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

October 29, 2026

[redacted], CEO
UNIVERSAL HEALTH RECOVERY CENTERS INC
[redacted]

RE: UNIVERSAL HEALTH RECOVERY CENTER
2000 PROVIDENCE AVENUE
CHESTER, PA, 19013
LICENSE/COC#: 18836

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/21/2026 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *UNIVERSAL HEALTH RECOVERY CENTER* **License #**: *18836* **License Expiration**: *03/25/2027*

Address: *2000 PROVIDENCE AVENUE, CHESTER, PA 19013*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *UNIVERSAL HEALTH RECOVERY CENTERS INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/08/1994* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *5* **Waking Staff**: *4*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/21/2026*

Inspection Dates and Department Representative

09/21/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served**: *5*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

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

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

09/21/2026 Full

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

10/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/27/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/19/2026*

Inspections / Reviews *(continued)*

10/20/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/27/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/23/2026*

10/29/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/27/2026*

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

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services shortly after hire; however, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until 9/16/26.

Direct care staff person B, hired on [redacted] began providing unsupervised ADL services shortly after hire; however, the home could not provide proof that the staff person completed and passed the Department-approved direct care training course and competency test.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Quality Assurance reeducated the Home's Administrator on 10/9/2026. The Home's Administrator will ensure that new employees are trained in Department-approved direct care training course and pass the competency test. Additionally, documentation of the certifications are retained and kept up to date.

The Direct Care Staff B certificate that was not provided during the survey was emailed post survey and within compliance of the regulation. This will be retained properly within the home's staff training binder. The Direct Care Staff B completed their training on 10/22/2023. Direct Care Staff A completed their department approved training on 9/16/2026. The Director of ECU/Home's Administrator was responsible for ensuring that these Direct Care Staff Training Certificates were retained.

The Home's Administrator has all current employees' Direct Care Staff Certificate from the department approved training retained as of 10/9/2026. Ongoing, the Home's Administrator will report the new employee's training

65d Initial Direct Care Training (continued)

compliance through the Performance Improvement Committee monthly to ensure ongoing compliance of the standard.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

65f - Training Topics

2. 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 person C did not receive training in medication self administration, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration or personal care service needs of the resident during the 2025 training year.

Repeat Violation: 9/8/25

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Quality Assurance reeducated the Home's Administrator on 10/9/2026 to ensure that new employees are trained in 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.

The Home's Administrator has reeducated all staff to complete their required trainings annually. The Home's Administrator conducted an all staff re training on the topics included in 65f. The Home's Administrator

65f - Training Topics (continued)

conducted the all-staff re-training with Direct Care Staff C on 10/9/2026, who completed the training on 01/9/2026, prior to the next scheduled shift.

The Home's Administrator and the Director of Human Resources have amended the monthly training calendar to include the annual re-training topics identified in 65f to occur every January moving forward. Ongoing, the home's Administrator will report the new employee's training compliance through the Performance Improvement Committee monthly to ensure ongoing compliance of the standard.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

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 persons C and D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, Resident rights, The Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during the 2025 training year.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Quality Assurance reeducated the Home's Administrator on 10/9/2026 to ensure that employees are trained 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.

The Home's Administrator has reeducated all staff to complete their required trainings annually. The Home's Administrator conducted the all-staff re-training with Direct Care Staff C and D on 10/9/2026, who completed the

65g - Annual Training Content (continued)

training on 10/9/2026, prior to the next scheduled shift.

The Home's Administrator and the Director of Human Resources have amended the monthly training calendar to include the annual re-training topics identified in 65g to occur every January moving forward. Ongoing, the home's Administrator will report the new employee's training compliance through the Performance Improvement Committee monthly to ensure ongoing compliance of the standard.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

103g - Storing Food

4. Requirements

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

Description of Violation

On 9/21/26, there was a box of opened and unsealed Taquitos in main kitchen freezer.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

Onsite, the taquitos were immediately placed in a zip-lock bag, dated and properly stored in the freezer.

The Director of Quality Assurance reeducated the Home's Administrator on 10/9/2026 to ensure all staff are to monitor and check daily that all food within the kitchen is properly sealed, dated and stored.

Ongoing, the home's Administrator will begin a weekly facility inspection audit for compliance of properly stored food on 10/9/2026. The compliance of the facility audit will be reported through the Performance Improvement Committee monthly to ensure ongoing compliance of the standard. This audit will continue indefinitely.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

107d - Procedure Emergency Management Agency Submission

5. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were last submitted to the local emergency management agency on 6/1/26 and 1/27/25.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Quality Assurance reeducated the Director of Plant Operations on 10/9/2026 on ensuring that written emergency procedures are reviewed, updated and submitted annually to Chester City.

107d - Procedure Emergency Management Agency Submission (continued)

The approval of the current plan was accepted and a letter confirming the acceptance was received on 9/25/2026.

Annually, the plan and confirmation of the plan submission will be added to the quarterly meeting of the Board of Governors Meeting for compliance monitoring with oversight by Director of Quality Assurance. All Hospital Plans are created in January of each new year; compliance will be reported in each 1st Quarter BOG meeting.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

124 - Notice to Fire Department

6. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Plant Operations immediately outreached the City of Chester for follow-up on confirmation letter documentation. The letter was received on 9/25/2026.

Annually, the plan and confirmation of the plan submission will be added to the quarterly meeting of the Board of Governors Meeting for compliance monitoring with oversight by Director of Quality Assurance. All Hospital Plans are created in January of each new year; compliance will be reported in each 1st Quarter BOG meeting.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

132b - Safety Inspection/Fire Drill

7. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire drill observed by a fire safety expert was conducted on 1/27/2025.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Plant Operations immediately notified the City of Chester for an observed fire drill. The observed Fire Drill occurred on 9/30/2026.

Annually, the observed fire drill documentation will be added to the quarterly meeting of the Board of Governors Meeting for compliance monitoring with oversight by Director of Quality Assurance. All Hospital Plans are created in January of each new year; the observed fire drill will be added to the annual hospital plan requirement, and compliance will be reported in each 1st Quarter BOG meeting.

132b - Safety Inspection/Fire Drill *(continued)*

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

132c - Fire Drill Records

8. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records from 9/2025 through 8/2026 do not include the number of residents evacuated during each drill.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Plant Operations has immediately modified the form to further clarify that the number of residents present is also the number of residents that were evacuated.

Ongoing, the Director of Plant Operations will audit the complete forms monthly to ensure that the forms are fully complete, beginning immediately. The compliance of the completed forms will be submitted to the Performance Improvement Committee monthly. This audit will continue indefinitely.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

132i - Testing Fire Alarm

9. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the overnight fire drills on 2/17/26 at 3:16am and 5/7/26 at 4:18am, the fire alarm was not sounded. Per the home's fire drill records, "Horns may be silenced during the hours of 9:00pm to 6:00am; however, a coded announcement is still required." Interviews with staff indicated lights flash during the overnight fire drills and an announcement is made.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Plant Operations has immediately modified the form to ensure that the horns are set off for each fire drill.

The Director of Quality Assurance reeducated the Director of Plant Operations on 10/6/2026 to ensure that the alarm is sounded for each fire drill.

Ongoing, the Director of Plant Operations will audit the complete forms monthly to ensure that the forms are fully complete, to begin immediately. The compliance of the completed forms will be submitted to the Performance Improvement Committee monthly. This audit will continue indefinitely.

132i Testing Fire Alarm *(continued)*

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

141a - Medical Evaluation

10. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted on [redacted]. The resident's medical evaluation was not completed as of [redacted] The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Repeat Violation: 9/8/25

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Quality Assurance reeducated the medical providers on 10/7/2026 fully completing the documented medical exam timely.

Deficient medical exams were immediately corrected on 9/30/2026.

Ongoing, The Home's Administrator will audit open and closed chart monthly for compliance of the DME completion. That compliance will be reported monthly to the Performance Improvement Committee. This audit will begin immediately and remain in effect indefinitely.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information *(continued)*

Description of Violation

The medical evaluation for Resident #2 dated [redacted] does not include medical diagnoses including physical or mental disabilities of the resident, if any. This area of the form is blank.

The medical evaluation for Resident #2 dated [redacted] does not indicate the needs of the resident can be met safely at the personal care home.

The medical evaluation for Resident #3 dated [redacted] does not indicate the needs of the resident can be met safely at the personal care home.

Plan of Correction ***Accept ([redacted] - 10/20/2026)***

The Director of Quality Assurance reeducated the medical providers on 10/7/2026 on fully completing the documented medical exam.

Deficient medical exams were immediately corrected on 9/30/2026.

Ongoing, The Home's Administrator will audit open and closed charts monthly for compliance of the DME completion. That compliance will be reported monthly to the Performance Improvement Committee. This audit will begin immediately and remain in effect indefinitely.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/29/2026)