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

April 13, 2023

[redacted]
BARCLAY FRIENDS
700 NORTH FRANKLIN STREET
WEST CHESTER, PA, 19380

RE: BARCLAY FRIENDS
700 NORTH FRANKLIN STREET
WEST CHESTER, PA, 19380
LICENSE/COC#: 14682

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/15/2023 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: *BARCLAY FRIENDS* **License #**: *14682* **License Expiration**: *04/07/2023*

Address: *700 NORTH FRANKLIN STREET, WEST CHESTER, PA 19380*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BARCLAY FRIENDS*

Address: *700 NORTH FRANKLIN STREET, WEST CHESTER, PA, 19380*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/29/2019* **Issued By**: *Borough of West Chester*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *73* **Waking Staff**: *55*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *02/15/2023*

Inspection Dates and Department Representative

02/15/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Bartram Way* **Capacity**: *23* **Residents Served**: *20*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *53*

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

Have Mobility Need: *20* **Have Physical Disability**: *0*

Inspections / Reviews

02/15/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/06/2023*

03/08/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/22/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/13/2023*

Inspections / Reviews *(continued)*

03/17/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/22/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/30/2023*

04/13/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/22/2023*

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

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 Violation

Staff Member A was hired on [redacted]1 but the home did not complete a criminal background check until [redacted]

Plan of Correction ***Accept (CM - 03/17/2023)***

The violation was reviewed with the Sr. HR Director. The criminal background check was obtained immediately. An audit of all current files for criminal background check was initiated immediately and completed on 3/1/23. Moving forward, the Administrator and the Sr. HR Director or designee will conduct quarterly random audits to ensure compliance. The next quarterly audit is due in June. These audits are ongoing. The home is in compliance with regulation 2600.51.

Licensee's Proposed Overall Completion Date: *03/09/2023*

Implemented (CM - 04/13/2023)

132f - Alternate Exit Routes

2. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Stairwell 2, Stairwell 3, and Main Lobby were the only exit routes used on the following dates: 9/12/22, 10/18/22, 11/1/22, 11/22/22, 12/29/22, and 1/27/23.

Plan of Correction ***Accept (CM - 03/17/2023)***

The violation was reviewed with the Sr. Director of operations. On 2/24 a fire drill using alternate route was conducted (see attached) by the Maintenance Manager. Moving forward alternate routes will be used for fire drills. The Sr. Director of operations and the Administrator will conduct random audit of the fire drill log to ensure compliance. The next audit of the fire drill log by the Sr. Director of Operations is due April 2023. These audits are ongoing. The home is in compliance with regulation 2600.132f

Licensee's Proposed Overall Completion Date: *03/09/2023*

Implemented (CM - 04/13/2023)

141b1 - Annual Medical Evaluation

3. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept (CM - 03/17/2023)***

The violation was reviewed with the Clinical Care Coordinator and the Quality improvement Coordinator. An audit of all residents' charts by the Quality improvement Coordinator was completed on 3/2/23 (see attached). An

141b1 - Annual Medical Evaluation (continued)

outlook calendar reminder was set up by the Clinical Care Coordinator and a tickler file are in place (see attached). Moving forward, the Quality improvement Coordinator will conduct monthly audits of residents' medical evaluations to ensure compliance. These audits are ongoing. The home is in compliance with regulation 2600.141.b.1

Licensee's Proposed Overall Completion Date: *03/09/2023*

Implemented (CM - 04/13/2023)

225c - Additional Assessment

4. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #1's current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted]

Plan of Correction ***Accept (CM - 03/17/2023)***

The violation was reviewed with the Clinical Care Coordinator and the Quality improvement Coordinator. An audit of all residents' charts for additional assessment was completed on 3/2/23 by the Quality improvement Coordinator. An outlook calendar reminder was set up by the Clinical Care Coordinator (see attached) and a tickler file are in place. Moving forward, the Quality improvement Coordinator will conduct monthly audits to ensure compliance. These audits are ongoing. The home is in compliance with regulation 2600.225.c

Licensee's Proposed Overall Completion Date: *03/09/2023*

Implemented (CM - 04/13/2023)

234a - Admission Support Plan

5. 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 #2 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 (CM - 03/17/2023)***

The violation was reviewed with the Clinical Care Coordinator and the Quality improvement Coordinator. An audit of all residents' charts for support plan was completed on 3/2/23 by the Quality improvement Coordinator. An outlook calendar reminder was set up by the Clinical Care Coordinator (see attached) and a tickler file are in place. Moving forward, the Quality improvement Coordinator will conduct monthly audits to ensure compliance. These audits are ongoing. The home is in compliance with regulation 2600.234.a

Licensee's Proposed Overall Completion Date: *03/09/2023*

Implemented (CM - 04/13/2023)