Corrective Action: Beginning the week of July 6, 2026, the Resident Care Director or designee will conduct weekly audits of residents with medication hold parameters to verify medications are administered or withheld in accordance with the prescriber's orders. Ongoing compliance will be reviewed as part of the quarterly QA meetings, beginning July 2026. The Executive Director will ensure compliance by providing weekly oversight.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 07/21/2026)