

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

August 31, 2026

[REDACTED]
CORNERSTONE LIVING MANAGEMENT LLC
[REDACTED]

RE: CORNERSTONE LIVING
4605 WERLEYS CORNER ROAD
NEW TRIPOLI, PA, 18066
LICENSE/COC#: 22791

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/21/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: CORNERSTONE LIVING

License #: 22791

License Expiration: 09/17/2026

Address: 4605 WERLEYS CORNER ROAD, NEW TRIPOLI, PA 18066

County: LEHIGH

Region: NORTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: CORNERSTONE LIVING MANAGEMENT LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2

Date: 09/09/2011

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 52

Waking Staff: 39

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint

Exit Conference Date: 07/21/2026

Inspection Dates and Department Representative

07/21/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 40

Residents Served: 26

Secured Dementia Care Unit

In Home: Yes

Area: Entire Home

Capacity: 40

Residents Served: 26

Hospice

Current Residents: 10

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 26

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 26

Have Physical Disability: 0

Inspections / Reviews

07/21/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/20/2026

08/19/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/25/2026

Inspections / Reviews (*continued*)

08/25/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/30/2026

08/31/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Residents [REDACTED] and [REDACTED] reside in a secure dementia unit and have diagnoses of [REDACTED]. According to the home's care notes for resident [REDACTED] resident [REDACTED] has been observed following resident [REDACTED] around the home and banging on the resident's door. According to the care notes for resident [REDACTED] the following occurred:

[REDACTED], 10:00 p.m.—resident [REDACTED] was seen banging on resident [REDACTED] door and yelling for them to come out; resident [REDACTED] also trying to escort resident [REDACTED] during dinner and resident [REDACTED] was visibly shaken.

[REDACTED], 11:25 a.m.—Resident [REDACTED] yelling at resident [REDACTED] to come sit with them before and after the lunch meal. Resident [REDACTED] was crying as a result and resident [REDACTED] had to be supervised to ensure they left resident [REDACTED] alone.

[REDACTED], 5:00 p.m.—Resident [REDACTED] grabbed resident [REDACTED] s arm. Resident [REDACTED] also seen banging on resident [REDACTED] s door. Resident [REDACTED] needed supervision to prevent contact with resident [REDACTED]

According to the home's administrator, approximately a month ago resident [REDACTED] was observed by staff in resident [REDACTED] room while resident [REDACTED] was changing and resident [REDACTED] was not wearing anything on top.

Also, on [REDACTED] at 6:35 p.m. resident [REDACTED] hit resident [REDACTED] in the abdomen during an argument.

The above incidents were not reported to the Area Agency on Aging.

Plan of Correction

Accept [REDACTED] - 08/19/2026

A verbal and written report was sent to the Area Agency on Aging on 8/13/2026. Abuse education for the administrator and DCS started 8/16/2026 to review education packet. Group meeting will take place 8/19/2026 at 2pm and 10pm for review and to answer questions. The attached education will be reviewed with the administrator and DCS. This will re-educate on abuse situations and reporting protocols. DCS will report abuse and resident altercations immediately to the administrator and assistant director of wellness. Step by step directions and forms are in the med tech office so that DCS, or anyone else, can report directly to DHS and the Area Agency on Aging.

Licensee's Proposed Overall Completion Date: 08/17/2026

Implemented [REDACTED] - 08/31/2026

15d - Resident Abuse-Notification

2. Requirements

2600.

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

Residents [REDACTED] and [REDACTED] reside in a secure dementia unit and have diagnoses of dementia. According to the home's care notes for resident [REDACTED] resident [REDACTED] has been observed following resident [REDACTED] around the home and banging on the resident's door. According to the care notes for resident [REDACTED] the following occurred:

[REDACTED], 10:00 p.m.—resident [REDACTED] was seen banging on resident [REDACTED] s door and yelling for them to come out; resident [REDACTED] also trying to escort resident [REDACTED] during dinner and resident [REDACTED] was visibly shaken.

[REDACTED], 11:25 a.m.—Resident [REDACTED] yelling at resident [REDACTED] to come sit with them before and after the lunch meal.

15d - Resident Abuse-Notification (continued)

Resident [REDACTED] was crying as a result and resident [REDACTED] had to be supervised to ensure they left resident [REDACTED] alone. [REDACTED], 5:00 p.m.—Resident [REDACTED] grabbed resident [REDACTED]’s arm. Resident [REDACTED] also seen banging on resident [REDACTED]’s door. Resident [REDACTED] needed supervision to prevent contact with resident [REDACTED]. According to the home’s administrator, approximately a month ago resident [REDACTED] was observed by staff in resident [REDACTED]’s room while resident [REDACTED] was changing and resident [REDACTED] was not wearing anything on top. Also, on [REDACTED] at 6:35 p.m. resident [REDACTED] hit resident [REDACTED] in the abdomen during an argument. The home did not notify the residents’ designated persons regarding the above incidents.

Plan of Correction**Accept ([REDACTED] - 08/19/2026)**

Education on regulations and facility policies for the administrator and DCS started 8/16/2026 to review education packet. Group meeting will take place 8/19/2026 at 2pm and 10pm for review and to answer questions. The attached education will be reviewed with the administrator and DCS. This will reinforce education on abuse situations and reporting protocols to the designated person. DCS will immediately report abuse and resident altercations to the administrator and assistant director of wellness. Step by step directions, forms and designated person contact information are in the med tech office so that DCS, or anyone else, can report accordingly. Administrator called resident [REDACTED] [REDACTED] and [REDACTED] designated person to review each situation to ensure proper communication was provided.

Licensee's Proposed Overall Completion Date: 08/17/2026**Implemented [REDACTED] - 08/31/2026)****16c - Written Incident Report****3. 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

Residents [REDACTED] and [REDACTED] reside in a secure dementia unit and have diagnoses of dementia. According to the home’s care notes for resident [REDACTED] resident [REDACTED] has been observed following resident [REDACTED] around the home and banging on the resident’s door. According to the care notes for resident [REDACTED] the following occurred: [REDACTED], 10:00 p.m.—resident [REDACTED] was seen banging on resident [REDACTED]’s door and yelling for them to come out; resident [REDACTED] also trying to escort resident [REDACTED] during dinner and resident [REDACTED] was visibly shaken. [REDACTED], 11:25 a.m.—Resident [REDACTED] yelling at resident [REDACTED] to come sit with them before and after the lunch meal. Resident [REDACTED] was crying as a result and resident [REDACTED] had to be supervised to ensure they left resident [REDACTED] alone. [REDACTED], 5:00 p.m.—Resident [REDACTED] grabbed resident [REDACTED]’s arm. Resident [REDACTED] also seen banging on resident [REDACTED]’s door. Resident [REDACTED] needed supervision to prevent contact with resident [REDACTED]. According to the home’s administrator, approximately a month ago resident [REDACTED] was observed by staff in resident [REDACTED]’s room while resident [REDACTED] was changing and resident [REDACTED] was not wearing anything on top. Also, on [REDACTED] at 6:35 p.m. resident [REDACTED] hit resident [REDACTED] in the abdomen during an argument. The home did not report the above incidents to the department until they were discovered on [REDACTED]

Plan of Correction**Accept ([REDACTED] - 08/19/2026)**

A verbal report was provided to DHS on 7/21/2026 and written report was sent to DCS on 7/24/2026. Education

16c - Written Incident Report (continued)

on regulations, abuse and facility policies for the administrator and DCS started 8/16/2026 to review education packet. Group meeting will take place 8/19/2026 at 2pm and 10pm for review and to answer questions. The attached education will be reviewed with the administrator and DCS. This will re-educate on abuse situations and reporting protocols. DCS will report abuse and resident altercations immediately to the administrator and assistant director of wellness. Administrator and/or assistant director of wellness will report incident to DHS per regulation within 24 hours. Step by step directions and forms are in the med tech office so that DCS, or anyone else, can report directly to DHS and the Area Agency on Aging.

Licensee's Proposed Overall Completion Date: 08/17/2026

Implemented [REDACTED] - 08/31/2026)

42b - Abuse**4. 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

Residents [REDACTED] and [REDACTED] reside in a secure dementia unit and have diagnoses of dementia. According to the home's care notes, resident [REDACTED] has obsessive behaviors toward resident [REDACTED] and has been observed both banging on resident [REDACTED]'s door and grabbing their arm to get them to sit with them.

[REDACTED] 10:00 p.m.—resident [REDACTED] was seen banging on resident [REDACTED]'s door and yelling for them to come out; resident [REDACTED] also trying to escort resident [REDACTED] during dinner and resident [REDACTED] was visibly shaken.

[REDACTED], 11:25 a.m.—Resident [REDACTED] yelling at resident [REDACTED] to come sit with them before and after the lunch meal. Resident [REDACTED] was crying as a result and resident [REDACTED] had to be supervised to ensure they left resident [REDACTED] alone.

[REDACTED] 5:00 p.m.—Resident [REDACTED] grabbed resident [REDACTED]'s arm. Resident [REDACTED] also seen banging on resident [REDACTED]'s door. Resident [REDACTED] needed supervision to prevent contact with resident [REDACTED]

According to the home's administrator, approximately a month ago resident [REDACTED] was observed by staff in resident [REDACTED]'s room while resident [REDACTED] was changing and resident [REDACTED] was not wearing anything on top.

Also, on [REDACTED] at 6:35 p.m. resident [REDACTED] hit resident [REDACTED] in the abdomen during an argument.

Plan of Correction

Accept [REDACTED] - 08/25/2026)

The Administrator/Director of Community Services (DCS) recognizes that residents residing in a secured dementia unit may exhibit behaviors associated with cognitive impairment. However, dementia-related behaviors do not eliminate the home's responsibility to protect all residents from harm, intimidation, unwanted contact, or violations of privacy. The Administrator/DCS must respond promptly and appropriately whenever a behavior or pattern of behavior places another resident at risk. DCS documented several concerning behaviors involving Residents [REDACTED] [REDACTED] and [REDACTED] including repeated following, yelling, banging on a resident's door, unwanted physical contact, and entering a resident's room during a private activity. These behaviors were not consistently escalated to administration for evaluation as potential abuse or reportable incidents. Upon identification of the concerns, the Administrator immediately reviewed the incidents and completed the required notifications and reports. A verbal and written report was made to the Area Agency on Aging, and the incident was reported to DHS as applicable. On 8/17/2026, the Administrator contacted the designated representatives for Residents [REDACTED] [REDACTED] and [REDACTED] to review the identified incidents and confirm that appropriate communication had been provided. Immediate Corrective Actions and Resident Safety Measures: The Administrator immediately implemented and documented an individualized safety and separation

42b - Abuse (continued)

42b Abuse (continued)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

42b Abuse (continued)

Licensee's Proposed Overall Completion Date: 08/24/2026

Implemented (JH - 08/31/2026)

234d - Support Plan Revision

5. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

According to the home's care notes regarding resident [REDACTED] resident [REDACTED] is frequently verbally and physically aggressive towards staff when redirected. On [REDACTED] resident [REDACTED] engaged in an argument with resident [REDACTED] and resident [REDACTED] hit resident [REDACTED] in the abdomen. Resident [REDACTED] also needs supervision when following resident [REDACTED] around the home to ensure resident [REDACTED]'s safety and comfort. The assessment date [REDACTED] for resident [REDACTED] did not include resident [REDACTED]'s need for supervision or a plan to address the resident's behaviors towards resident [REDACTED].

Plan of Correction

Accept [REDACTED] 08/19/2026)

Education on support plan regulations and facility policies for the administrator and DCS started 8/16/2026 to review education packet. Group meeting will take place 8/19/2026 at 2pm and 10pm for review and to answer questions. The attached education will be reviewed with the administrator and DCS. This will re educate on the support plan and completing the RASP update form. Resident [REDACTED] support plan updated and attached. DCS will document changes or concerns. Administrator and/or assistant director of wellness will update the RASP per regulation. Administrator and assistant director of wellness will hold a weekly end of week meeting to ensure concerns are addressed, and proper communication and documentation are completed.

Licensee's Proposed Overall Completion Date: 08/17/2026

Implemented [REDACTED] - 08/31/2026)