

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

April 3, 2023

[REDACTED], COO
CARE HSL BELLE REVE OPCO LLC
[REDACTED]

RE: BELLE REVE SENIOR LIVING CENTER
404 EAST HARFORD STREET
MILFORD, PA, 18337
LICENSE/COC#: 22513

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/09/2023, 03/14/2023 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: BELLE REVE SENIOR LIVING CENTER **License #:** 22513 **License Expiration:** 06/25/2023
Address: 404 EAST HARFORD STREET, MILFORD, PA 18337
County: PIKE **Region:** NORTHEAST

Administrator

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

Legal Entity

Name: CARE HSL BELLE REVE OPCO LLC
Address: [REDACTED]
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: I 1 **Date:** 01/31/2022 **Issued By:** Milford Borough

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 88 **Waking Staff:** 66

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 03/14/2023

Inspection Dates and Department Representative

03/09/2023 On Site: [REDACTED]
03/14/2023 Off Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	86	Residents Served:	54
Secured Dementia Care Unit			
In Home:	Yes	Area:	3rd floor
Capacity:	40	Residents Served:	23
Hospice			
Current Residents:	3		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	54
Diagnosed with Mental Illness:	0	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	34	Have Physical Disability:	0

Inspections / Reviews

03/09/2023 - Partial
Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 03/24/2023

Inspections / Reviews *(continued)*

03/22/2023 POC Submission

Submitted By: [REDACTED] Date Submitted: 03/31/2023
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 03/29/2023

03/22/2023 POC Submission

Submitted By: [REDACTED] [REDACTED] Date Submitted: 03/31/2023
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 03/28/2023

04/03/2023 Document Submission

Submitted By: [REDACTED] Date Submitted: 03/31/2023
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 #1 suffered a fall overnight and two falls in the early morning. After the 2nd fall resident #1 was left on the bathroom floor on hands and knees in front of the toilet while staff person A left the room to call 911 and did not return to the resident's room until EMS had arrived approximately 10 minutes later. By that time resident #1 was unresponsive and subsequently passed away due to cardiac arrest after EMS performed CPR on the resident.

Plan of Correction

Accept ([REDACTED] - 03/22/2023)

What: "On [REDACTED] resident #1 suffered a fall overnight and two falls early in the morning. After the 2nd fall resident #1 was left on the bathroom floor on hands and knees in front of the toilet while staff person A left the room to call 911 and did not return to the resident's room until EMS had arrived approximately 20 minutes later. By that time resident #1 was unresponsive and subsequently passed away due to cardiac arrest after EMS performed CPR on the resident."

Who: The Resident Care Director will educate all current direct care staff to understand that a resident should not be left alone in moments of possible distress, including while waiting for EMTs to arrive at the community.

When: Training will be completed by April 1, 2023. Staff will sign in to confirm attendance.

How: In this circumstance, staff did not perceive the resident to be in distress. He was kneeling on the floor and able to communicate, and also knew staff were calling 911 and preparing his transfer sheet. In an effort to prevent the need for staff to attempt to determine when someone is in distress, staff will be trained that when 911 is called for any reason a staff member should remain with the resident.

Ongoing: The Resident Care Director will continue to review Incident Reports, and staff will continue to be encouraged to consider if a situation is serious enough to warrant the need to call 911, the resident should not be left alone. Any patterns or trends in Incident Reports will be reviewed at the quarterly Quality Assurance meetings.

*Update 3/22: Resident Care Director will be responsible for overall compliance. This will begin as of April 1 when trainings are complete. Both Resident Care Director and Executive Director will review resident incident reports.

Licensee's Proposed Overall Completion Date: 04/01/2023

Implemented ([REDACTED] - 04/03/2023)