pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BRISTOL HOUSE MEMORY CARE LLC**
LEGAL ENTITY

To operate **BRISTOL HOUSE MEMORY CARE**
NAME OF FACILITY OR AGENCY

Located at **2527 BRISTOL ROAD, WARRINGTON, PA 18976**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **48** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 48**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 11, 2021** until **November 11, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144581**

ISSUING OFFICER

Jamie L. Buchenauer
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 01/21

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: May 11, 2021

Mr. Arvind Bhakta
Manager
Bristol House Memory Care, LLC
P.O. Box 564
Gwynedd, Pennsylvania 19437

RE: Bristol House Memory Care
2527 Bristol Road
Warrington, Pennsylvania 18976
License #: 144581

Dear Mr. Bhakta:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection October 20, 2020 and January 15, 2021 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 144580 dated June 6, 2020 to June 6, 2021 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 11, 2021 to November 11, 2021.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
96a	III	75	$3	$225	15 calendar days from mailing date of this letter
185a	III	75	$3	$225	15 calendar days from mailing date of this letter
233c	III	75	$3	$225	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Inspection Summary

cc: Patrick Marano, Office of General Counsel
Jeanne Parisi, Director, Human Services Licensing
Patricia Adams, Regional Director, Human Services Licensing
Shivani Patel, Human Services Licensing

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

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* **License #**: *14458* **License Expiration Date**: *06/06/2021*
Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*
County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: *Nathan Benoit* **Phone**: *2154911501* **Email**: *edir@bristolhousememorycare.com*

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*
Address: *PO BOX 564, GWYNEDD VALLEY, PA, 19437*
Phone: *2154911501* **Email**: *ARVINDBHAKTA@YAHOO.COM*

Certificate(s) of Occupancy

Type: *I-2* **Date**: **Issued By**:

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *41* **Waking Staff**: *31*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *10/20/2020*

Inspection Dates and Department Representative

10/20/2020 - On-Site: Susan Smith, Claire Mendez

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *27*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire facility* **Capacity**: *48* **Residents Served**: *27*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *27*
Diagnosed with Mental Illness: *27* **Have Diagnosed with Intellectual Disability**: *27*
Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

10/20/2020 - Full

Lead Inspector: *Susan Smith* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/15/2020*

Inspections / Reviews *(continued)*

12/16/2020 - POC Submission

Lead Reviewer: *Claire Mendez* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/18/2020*

12/31/2020 - POC Submission

Lead Reviewer: *Claire Mendez* **Follow-Up Type**: **Follow-Up Date**:

3c - Post Current License

1. **Requirements**

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home's most recent Licensing Inspection Summary from 8/8/19 was posted in a conspicuous and public place, but not in a manner that is easily accessible to residents and visitors. The LIS is posted in a locked glass cabinet; anyone who wanted to view the document would have to request access from the front desk.

Plan of Correction **Directed**

A new bulletin board will be placed in hallway, accessible to all residents and visitors. The current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter will be posted. The front desk staff member will be in charged of making sure this is monitoring and keep posted. Supervisors also will check to make sure this is being done correctly.

DPOC: 12/23/2020 (CM) - Ongoing - The administrator or designee will check monthly to ensure that the most recent LIS is posted in a conspicuous place and accessible.

Licensee's Proposed date of POC implementation: 12/16/2020 *Implemented: 4/13/2021 CM*

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 10/20/20, at 12:30pm, it was observed that the med cart with electronic resident records was placed in the large common room/dining room near the home's reception area. When accessed, the computer screen displaying resident records were in full view of residents and staff. At 1:05pm, Staff A walked away from this med cart and left the room, leaving the computer screen unlocked, and a resident's eMAR records in full view on the screen.

Plan of Correction **Accept**

Nursing director met with all med technicians and reviewed using privacy screen button on computer and will place privacy screen covers on med tech cart computer and front desk computer. Medication carts removed from dining and common area. Resident rights training will be given to all staff by nursing director.

Completion Date: *11/10/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

25b - Contract Signatures

1. **Requirements**

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Repeat Violation

The resident-home contract for Resident #1, dated 10/1/19, was not signed by the resident.

Repeated violation: 8/8/19

Plan of Correction **Accept**

ED went through all contracts and is working with each resident to sign all contract that are blank and needs a initial or signatures. Also ED is working with business office mangers to train on this topic.

Completion Date: *11/13/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

41e - Signed Statement

1. **Requirements**

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction **Accept**

ED went through all contracts and is working with each resident to sign all contract that are blank and needs a initial or signatures. Also ED is working with business office mangers to train on this topic

Completion Date: *11/13/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

42s - Privacy

1. **Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 10/20/20 at 12:30pm, Staff A was observed administering medication to Resident #2 while the resident was sitting at a dining table with 3 other residents. At this time, there were approximately 24 residents in the room.

Plan of Correction Repeat Violation - 5/6/2019 **Accept**

ED and Nursing Director had meeting with all med technician's and trained all staff on this requirement for the state. Also Med Carts are no longer in use in dining room area. To prevent this from happening in the future.

Completion Date: *11/13/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

51 - Criminal Background Check

1. **Requirements**

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Repeat Violation

There is no criminal background check for Staff B, who was hired on [redacted]
There is no criminal background check for Staff C, who was hired on [redacted]

Repeated violation 8/8/19

Plan of Correction **Directed**

ED talked to staff member in business office to explained that all back ground checks need to be done and enter by state code. business office manger is to scan all background checks and put into file. The staff b and staff c members had their background checks done and is in file.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator or designee will audit all employee files to ensure they contain correct criminal background checks.

Ongoing: Within 30 days of the receipt of the Plan of Correction, the administrator or designee will develop a tracking system for new hires that ensures that the criminal background check is completed for each employee and is retained in the employee's file.

Ongoing: The administrator or designee will review employee files quarterly to ensure that the criminal background check was completed and is in the employee file for each employee.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

65a - FS Orientation 1st Day

1. **Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

    1. Evacuation procedures.
    2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
    5. The location and use of fire extinguishers.

65a - FS Orientation 1st Day *(continued)*

6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Repeat Violation

Staff person A, whose first day of work was on [redacted] did not receive orientation on topics 1, 2, 5, 6 and 7.
Staff person B, whose first day of work was on [redacted], did not receive orientation on topics 1, 2, 5, 6 and 7.

Repeated violation - 8/8/19

Plan of Correction **Directed**

ED is talking with supervisors to set up a detail new hire class and this will cover all these topics and the requirements .Also ED will go back to staff member A and B and train them on 11/13/2020 on all topics in 65.a. This covered topics 1,2,5,6,and7 in this reg. Moving forward we have pointed out the resident care supervisor to make sure all these requirements are being done in new hire training. ED has train resident care supervisor on these topics so she can train new staff members and old staff members on 11/14/2020.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator or designee will audit all employee files to ensure the required trainings have been completed and documented.

Ongoing: Within 30 days of the receipt of the Plan of Correction, the administrator or designee will develop a tracking system for new hires that ensures that orientation topics outlined in 2600.65.a are completed for each employee and proof of completion is retained in the employee's file.

Ongoing: The administrator or designee will review employee files quarterly to ensure that orientation topics outlined in 2600.65.a have been completed and proof of training is in the employee file for each employee.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours *(continued)*

Description of Repeat Violation

Staff person A, whose first day of work was on [redacted], did not receive orientation on topics 1 through 4.
Staff person B, whose first day of work was on [redacted], did not receive orientation on topics 1 through 4.

Repeated violation : 8/8/19

Plan of Correction **Directed**

ED is talking with supervisors to set up a detail new hire class and this will cover all these topics and the requirements .Also ED and Nursing Director will go back to staff member A and B and train them on these topics on 11/13/2020. ED has train the resident care supervisor on 11/14/2020 on these topics so she can ensure all staff trainings can get done and any new hires can be done correctly the first time.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator or designee will audit all employee files to ensure all employees have received training on topics outlined in 2600.65.b within the staff person's first 40 hours of work.

Ongoing: Within 30 days of the receipt of the Plan of Correction, the administrator or designee will develop a tracking system for new hires that ensures that the training topics outline in 2600.65.b are completed for each employee within the first 40 scheduled hours of work and proof of training is retained in the employee's file.

Ongoing: The administrator or designee will review employee files quarterly to ensure that the training topics outline in 2600.65.b are completed for each employee within the first 40 scheduled hours of work and proof of training is retained in the employee's file.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Implemented: 4/13/2021 CM*

65c - Ancillary Staff Orientation

1. **Requirements**

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Repeat Violation

Ancillary staff person C, whose first day of work was 3/23/20, did not have a general orientation to his/her specific job functions.

Repeated violation: 8/8/19

65c - Ancillary Staff Orientation *(continued)*

Plan of Correction **Directed**

ED has train all supervisors on specific job functions needed it. ED trained staff person C on 11/12/2020. ED also all supervisors on these topics for reg 65.c. so they can train all staff on 11/15/2020. The plan is for ED to train supervisors moving forward and any front line staff to be trained by their department heads for the specific job functions.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator or designee will audit all employee files to ensure all ancillary employees have received a general orientation specific to their job functions.

Ongoing: Within 30 days of the receipt of the Plan of Correction, the administrator or designee will develop a tracking system for ancillary staff newly hired receives a general orientation specific to their job function and that proof of training is retained in the employee's file.

Ongoing: The administrator or designee will review employee files quarterly to ensure that ancillary employees have received a general orientation specific to their job function and proof of training is retained in the employee's file.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

82c - Locking Poisonous Materials

1. **Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 10/20/20, at approximately 10:30am, an unlocked and unattended housekeeping cart was in the Blue Jay section hallway of the home. The cart contained Clorox cleaner, which has a warning that states "If ingested call the Poison Control Center." The home is entirely a secured dementia unit.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction **Accept**

ED talked to all supervisors and housekeeping staff about this topic. We explained the importance of making sure no resident can get into any supplies that can be consider chemicals. ED and business office manger will do spot checks every month on the cleaning cart to make sure it's lock at all times. Also do trainings with housekeeping staff every month. Just making sure they remember the basics of why it's important to lock chemicals up.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

85a - Sanitary Conditions

1. **Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/20/20 at 12:30 pm, it was observed that Staff A was not wearing gloves when administering medications to residents.

Plan of Correction **Accept**

ED and Nursing Director had a meeting with med techs about wearing gloves and hand washing procedures for medication administration. The Nursing Director will monitor and the resident care supervisor will do spot checks every month to make sure their med techs are wearing gloves and hand washing. Also during monthly meetings with nursing we will bring these topic up ever time.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

95 - Furniture and Equipment

1. **Requirements**

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 10/20/20 at 10:20am, the Men's Bathroom in the hallway near "The Big Room," which is the dining room and large activity room of the home, was locked, and had an "out of order" sign on the door. The door handle is broken.
On 10/20/20 at 10:43am, in the laundry room of the Blue Jay section of the home, a washing machine had a sign that read "out of order."

95 - Furniture and Equipment *(continued)*

Plan of Correction

Accept

ED has made a repair book for anything broken in community and Business office manger and ED will make sure these are getting fixed in a timely manner. Any staff can report something that they believes needs fix in the book and it's the job of the ED and business office manger to fix it. The ED and Business office manger will look at the book every two days. If anything that needs to be fix right away the staff can call ED or Business office and then we will take care of it that day if possible.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

96a - First Aid Kit

1. **Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Repeat Violation

The first aid kit in the Blue Jay section of the facility does not include antiseptic, a thermometer, scissors, a breathing shield, or eye coverings.

Repeated violation: 5/6/19

Plan of Correction

Accept

ED and Nursing Director has trained all staff on if there is any use of first aid kit. The importance of telling the supervisors so we can replaced them. Currently all first aid kits are updated and fixed. Training took place on 11/12/2020 with all staff. Nursing Director and Resident Care supervisor are in charge of checking the first aid kits and it's every two weeks or when the first aid kit is used.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Not Implemented: 4/13/2021 CM

101i - Access to Bedroom

1. **Requirements**

2600.

101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On 10/20/20 at 10:52am, room ████ belonging to resident #3 was locked, subsequently denying the resident access to his/her bedroom.

101i - Access to Bedroom *(continued)*

Plan of Correction **Directed**

ED and Nursing Director talked to all staff on 11/09/2020 and supervisors on these topics. We explained that resident room can't be lock when they are in other area's in the building. This will allowed resident to be able to go back to their bedroom independently. The med tech on staff that day will do rounds to make sure no door isn't lock if resident is outside the room. Ever two hours as they are doing their rounds per normal.

DPOC: 12/23/2020 (CM) - Immediately, the administrator or designee will instruct all staff that resident bedrooms are not to be locked at any time while the resident is present in the building.

Ongoing: The administrator or designee will check all bedroom doors daily for the first 30 days, then weekly for an additional 30 days to ensure that resident bedrooms remain unlocked at all times while the resident is present in the building.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

101j5 - Bedside Table/Shelf

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

The bedside table in room [redacted] belonging to Resident #3 was approximately 4 feet away from the resident's bed

Plan of Correction **Accept**

ED and Nursing Director will check every room to make sure all table or a shelf is near the resident bed. Moving forward we will check every room as move in enters. The Resident care supervisor will make sure all rooms meet the requirements for 101.j. moving forward and be monitoring these regulations. Every month the Resident Care Supervisor will be looking at this. Any new move in will be done before entering the building.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

101j7 - Lighting/Operable Lamp

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The lamp in room ███ belonging to Resident #3 was approximately 4 feet away from the resident's bed, and can not be turned on/off at bedside.

Plan of Correction **Accept**

ED and Nursing Director will check every room to make sure each resident has an lamp near the bed. Also making sure it works. Moving forward will we have this monitor by resident care supervisor once a month. Any new resident will have this in their room before entering the building.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

103f - Refrigerator/Freezer Temps

1. **Requirements**

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 10/20/20, the temperature in the Blue Jay section hallway refrigerator was 50 degrees Fahrenheit.

Repeat Violation - 5/6/2019

Plan of Correction **Accept**

ED talked to Kitchen staff about refrigerators being checked on everyday and make a checklist stating who did it. This will be monitor by kitchen supervisor and cooks. Supervisor is to check this every week to make sure this is being done correctly.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Not Implemented: 4/13/2021 CM

105g - Lint Removal and Duct Cleaning

1. **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.

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

On 10/20/20, there was an accumulation of lint in the lint trap of the Blue Jay laundry room. There were no clothes in the dryer at the time.

Plan of Correction **Accept**

ED and Nursing Director talked to all staff about this violation. We stated that we want the lint to be removal after ever use of machine. Training on lint removal according to the manufacturer instruction booklet. All staff is to check the lint every use and sign is posted. Resident care supervisor is to do spot checks every once a week and keep monitoring this.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

107c - Food/Water 3 Day Supply

1. **Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 10/20/20, the amount of the emergency food supply in the kitchen was not sufficient to serve the home's 27 residents for three days at 3 meals per day. There were 13 large cans of beans, 9 large containers of rolled oats that require water for preparation, 4 large cans of diced beets, 5 large jars of applesauce, 3 mandarin oranges, 3 large cans of apples, 2 large cans of pears, 1 large can of peaches, 2 four pound cans of tuna, and 2 large jars of peanut butter. The emergency food was neither stored separately, nor designated to be used just for emergencies.

Repeaat Violation - 5/6/2019

Plan of Correction **Accept**

ED talked to chef about this topic and all supervisors. We put a order into are food company and order more food and will separate what is the emergency food supply. Chef supervisor will be monitoring the three day supply to ensure regulation is taken care of. Chef Supervisor will check every two weeks to make sure water and food supplies are being keep up.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

121a - Unobstructed Egress

1. **Requirements**

121a - Unobstructed Egress *(continued)*

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 10/20/20 at 10:47am, a blocked egress was observed near room 315 of the Blue Jay section of the home. The locks on the doors of the home are released when a green button on the wall adjacent to the door is pressed. There was a chair leaning against the wall that blocked access to the green button.

Plan of Correction **Directed**

ED talked to all supervisors about these topic and staff. Making sure it's very clear not to put chairs in egress pathways or anything to prevent residents from using the green button. ED and Business office manger will be monitoring exit doors and anything in the hall that can prevent residents from getting to the doors.

DPOC: 12/23/2020 (CM) - Ongoing: The administrator or designee with complete a walk-through of the facility daily for the first 30 days, then weekly thereafter to ensure that all egress routes are accessible.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

162c - Menus Posted

1. **Requirements**

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu, stating the specific food being served at each meal, was not posted in a conspicuous place in the home. The menu was laying on top of the bookshelf in the lobby.

Plan of Correction **Accept**

ED talked to supervisors and chef about making sure we have them posted on walls and making sure residents know what is going on with food daily and weekly. Chef supervisor will be monitoring this and making sure every week food menu is posted for the next week afterwards.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

185a - Implement Storage Procedures

1. **Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Repeat Violation

On 10/20/20, the glucometers for Residents #4 & 5 were not calibrated to correct date and time. For Resident #4, on 10/20 at 12:40pm, the glucometer read 6/26 at 12:18am. For Resident #5, on 10/20 at 1:35pm, the glucometer read 8/11 at 3:53pm.

Resident #4's physician ordered blood sugar to be checked every other day. On 9 occasions from 9/1/20 to 10/20/20, blood sugar results for Resident #4 were recorded by Staff A on the blood sugar log. No corresponding readings were found on the resident's glucometer on the following dates:

- *9/1/20 – 157*
- *9/3/20 – 167*
- *9/15/20 – 149*
- *9/17/20 – 143*
- *9/21/20 – 127*
- *9/29/20 – 149*
- *10/5/20 – 148*
- *10/13/20 – 147*
- *10/19/20 - 143*

On 10/15/2020, blood sugar results for Resident #4 were recorded by Staff D on the blood sugar log. No corresponding readings were found on the resident's glucometer (10/15/2020 – 123.)

On 10/11/20, Staff E recorded a blood sugar reading for Resident #4 of 178. The glucometer registered a reading of 187.

Resident #2's blood sugar readings from 10/1/20 through 10/20/20 were incorrectly recorded. Of the 7 readings recorded, none of the readings on the glucometer matched the recorded eMAR readings:

- *10/5/20, the glucometer reading was 133. This was recorded on the eMAR as 122*
- *10/7/20, the glucometer reading was 116. This was recorded on the eMAR as 118*
- *10/9/20, the glucometer reading was 132. This was recorded on the eMAR as 119*
- *10/14/20, the glucometer reading was 111. This was recorded on the eMAR as 132*
- *10/16/20, the glucometer reading was 109. This was recorded on the eMAR as 114*
- *10/19/20, the glucometer reading was 119. This was recorded on the eMAR as 123*

The narcotics log for Resident #4 shows that on 10/5, 10/9 and 10/11, the 8:00am and 8:00pm dosages of Lorazepam were administered to the resident. This contradicts the resident's eMAR, which shows that the 8:00pm dosages for these dates were refused by the resident. On 10/20/20, the amount of medication in the blister pack showed as if all medications had been administered, leaving a discrepancy of 3 Lorazepam pills. The home could not account for these missing narcotics.

Repeated violation: 8/8/19

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Directed**

All med technicians provided training on glucometer calibration, date and time check and proper documentation. LPN will provide routine glucometer calibrations as well as completing a weekly audit on documentation accuracy. Any discrepancy will be addressed. The person doing the training is the Nursing Director and Night supervisor that is LPN also. The training was provided on 11/12/2020 with all med techs. Also Executive director and Nursing director talk to the med techs on them days that the pills went missing and we found that the med tech wasn't train the right way from old nursing director. The med tech admitted that she didn't take the pills, but simply put them into the trash can. The pill was already pop out the blister pack. We explain to the med tech that for any pills in that nature we need to use the drug bluster. The doctor was call and it was reported the resident was refusing the night time med. So Nursing director train her on 11/17/2020 about reporting, 5 step rule, and all these in nature to being a med tech.

DPOC: 12/23/2020 (CM) - within 15 days of the receipt of the Plan of Correction, the administrator or designee will in-service all Medication Technicians in the proper disposal of medications.

Ongoing: The administrator or designee will audit the receipt, distribution, and disposal of narcotic medications weekly for the first three months, then quarterly thereafter. Documentation of audits will be kept for Department review.

Completion Date: *11/17/2020* Licensee's Proposed Date of POC Implementation *Not Implemented: 4/13/2021 CM*

187c - Refusal of Medication

1. **Requirements**

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

The narcotics log for Resident #4 shows that on 10/5, 10/9 and 10/11, the 8:00am and 8:00pm dosages of Lorazepam were administered to the resident. The resident's eMAR, shows that the 8:00pm administration for these dates were refused by the resident. The home could not provide documentation that the prescriber was notified of the refusals.

187c - Refusal of Medication *(continued)*

Plan of Correction **Accept**

ED and Nursing Director talked with Med Techs and stating they are to report all refusals to the director of wellness so timely notifications of prescribes can be received. Nursing director will be monitoring this regulation and checking ever week. Also having training done once a month on these topics.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Implemented: 4/13/2021 CM*

187d - Follow Prescriber's Orders

1. **Requirements**

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed "Check Blood Sugar 3 times a week". During the second full week of October, the resident's blood sugar was only taken twice, on 10/14/20 and 10/16/20.

Plan of Correction **Directed**

Med tech training on importance of following physician orders, and to report any missed item to Director of Nursing. Nursing Director

DPOC: 12/23/2020 (CM) - Ongoing: The administrator or designee will audit a random sample of Medication Administration Records weekly to ensure that any medication refusals are documented and reported in accordance with 2600.187.d. Audits will be maintained for Department review.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

225c - Additional Assessment

1. **Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On 10/20/20, at 10:59am, Resident #6 was observed in a geri chair in the large common room/dining room of the home. An incident report dated 10/4/20 at 1:30am shows that the resident had fallen onto the floor. This device was not prescribed, and is not reflected on the resident's RASP or DME. The home did not re-evaluate the resident to ensure that they are able to meet the resident's needs after this incident, and subsequently did not update the resident's RASP.

Plan of Correction **Directed**

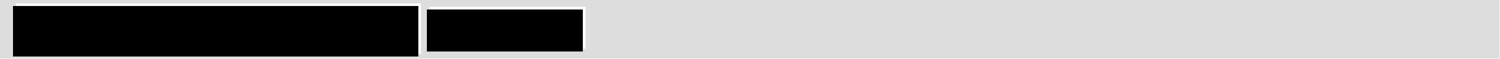
Director of Nursing and RCC will review carefully RASP requirements and needs for updating. Geri chair has no physician order and was removed from facility. Nursing Director will ensure this regulation is being monitoring and will change the rasp as the need for change occurs. Rasp will be change the same day as the order is made and chair is in.

DPOC 12/30/2020 CM: Within 15 days if the receipt of the Plan of Correction, Resident #6 will be re-evaluated by a physician and update all plans accordingly.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Implemented: 4/13/2021 CM*

Violation Withdrawn

By: CM Date: 4/13/2021



Plan of Correction **Directed**

227f - Resident Participation

1. **Requirements**

   2600.

   227.f. A resident may participate in the development and implementation of the support plan. A resident may include a designated person in making decisions about services.

   Description of Violation

   Resident #1's RASP, dated 10/4/19, is not signed by the resident or the resident's responsible party. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign.
   Resident #3's RASP, dated 4/9/2020, is not signed by the resident. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .
   Resident #6's RASP, dated 7/10/20, is not signed by the resident. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .
   Resident #7's RASP, dated 8/26/20, is not signed by the resident or the resident's responsible party. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .

227f - Resident Participation *(continued)*

Plan of Correction **Directed**

Director of Nursing and RCC will carefully review RASP requirements and signing protocols. Documentation for resident signing will be implemented. Also Nursing Director call all families and made dates for the ones that need the support plans update it. Nursing Director got the residents to be apart of the support plan (Unless try). Most of them was able too, but some couldn't. Nursing Director will be monitoring this and will ensure all rasp are review. Also we got all signatures done by the 11/25/2020. We had to wait for one family because they was out of state with no computer system. Nursing Director Will be reviewing this per each support plan given to families. Meaning that all signatures need to be sign the same day or the day after for family member and resident.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator will develop a tracking system to ensure that all Resident Assessment and Support Plans are signed by the resident or contain documented refusals or inability to sign showing that the resident or designee was offered the opportunity to participate in the development of the plan.

Ongoing: The administrator or designee will audit resident RASPs quarterly to ensure that the resident RASPs are signed by the resident or contain documented refusals or inability to sign showing that the resident or designee was offered the opportunity to participate in the development of the plan.

Completion Date: *12/16/2020* Licensee's Proposed Date for POC Implementation *Implemented 4/13/21 CM*

227g -Support Plan Signatures

1. **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 #1's RASP, dated 10/4/19, is not signed by the resident or the resident's responsible party. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign.
Resident #3's RASP, dated 4/9/2020, is not signed by the resident. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .
Resident #6's RASP, dated 7/10/20, is not signed by the resident. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .
Resident #7's RASP, dated 8/26/20, is not signed by the resident or the resident's responsible party. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign.

227g -Support Plan Signatures *(continued)*

Plan of Correction **Directed**

Director of Nursing and RCC will carefully review RASP requirements and signing protocols. Documentation for resident signing will be implemented. Also Nursing Director call all families and made dates for the ones that need the support plans update it. Nursing Director got the residents to be apart of the support plan (Unless try). Most of them was able too, but some couldn't. Nursing Director will be monitoring this and will ensure all rasp are review. Also we got all signatures done by the 11/25/2020. We had to wait for one family because they was out of state with no computer system. Nursing Director Will be reviewing this per each support plan given to families. Meaning that all signatures need to be sign the same day or the day after for family member and resident.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator will develop a tracking system to ensure that all Resident Assessment and Support Plans are signed by the resident or contain documented refusals or inability to sign.

Ongoing: The administrator or designee will audit resident RASPs quarterly to ensure that the RASPs are signed by the resident or contain documented refusals or inability to sign.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Implemented: 4/13/2021 CM*

227h - Support Plan Refuse Sign

1. **Requirements**

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's RASP, dated 10/4/19, is not signed by the resident or the resident's responsible party. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign.
Resident #3's RASP, dated 4/9/2020, is not signed by the resident. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .
Resident #6's RASP, dated 7/10/20, is not signed by the resident. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign .
Resident #7's RASP, dated 8/26/20, is not signed by the resident or the resident's responsible party. There is no indication that the resident refused to sign, was unable to participate, declined to participate, or was unable to sign.

227h - Support Plan Refuse Sign *(continued)*

Plan of Correction **Directed**

Director of Nursing and RCC will carefully review RASP requirements and signing protocols. Documentation for resident signing will be implemented. The Nursing Director will be monitoring and reviewing that this part of the support plan is getting done. So ever new rasp or update the Director of Nursing and Resident care supervisor will make sure that the resident is given a choose to read and sign. If resident can't sign or refuse to sign. Nursing Director will make sure why this happened and there is a witness and both sign off stating the resident refuse or can't sign documented. Nursing Director will check on this with any change or every month that this paperwork is being done with the support of Resident care supervisor.

DPOC: 12/23/2020 (CM) - Within 15 days of the receipt of the Plan of Correction, the administrator will develop a tracking system to ensure that all Resident Assessment and Support Plans are signed by the resident or contain documented refusals or inability to sign.

Ongoing: The administrator or designee will audit resident RASPs quarterly to ensure that the RASPs are signed by the resident or contain documented refusals or inability to sign.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

231c - Preadmission Screening

1. **Requirements**

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

On Resident #3's Preadmission Screen form, the section entitled Part III: Determination, which says that "the needs of this applicant can be met in this personal care home," has been checked off. However, this home is a Secured Dementia facility. The section of the form entitled Part IV: Cognitive Screening, which indicates that "the needs of the applicant require secured care due to Alzheimer's Disease or other dementia," has not been checked off.

Repeat Violation - 8/8/2019

Plan of Correction **Accept**

Director of Nursing has fixed the correction with resident Doctor by 11/13/2020. The Nursing Director will be checking all cognitive screenings to make sure it ensures this requirement is being taken care of in reg 231.c. So every new move in this form will be done within 72 hours of resident moving into the building. Nursing Director will be monitoring this every time with the support of the in house doctor or the resident choice doctor. Nursing Director will also make a checklist of all requirements that need to be meet by state with move ins prior to move ins. Executive Director also will look over these paperwork as part of the team.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

231e - No Objection Statement

1. **Requirements**

2600.
231.e. Each resident record must have documentation that the resident and the resident’s designated person have not objected to the resident’s admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. Addendum 1 to the Contract entitled "Consent to Live in a Secure Dementia Unit" was not signed by the resident. There is no further documentation that the resident has not objected to the admission.

Plan of Correction **Directed**

ED and business office manager will ensure contracts to be signed fully and addressing "Consent to Live in a Secure Dementia Unit". ED made sure all paperwork was sign with residents and POA's. All contracts will be reviewed by Executive Director and this is before resident is in the building. If move in happens quickly no later then 24 hours after move in. Executive Director will make sure all signatures are done correctly by state requirements on all contract paperwork and on the paperwork for secure dementia care unit. So Executive Director will be monitoring this and for ever move in this will be check on and every month Executive Director and office manger will check for any errors.

DPOC: 12/23/2020 (CM) - Immediately, the administrator or designee will review all current resident files to ensure that documentation that the resident and the resident’s designated person have not objected to the resident’s admission or transfer to the secured dementia care unit is present.

Within 15 days of the receipt of the Plan of Correction, the administrator will develop a tracking system to ensure that all resident files contain documentation that the resident and the resident’s designated person have not objected to the resident’s admission or transfer to the secured dementia care unit.

Ongoing: The administrator or designee will audit resident files quarterly to ensure that documentation that the resident and the resident’s designated person have not objected to the resident’s admission or transfer to the secured dementia care unit.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Implemented: 4/13/2021 CM*

233c - Key-Locking Devices

1. **Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Repeat Violation

The code to a locked gate outside of the Gold Finch section of the facility was typed on a piece of tape. This tape is posted on top of the pin pad where the code is to be entered. The code had worn off of the tape; subsequently, there was no code posted.

At another outside location, the code to the locked door was incorrect. The numbers on the code were transposed. The gate could not be opened because the code was incorrect.

Repeated violation: 5/6/19

Plan of Correction **Directed**

ED talked with all supervisors and fixed the posting. All outside gates have the correct signs that state the number code. Also ED will be monitoring the gates to make sure the post is still post it and there is no issues. ED plans to check it once a week unless someone else reports damage to it. Then it will get fix right away. The method I will use is my eyes to see if the numbers are post it or not.

DPOC: 12/23/2020 (CM) - Immediately, the administrator or designee will complete a physical site walk through of all doors containing a numerical code to ensure the code is posted and that the code works to release the doors/gates.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Not Implemented: 4/13/2021 CM*

233d - Electronic/Magnetic System

1. **Requirements**

2600.

233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

233d - Electronic/Magnetic System *(continued)*

Description of Violation

On 10/20/20, at 2:08pm, Resident #7 entered the conference room that was occupied only by the 2 BHSL inspectors. This room is in the Gold Finch section of the building. Staff B previously reported that the Gold Finch section was unoccupied, and staff do not typically come to this section for any reason. The unoccupied Gold Finch section of the home mirrors the occupied Blue Jay section, with 24 bedrooms, a lounge area, and a conference room. The two sections are separated in the middle of the facility by the main entrance reception area, and the large common room/dining room that is across from the reception area. This resident, who resides in the Blue Jay section, was not accompanied by staff. The nearest direct care staff were located in the reception area, down a long corridor, and through double doors. Should the resident need assistance, staff in the middle of the building could neither see nor hear the resident in the Gold Finch section.
At 2:18pm, the Administrator entered the room to touch base with the inspectors, unaware that Resident #7 was on this side of the building. Page 5 of the resident's RASP shows that this resident "needs regular supervision in the home, and cannot leave unattended due to the resident's ability to wander throughout the facility due to dementia."

Repeat Violation - 5/6/2019

233d - Electronic/Magnetic System *(continued)*

Plan of Correction **Directed**

Executive Director and Nursing Director will be monitoring and training the staff about spreading the duties of each wing. I know most residents are on one side of the building, but needs to have a staff member over on gold finch wing as much as possible. If not to make sure someone is going over there ever 15 minutes or so to make sure residents are being check on. Training was done on 12/16/2020. Nursing Director will make sure staff is being spread out through out the floor to make sure the resident that likes to walk around the building is being supervisor.

DPOC: 12/23/2020 (CM) - Immediately, the home will have a staff person present at the door between the Gold Finch and Blue Jay sides of the home at all times to monitor resident movement and prevent access to the unoccupied portion of the building. The administrator or designee will complete hourly walk-throughs of the unoccupied side of the building to ensure that no residents have wandered to the area until such time electronic door locks or magnetic locks are installed between the two sides of the home.

Within 15 days of the receipt of the plan of correction, the home will install a magnetic or electronic lock on the doors between the Gold Finch and Blue Jay sections of the home.

Ongoing: The administrator or designee will test newly installed electronic or magnetic locks for functionality at least weekly for the first three months, and then monthly thereafter.

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

251b - Record Entries Legible

1. **Requirements**

2600.
251.b. The entries in a resident’s record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On Resident #4's Controlled Substance/Narcotic Count Sheet, the entry for 10/17/20 had the count written as 6, with the number 7 written over top of the 6. There were no staff initials to indicate that an error had been made.

251b - Record Entries Legible *(continued)*

Plan of Correction **Directed**

Nurse supervisor gave Med Technicians an provided in-service on "Handling documentation errors" and insisted handwriting must be legible. This was done on 11/13/2020. Nursing supervisor will check the logs ever week to make sure these things aren't happening again.█ will use █ eyes as methods to make sure nobody gets to far behind with understanding you have to write initials for any error made. So Nursing Supervisor will be monitoring this and making sure the requirement is being taken care of.

DPOC: 12/23/2020 (CM): Immediately: The Director of Nursing will conduct weekly audits of written medication records to ensure that documentation is in accordance with 2600.251.b. Documentation of audits will be maintained for Department review

Completion Date: *12/16/2020* Licensee's Proposed Date of POC Implementation *Implemented: 4/13/2021 CM*

252 - Record Content

1. **Requirements**

2600.

252. Content of Resident Records - Each resident's record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident records for Residents #1, 3 and 6 have a photo of the resident that is not dated. It can not be determined if the photo is more that 2 years old.

Plan of Correction **Accept**

All photo dates have been added to photos in building. On Admission, photo will be dated and rechecked upon yearly RASP assessment.

Completion Date: *11/13/2020* Licensee's Proposed Date of POC Implementation

Implemented: 4/13/2021 CM

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

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* **License #**: *14458* **License Expiration Date**: *06/06/2021*
Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*
County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: *Nathan Benoit* **Phone**: *267-377-7564* **Email**: *edir@bristolhousememorycare.com; shparker@pa.gov*

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*
Address: *PO BOX 564, GWYNEDD VALLEY, PA, 19437*
Phone: *2154911501* **Email**: *ARVINDBHAKTA@YAHOO.COM*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Interim* **Exit Conference Date**: *01/15/2021*

Inspection Dates and Department Representative

01/15/2021 - On-Site: Sabrina Freeman

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *18*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire bldg Memory Care* **Capacity**: *48* **Residents Served**: *18*

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *18*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *18*
Have Mobility Need: *18* **Have Physical Disability**: *9*

Inspections / Reviews

01/15/2021 - Partial

Lead Inspector: *Sabrina Freeman* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/10/2021*

2/25/2021 - POC Submission

Lead Reviewer: *Shawn Parker* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/01/2021*

3/9/2021 - Document Submission

Lead Reviewer: *Shawn Parker* **Follow-Up Type**: *Exception*

96a - First Aid Kit

1. **Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit did not include a thermometer, gauze pads or eye coverings.

Plan of Correction Repeat violation et al - 05/6/19 **Accept**

Executive Director and Nursing Director will check every month to make sure everything is account it for in the first aid kit. Executive Director order back up supplies for the first aid kit to make sure first aid kit always applies with the requirements with the state.

Completion Date: *02/05/2021* Licensee's Proposed Date for POC Implementation

Document Submission **Not Implemented**

First aid kit is all count it for and it's in the red box in picture. SP 04-22-2021

96c - First Aid Accessible

1. **Requirements**

2600.

96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

The first aid kit was in a locked room behind the nurses station and all staff do not have access to this room.

Plan of Correction **Accept**

Nursing Director and Executive Director move the first aid kit to a accessible area and train the staff on where the first aid kit is and will train all new staff on location of the first aid kit in new hire class. Also Executive Director will check once a month to make sure the first aid kit was and is place in right area.

Completion Date: *02/05/2021* Licensee's Proposed Date for POC Implementation SP 04-22-2021

Document Submission **Implemented**

In the one photo you will see that we put it out front where all staff knows where it is and everyone in building knows.

103f - Refrigerator/Freezer Temps

1. **Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Repeat Violation - 5/6/2019

Description of Violation

On 1/15/21 at approximately 10:30am, the temperature in the freezer on Blue Jay was 10 degrees Fahrenheit.

Plan of Correction **Accept**

Executive Director order new thermometers for the building and will check once a month to make sure the temperature logs are being done and will check temperature also. Chef's will be in charge of doing temperature checks everyday and making sure logs are also being done correctly.

Completion Date: *02/05/2021* Licensee's Proposed Date for POC Implementation

103f - Refrigerator/Freezer Temps *(continued)*

Document Submission **Not Implemented**

In the photo you will see the fridge that had a bad thermometer and now is fix with the right one.

SP
04-22-2021

233c - Key-Locking Devices

1. **Requirements**

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door on Blue Jay or Gold Finch.

Repeat et al 05/06/19

Plan of Correction **Accept**

Executive Director posted all signs near all doors with the key-locking devices and will check once every month to insure the signs are up and readable. Also ask mangers to keep their eyes on the signs.

Completion Date: *02/05/2021* Licensee's Proposed Date for POC Implementation

Document Submission Not **Implemented**

In two photos you will see one with a sign and one with a number code. Each door has that in photo's.

SP
04-22-2021