

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

May 20, 2025

[REDACTED]
JUNIPER VILLAGE AT BENSALEM OPERATIONS LLC
[REDACTED]

RE: JUNIPER VILLAGE AT BUCKS
COUNTY SENIOR LIVING
3200 BENSALEM BOULEVARD
BENSALEM, PA, 19020
LICENSE/COC#: 14246

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/03/2025 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: JUNIPER VILLAGE AT BUCKS COUNTY SENIOR LIVING **License #:** 14246 **License Expiration:** 02/02/2025
Address: 3200 BENSLEM BOULEVARD, BENSLEM, PA 19020
County: BUCKS **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: JUNIPER VILLAGE AT BENSLEM OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C 2 LP **Date:** 04/28/1993 **Issued By:** CWOPA L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 61 **Waking Staff:** 46

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 03/03/2025

Inspection Dates and Department Representative

03/03/2025 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	60	Residents Served:	40
Secured Dementia Care Unit			
In Home:	Yes	Area:	Wellspring
Capacity:	21	Residents Served:	13
Hospice			
Current Residents:	6		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	40
Diagnosed with Mental Illness:	1	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	21	Have Physical Disability:	0

Inspections / Reviews

03/03/2025 - Partial
Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 04/18/2025

Inspections / Reviews *(continued)*

04/21/2025 POC Submission

Submitted By: [REDACTED] Date Submitted: 05/16/2025
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 04/24/2025

04/30/2025 POC Submission

Submitted By: [REDACTED] Date Submitted: 05/16/2025
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 05/16/2025

05/20/2025 Document Submission

Submitted By: [REDACTED] Date Submitted: 05/16/2025
Reviewer: [REDACTED] Follow Up Type: Not Required

42b - Abuse

1. 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], Resident [REDACTED] was admitted to the memory care unit due to increasing confusion, wandering, and exit-seeking behavior. Their most recent assessment and support plan, dated [REDACTED], indicated a need for extensive supervision at home. While Resident [REDACTED] occasionally exhibited exit-seeking tendencies and required redirection, they were also noted to wander, talk about leaving, and become irritable. Staff were advised to take time to redirect the resident when necessary.

Psychiatric progress notes from the resident's provider, dated [REDACTED], and [REDACTED], indicated that although Resident [REDACTED] was generally receptive to redirection, they continued to pull the fire alarm, throw their walker at staff, and engage in exit-seeking behavior, at times encouraging others to join them.

On [REDACTED], Resident [REDACTED] is believed to have followed a visitor who was exiting the SDCU through the main doors. At approximately 4:40 PM, while staff were bringing memory care residents to the dining table, they noticed Resident [REDACTED] was missing from the unit. A search was initiated. Resident 1 was last seen in the lounge area by a staff person approximately 10 minutes before it was discovered that the resident was missing. Staff reported that resident had been observed wandering from room to room during the day, and was observed trying to leave at times.

A thorough search was conducted, covering the stairwells, back courtyard, parking lot, and wooded area surrounding the building. At 5:02 PM, a staff person who was searching by car around the property located Resident [REDACTED] on a pathway leading to a parking lot of the B Building. Resident [REDACTED] was wearing a light sweater with a heavier sweater jacket over top, however the temperatures in the area on that date ranged from -14F to -25F. Resident [REDACTED] was observed to have cold hands and was confused, believing that someone left them alone while on their way to a party together.

Resident [REDACTED] was returned to the memory care area and assessed for injury or illness with none being noted. Resident [REDACTED] was placed on hourly checks following the incident, however the home does not have a specific policy or procedure for monitoring residents who require extensive supervision in the home, other than to redirect residents and attempt to engage the residents in an activity.

Plan of Correction

Accept [REDACTED] - 04/30/2025)

Per resident [REDACTED] annual assessment and support plan done on 10/29/2024, it states that Resident [REDACTED] becomes irritable at times, especially in the evening, requires re-direction and one on one with staff, wanders sometimes and talks about leaving, when becomes irritable staff will take the time to re-direct. Resident 1 has to the extent of a one to one if needed within [REDACTED] support plan which would be within the category of extensive supervision. A one to one would be implemented for this resident if [REDACTED] anxiousness/irritation over exceeded redirection or engaging in activities which the limit was not reached on the day of elopement. The interdisciplinary team has responsibility of implementing and deciding on a one to one. On the day of the elopement the high temperature was 33F and the low was 14F, the time Resident [REDACTED] eloped the temperature was roughly 30F. Due to it being dinner time, there was 7 staff members in the unit for 13 residents. Staff followed elopement policy and Resident [REDACTED] was found within 20 minutes. Resident 1 was assessed and deemed to have no injuries once returning. Door alarms were in good working condition. Signage for guests was put on display to please be aware and alert to any resident that may want to exit with them. Per policy, it is the responsibility of the multidisciplinary team to identify if a resident is a high risk

42b Abuse (continued)

wanderer and develop specifics for a support plan when someone is identified to be a high risk wanderer. As stated the policy for the elopement was followed by the associates on shift; administrator/designee will complete a refresher of elopement policy with all of the wellness associates by 5/16/2025.

Licensee's Proposed Overall Completion Date: 05/16/2025

Implemented [REDACTED] - 05/20/2025)

225c - Additional Assessment**2. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On [REDACTED] at approximately 4:40 PM, while staff were bringing memory care residents to the dining table, they noticed Resident [REDACTED] was missing from the unit. A thorough search of the building was conducted, and at 5:02 PM, a nurse searching by car around the property found Resident [REDACTED] outside the B building.

Despite this elopement incident, no additional assessment was conducted to address the event or implement further support measures beyond the most recent annual assessment and support plan dated [REDACTED]

Plan of Correction

Accept [REDACTED] - 04/21/2025)

Resident [REDACTED] support plan has to an extent of one on one with staff. Administrator will conduct an education with the Director of Wellness on creating an additional assessment to address reportable events, if applicable, to add to a residents annual assessment and support plan by 4/21/2025. Administrator will audit all reportable events for the next six months starting in the month of April to monitor if an additional assessment was needed and if so, that it was completed.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented [REDACTED] - 05/20/2025)

234a - Admission Support Plan**3. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's initial support plan was completed on [REDACTED]

Plan of Correction

Accept [REDACTED] - 04/21/2025)

Deficient practice cannot be retroactively fixed. Administrator will conduct an education with the Director of Wellness on Regulation 234A regarding a support plan be developed within 72 hours of the admission, or within 72 hours prior to the admission, when being admitted a secured dementia care unit by 4/21/2025. Administrator will audit all support plans starting the month of April for three months to ensure all support plans are completed within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit.

234a Admission Support Plan (*continued*)

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented [REDACTED] - 05/20/2025)