

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

October 1, 2026

[REDACTED]
LCS BELLINGHAM TENANT LLC
[REDACTED]
[REDACTED]

RE: BELLINGHAM AT WEST CHESTER
1615 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 15199

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/08/2026 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: BELLINGHAM AT WEST CHESTER

License #: 15199

License Expiration: 05/30/2027

Address: 1615 EAST BOOT ROAD, WEST CHESTER, PA 19380

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: LCS BELLINGHAM TENANT LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1

Date: 02/21/2008

Issued By: East Goshen Township

Type: I-2

Date: 05/04/2023

Issued By: East Goshen Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 89

Waking Staff: 67

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Monitoring

Exit Conference Date: 07/08/2026

Inspection Dates and Department Representative

07/08/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 80

Residents Served: 57

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 24

Residents Served: 15

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 57

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 32

Have Physical Disability: 5

Inspections / Reviews

07/08/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/21/2026

09/22/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/25/2026

Inspections / Reviews *(continued)*

10/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2026

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

On [REDACTED], at 9:48 am, there was a laptop on top of the medication cart on the 2nd floor left unlocked, unattended, and accessible with medication list and medication administration records for [REDACTED] to [REDACTED] for two different residents.

Plan of Correction

Accept [REDACTED] - 09/22/2026)

Immediately upon identification of the concern, the laptop was secured by an authorized staff member and the resident information displayed on the screen was no longer accessible to unauthorized individuals. The community determined that staff did not consistently secure electronic devices containing resident information when stepping away from the medication cart. The incident reflected a need for reinforced staff education and monitoring related to confidentiality of resident records, screen locking, and safeguarding electronic protected resident information. Staff was reeducated on 9/14/26 about maintaining confidentiality of resident records, securing medication administration records and medication lists, locking computer screens before leaving a workstation or medication cart, and ensuring electronic devices containing resident information are never left unlocked, unattended, or accessible to unauthorized individuals. Director of nursing, health services assistant and executive director will do spot checks daily to make sure all electronic items have nothing displayed, effective immediately until compliance is achieved.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] 10/01/2026)

62 - Contact List

2. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

The home does not keep an updated staff list. An updated staff list was not provided until 3:26 pm by staff person A. The home's staff list did not include staff person B.

Plan of Correction

Accept [REDACTED] - 09/22/2026)

The community acknowledges the requirement under 2600.62 that the administrator maintain a current list of the names, addresses, and telephone numbers of all staff persons, including substitute personnel and volunteers. During the survey, a staff list was requested, and a 2024 staff list was initially provided because staff understood the request to be for documentation from 2024. The community does maintain an up-to-date employee list; however, due to miscommunication regarding the specific timeframe and document being requested, the most current staff list was not provided until later that day. The community's intent was not to withhold information or documentation from the Department. Business office Manager updates system as new hires and terminations occur so that up-to-date lists are always available.

62 - Contact List (*continued*)

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] - 10/01/2026)

65g - Annual Training Content

3. 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).
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 A did not receive training in the following topics during the 2025 training year:

- *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.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*

Staff person C did not receive training in the following topics during the 2025 training year:

- *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.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*

Plan of Correction

Accept [REDACTED] - 09/22/2026)

The community has implemented an updated version of the Relias training platform to ensure required and supplemental staff education is completed, tracked, and documented as of 9/14/26. Relias will be used to assign additional trainings related to Chapter 2600 compliance, resident safety, fire safety, incident reporting, documentation standards, and department-specific responsibilities.

Staff will be assigned applicable training modules based on role and department. Completion records will be maintained through the Relias platform and reviewed by leadership to verify timely completion. Each department head will be responsible for overseeing compliance within their respective department. This includes ensuring staff understand applicable Chapter 2600 requirements, completing assigned trainings, following established policies and procedures, and maintaining required documentation.

Department heads will conduct ongoing reviews within their departments and will report compliance concerns, training deficiencies, or documentation issues to the Executive Director for follow-up and corrective action as needed. The community now has a fire safety trained expert on the team to provide additional oversight, guidance, and support related to fire safety practices. This individual will assist with monitoring fire safety procedures, reviewing

65g Annual Training Content (continued)

staff understanding of fire safety expectations, and supporting ongoing compliance with applicable Chapter 2600 fire safety requirements.

Fire safety training and drills will continue to be completed in accordance with regulatory expectations and community policy. Any identified concerns will be addressed promptly through retraining, documentation review, or corrective follow up. The Executive Director, in collaboration with department heads, will monitor ongoing compliance through routine audits, staff education reviews, department meetings, and quality management oversight. Training completion reports from Relias will be reviewed regularly to ensure staff remain current with assigned trainings.

Any deficiencies identified through audits, observations, or documentation review will be corrected promptly. Follow up education and coaching will be provided when needed to ensure sustained compliance and prevent recurrence. Ongoing monitoring, Relias training assignments, department head oversight, and fire safety review will continue as part of the community's quality management and regulatory compliance process.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] - 10/01/2026)

105g - Lint Removal and Duct Cleaning**4. Requirements**

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On [REDACTED], at 9:37 am, there was an approximate one inch accumulation of lint in the lint trap of the kenmore dryer on the lower level personal care side. There were no clothes in the dryer at the time.

Plan of Correction

Accepted [REDACTED] 09/22/2026)

The lint trap and dryer drum were cleaned immediately upon identification of the accumulation. The dryer was inspected to ensure that no lint remained in the lint trap or drum prior to further use. All staff who use or monitor the personal care laundry areas will be re educated on the requirement to remove lint from the lint trap and dryer drum after each use. A reminder sign will be posted in the laundry area stating that lint must be removed after every dryer cycle. Effective immediately, the housekeeping supervisor will inspect the lower level personal care dryer area regularly to verify that the lint trap, drum, and accessible vent areas are free from lint accumulation. Any concerns identified during inspection will be corrected immediately and documented. Corrective action was completed immediately on 7/8/2026. Staff re education and signage will be completed by 9/25/2026. Ongoing monitoring will begin immediately and continue as part of the community's routine maintenance and quality assurance process.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] 10/01/2026)

190c - Record of Training**5. Requirements**

2600.

190c - Record of Training (*continued*)

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person C does not include medication record review checklist and the medication administration observation checklist completed for the annual practicum on [REDACTED].

Plan of Correction

Accept [REDACTED] - 09/22/2026)

The medication administration training record for Staff Person C was reviewed. The missing medication record review checklist and medication administration observation checklist for the annual practicum dated 10/17/2025 were obtained, completed as applicable, and placed in Staff Person C's medication administration training record. The record now includes the staff person trained, date of training, source, name of trainer, and documentation that the annual practicum was successfully completed. The Director of Nursing will ensure that all medication administration training records are complete following initial and annual medication administration training. A medication administration training file audit checklist will be used to verify that each staff record includes the staff person trained, date of training, training source, name of trainer, documentation of successful course completion, medication record review checklist, and medication administration observation checklist. The Director of Nursing is responsible for implementing and monitoring this plan of correction. Corrective action was completed upon review and placement of the missing checklist documentation in Staff Person C's medication administration training record. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] - 10/01/2026)

224a - Preadmission Screen Form

6. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [REDACTED] was admitted to the home on [REDACTED]; however, the resident's preadmission screening form was not completed.

Repeated Violation - [REDACTED], et al.

Plan of Correction

Accept [REDACTED] - 09/22/2026)

The home acknowledges the cited deficiency. This citation relates to documentation from 2024, prior to the arrival of the current Executive Director and Director of Nursing in July 2025. Upon assuming their roles, leadership reviewed resident record processes and identified the need to strengthen admission documentation practices, including completion and verification of the Department's preadmission screening form prior to admission.

Resident #1 was no longer residing in the home when the current Executive Director and Director of Nursing joined the community in July 2025. Therefore, the home was unable to retroactively correct or complete the missing preadmission screening for this resident. However, the issue was self-identified as part of leadership's review of historical resident records, and corrective systems were implemented moving forward to prevent recurrence. Effective July 2025, the home implemented a triple-check admission review process to ensure required admission

224a - Preadmission Screen Form (continued)

documentation is completed prior to admission. The preadmission screening form is now reviewed before admission by the Director of Nursing. The home will continue using admission checklist and triple-check forms to confirm that each required preadmission screening is completed within 30 days prior to admission and documented before the resident is admitted. Admission files will be reviewed for compliance before move-in, and any missing required documentation must be obtained before admission proceeds. Corrective action was implemented in July 2025 and remains in place. Ongoing monitoring will continue as part of the home's quality assurance and admission review process.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] - 10/01/2026)

225a - Assessment 15 Days**7. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [REDACTED] was admitted on [REDACTED] however, the resident's assessment was not completed until [REDACTED]

Plan of Correction

Accepted [REDACTED] - 09/22/2026)

This citation was related to a historical documentation issue from 2024. When the Executive Director and Director of Nursing joined the community in June 2025, leadership identified the need to strengthen the admission review process and corrected the issue moving forward. Resident #1 was no longer residing in the community at the time the Executive Director and Director of Nursing arrived; therefore, the assessment could not be corrected retroactively for that resident. However, leadership self-identified the process gap and implemented corrective measures to ensure timely completion of initial assessments for all newly admitted residents going forward. All current admission processes have been reviewed and updated to ensure that initial assessments are completed on the Department's assessment form within 15 days of admission. A triple-check admission review form has been implemented to verify that required assessment documentation is completed timely and filed appropriately. The Director of Nursing reviews every admission documentation to confirm compliance with Chapter 2600 requirements. The community will continue to use the triple-check admission review process for each new admission. The review includes confirmation that the initial assessment is completed within the required 15-day timeframe, documented on the appropriate Department form, and reviewed by the Director of Nursing. Any missing or incomplete admission documentation will be immediately addressed and corrected before the 15-day deadline. Corrective measures were implemented upon identification by the Director of Nursing after joining the community in July 2025 and remain in place moving forward.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] - 10/01/2026)

227a - Support Plan 30 Days**8. Requirements**

2600.

227a Support Plan 30 Days (continued)

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident [REDACTED] was admitted on [REDACTED]; however, the resident's initial support plan was not completed until [REDACTED].

Plan of Correction

Accept [REDACTED] - 09/22/2026)

The community acknowledges the cited deficiency. This citation related to an admission that occurred in August 2024, prior to the current Executive Director and Director of Nursing joining the community in June 2025. Upon assuming their roles, the Executive Director and Director of Nursing identified documentation and process needs related to support plan completion and implemented corrective measures moving forward.

Resident #1 was no longer residing at the community when the current Executive Director and Director of Nursing arrived; therefore, the community was unable to retroactively correct the resident specific support plan deficiency. For any items that could not be corrected due to the passage of time or the resident no longer residing in the home, the community self identified the concern, reviewed the underlying process issue, and implemented system safeguards to prevent recurrence.

All identified process concerns related to this citation have been corrected. The community now requires completion and review of the Department's support plan form within the required 30 day timeframe for residents requiring personal care services. A triple check admission documentation process has been implemented to verify timely completion of required support plans. New admissions are tracked to ensure the Department's support plan form is completed and implemented within 30 days of admission, when required.

Any missing or incomplete documentation is addressed promptly through follow up with the responsible team member. Director of Nursing will continue to monitor new admission records to ensure support plans are completed within the required timeframe. Audits will be conducted on new admissions for continued compliance. Findings will be reviewed through the community's quality management process, and any identified concerns will be addressed immediately.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] 10/01/2026)

227d - Support Plan Medical/Dental**9. Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident [REDACTED] dated [REDACTED], indicates the resident has a moderate level of need for toileting, transfers, dressing, and bathing. The resident's support plan, dated [REDACTED] does not document how frequent this need will be met.

The assessment for resident [REDACTED], dated [REDACTED], indicates the resident has a moderate need for transfers utilizing a

227d Support Plan Medical/Dental (continued)

bedside device. The resident's support plan, dated [REDACTED] does not indicate the following:

- The intended use.
- Any risks associated with the device.
- The resident's ability to use the device safely for the intended purpose.
- Identification of the specific device to be used.
- If a cover is required to meet FDA guidelines.

Repeated Violation [REDACTED], et al.

Plan of Correction

Accept [REDACTED] /22/2026)

These concerns relate to 2024 documentation and were brought to the attention of the current Executive Director and Director of Nursing following their start in July 2025. The home cannot retroactively change the 2024 record; however, the home has completed a full review, added appropriate addenda where correction could not be made, and implemented additional safeguards to prevent recurrence. Upon identification of the concern, the Executive Director and Director of Nursing initiated a comprehensive audit of Residents support plan, and related documentation. For any information that could be updated accurately, the support plans were reviewed and revised to include each residents needs. Support plans were also reviewed to address bedside device documentation, including the intended use, risks associated with use, the resident's ability to use the device safely for the intended purpose, identification of the specific device, and whether a cover was required to meet FDA guidelines. For any item that could not be retroactively corrected because the documentation period had already passed, an addendum was added to explain the audit findings and the reason the record could not be changed. Nursing now uses triple check audits for each move in and when updating assessments. This will continue indefinitely to achieve compliance.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented [REDACTED] 10/01/2026)

227g -Support Plan Signatures**10. 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 [REDACTED] participated in the development of [REDACTED] support plan on [REDACTED]. However, the resident and the assessor did not sign the support plan.

Plan of Correction

Accept [REDACTED] - 09/22/2026)

The support plan referenced in this citation was completed prior to the current Executive Director and Director of Nursing assuming their roles. Because the omission occurred before the current leadership team was in place, the home is unable to go back and change the original missed signatures from 9/28/2024. When missing signatures or incomplete support plan documentation were self identified, addendums were completed as appropriate to clarify and correct the record.

Resident #1 was no longer residing in the home when the current Executive Director and Director of Nursing began in their positions; therefore, the home was unable to obtain the missing signatures after the fact. Current procedures have been implemented to ensure that support plans are reviewed for completion, including required signatures and dates from all individuals who participate in the development of the support plan. The Director of Nursing now audits all move in documentation using a triple check form. This audit includes review of the support plan to verify

227g -Support Plan Signatures (continued)

that all required participants have signed and dated the document. The triple-check process includes signature verification and review by nursing leadership prior to filing the support plan in the resident record. The Director of Nursing will continue to audit all new move-in support plans for completion, accuracy, and required signatures. Any missing or incomplete documentation identified during the audit will be corrected promptly through appropriate follow-up and/or addendum documentation. Corrective procedures are currently in place and ongoing.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented () - 10/01/2026)

251e - Records Availability**11. Requirements**

2600.

251.e. Resident records shall be made available to the resident and the resident's designated person during normal working hours.

Description of Violation

Resident family requested the resident's records from the home on an unknown date. However, the home does not have documentation indicating that the records were provided to the resident's family.

Plan of Correction

Accepted () 09/22/2026)

The home will implement a Resident Record Request Log to ensure all requests for resident records are tracked from receipt through completion. The log will include the resident's name, requester's name and relationship, date of request, records requested, date records were made available, staff member responsible, and any follow-up needed. Requests will be reviewed by the Executive Director to ensure records are made available to the resident or designated person during normal working hours in accordance with Chapter 2600.251(e). Administrative staff and department leaders who may receive requests for resident records will be re-educated on Chapter 2600.251(e), including the requirement to make resident records available to the resident and the resident's designated person during normal working hours and to document all requests and outcomes. Education will include review of the Resident Record Request Log and the process for notifying the Executive Director or designee when a request is received. Executive Director to review until compliance achieved. Findings will be reviewed during the Quality Management meeting, and any identified concerns will be addressed through additional staff education or corrective action as needed.

Licensee's Proposed Overall Completion Date: 09/21/2026

Implemented () - 10/01/2026)

253a - Record 3 Years**12. Requirements**

2600.

253.a. The resident's entire record shall be maintained for a minimum of 3 years following the resident's discharge from the home or until any audit or litigation is resolved.

Description of Violation

Resident # was discharged from the home on However, On , the home was no longer in possession of the resident's entire record.

253a - Record 3 Years (continued)

Plan of Correction**Accept** [REDACTED] - 09/22/2026)

Since 2024, the community has transitioned to a completely electronic record system, which supports record retention by allowing resident records to be stored, accessed, and maintained electronically rather than relying on paper files. Moving forward, discharged resident records will be retained electronically in accordance with the 3-year retention requirement. The community will maintain all discharged resident records electronically for a minimum of 3 years following discharge. The Executive Director will ensure that records are not deleted, removed, or archived in a manner that prevents access prior to the end of the required retention period. Electronic recordkeeping will assist the community in tracking discharged residents, maintaining complete records, reducing the risk of misplaced paper files, and ensuring records remain available for review upon request. The Executive Director will be responsible for ongoing compliance with this plan of correction.

Licensee's Proposed Overall Completion Date: 09/21/2026**Implemented** [REDACTED] - 10/01/2026)