

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

September 9, 2026

[REDACTED]
CHESTER SPRINGS SENIOR LIVING PARTNERS LLC
[REDACTED]
[REDACTED]

RE: FIELDSTONE AT CHESTER SPRINGS
145 BYERS ROAD
CHESTER SPRINGS, PA, 19425
LICENSE/COC#: 15181

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/20/2026 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: FIELDSTONE AT CHESTER SPRINGS

License #: 15181

License Expiration: 03/07/2027

Address: 145 BYERS ROAD, CHESTER SPRINGS, PA 19425

County: CHESTER

Region: SOUTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: CHESTER SPRINGS SENIOR LIVING PARTNERS LLC

Address:

Phone:

Email:

Certificate(s) of Occupancy

Type: I-1

Date: 08/19/2024

Issued By: Upper Uwchlan Township

Type: Other

Date: 08/19/2024

Issued By: Upper Uwchlan Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 129

Waking Staff: 97

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint, Incident

Exit Conference Date: 07/20/2026

Inspection Dates and Department Representative

07/20/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 132

Residents Served: 95

Secured Dementia Care Unit

In Home: Yes

Area: 1st and 2nd Floor

Capacity: 50

Residents Served: 34

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 95

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 34

Have Physical Disability: 0

Inspections / Reviews

07/20/2026 Partial

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 08/15/2026

08/17/2026 - POC Submission

Submitted By:

Date Submitted: 09/04/2026

Reviewer:

Follow-Up Type: Document Submission Follow-Up Date: 09/04/2026

Inspections / Reviews (*continued*)

09/09/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/04/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

16c - Written Incident Report**1. Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED] the residence received a complaint alleging possible abuse or neglect of a resident. The home did not report this incident to the department until [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/17/2026)

1. Upon identification of the reporting concern, the Executive Director reviewed the circumstances surrounding the 6/21/2026 complaint and submitted the required notification to the Department on 6/29/2026. The community will continue to cooperate with any Department review or investigation related to the incident.
2. On 7/6/26, the Executive Director reviewed all reportable incidents and allegations of abuse or neglect from the previous 12 months to verify that required notifications were submitted to the Department within the required timeframes. No deficiencies were identified as a result of this audit.
3. On 7/2/26, associates were in-serviced by the Executive Director on the requirements of recognizing heat-related illnesses.
4. Beginning on 7/6/2026 the Executive Director, or designee, will review all incidents and allegations of abuse or neglect to verify that required Department notifications are completed within the required timeframe and appropriately documented.
5. Incident reports will also be reviewed at quarterly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented [REDACTED] - 09/09/2026)

42b - Abuse**2. Requirements**

2600.

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 2:00am, Resident [REDACTED] was wandering around the secure dementia care unit, knocking on other resident doors. Staff Member A brought Resident [REDACTED] back to their room and then restrained them in their room, against their will, by holding the resident's door shut for at least five minutes to prevent them from leaving the room. The resident was crying, yelling and banging on the door to get out of the room. Staff person B observed this and called over to Staff person C, a supervisor, who was working in another unit to advise of the situation. Staff Member C arrived and found Staff Member A still holding the door shut while resident continued to cry and yell to be let out. Staff Member C had to request that Staff member A release the door and let resident out multiple times before Staff Member A released the door. Once the door was opened, the resident was crying, shaking and said they were afraid of getting killed. Staff member A was immediately suspended pending the homes internal investigation and subsequently terminated.

Plan of Correction

Accept [REDACTED] - 08/17/2026)

1. Upon discovery of the concern, Staff Member A was immediately suspended pending the home's internal

42b Abuse (continued)

investigation and was subsequently terminated. Management completed an internal investigation of the incident, including review of the circumstances surrounding the resident's treatment and the actions of the involved associates.

2. On 7/6/26, department leaders and associates providing direct care in the secured dementia care neighborhood were re educated, by the Executive Director, on resident rights, abuse prevention, prohibited practices, appropriate responses to dementia related behaviors, and the requirement to immediately report and intervene when a resident is at risk of abuse, neglect, mistreatment, or inappropriate restriction.

3. The department leaders will be educated, by Executive Director or Designee on the need to observe associate to resident interactions while completing daily rounds, and to report any interactions that may be in violation of resident rights, along with when and who to report their findings too by 8/31/2026.

4. Any identified concern will be addressed immediately, including additional education, coaching, corrective action, agency reporting, or other intervention as appropriate.

5. All findings will be reviewed at the Quality Assurance Meeting in September 2026.

Licensee's Proposed Overall Completion Date: 08/31/2026

Implemented [REDACTED] - 09/09/2026)

187d - Follow Prescriber's Orders**3. Requirements**

2600.

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

Description of Violation

On [REDACTED], Resident [REDACTED] was administered prescribed [REDACTED] at 5:32am, 6:35am and 3:31pm. The medication is prescribed for resident [REDACTED] to be given every 8 hours as needed for anxiety and agitation. The home did not follow the prescriber's order in administering the medication at 6:35am when it was administered less than 8 hours prior.

Plan of Correction

Accept [REDACTED] - 08/17/2026)

1. Upon identification of the concern, the Resident Care Director reviewed the resident's medication administration record and prescriber's order to verify the prescribed parameters for [REDACTED] every 8 hours as needed for anxiety and agitation. Based on the community's internal investigation it was determined that the medication was administered on 7/9/26 at 0635AM and 331PM per physician's order. The 0522AM med administration was a documentation error and was confirmed to not have been given.

2. On 7/9/26, the Resident Care Director reviewed the medication administration records for all residents receiving medications ordered on an "as needed" basis with specific time intervals between doses to verify that medications were administered according to the prescriber's orders. No discrepancies were noted during this review.

3. On 7/9/26, nurses and medication technicians were re educated by the Resident Care Director on following prescriber's orders, specifically including PRN medications with a specified amount of time between doses, reviewing medication orders prior to administration, and the rights of medication administration which includes the right documentation.

4. The Resident Care Director, or designee, will review medication administration records monthly for three months, beginning July 2026, with specific attention to PRN medications with a specified amount of time between doses to verify compliance with prescriber's orders.

5. Any medication administration discrepancies identified through the audit process will be immediately

187d - Follow Prescriber's Orders (continued)

investigated and corrected, reported to the department if applicable, with additional education or retraining provided as necessary.

6. Findings from the audits will be documented and reviewed by the Quality Assurance Committee during the September 2026 meeting.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented [REDACTED] - 09/09/2026)

202 - Prohibitions**4. Requirements**

2600.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move [REDACTED] arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompt escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [REDACTED] at 2:00am, Resident [REDACTED] was involuntarily confined to their room by Staff Member A for at least 5 minutes when Staff Member A held the resident's door closed despite the resident yelling and banging on the door to exit.

Plan of Correction

Accepted [REDACTED] - 08/17/2026)

1. The immediate concern was addressed when Staff Member A was removed from duty and immediately suspended pending the home's internal investigation. Staff Member A was subsequently terminated.
2. On 7/6/26, department leaders and associates providing direct care in the secured dementia care neighborhood were re-educated, by the Executive Director, on resident rights, abuse prevention, prohibited practices, appropriate responses to dementia-related behaviors, and the requirement to immediately report and intervene when a resident is at risk of abuse, neglect, mistreatment, or inappropriate restriction.
3. Any identified concern will be addressed immediately, including additional education, coaching, corrective action, agency reporting, or other intervention as appropriate.
4. All findings will be reviewed at the Quality Assurance Meeting in September 2026.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented [REDACTED] - 09/09/2026)