pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 2, 2023

[redacted]
CARE HSL BELLE REVE OPCO LLC
660 SENTRY PARKWAY, SUITE 220
BLUE BELL, PA, 19422

RE: Belle Reve Senior Living Center
License #: 225131

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 13 and 14, 2023, August, 3, 2023 and August 23 and 28, 2023 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 (license number 225980) dated June 25, 2023, to June 25, 2024, 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. The license dated June 25, 2023, to June 25, 2024, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 2, 2023 to April 2, 2024.

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 (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)

42b	II	63	$5	$315	5 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:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

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

Facility Information

Name: *BELLE REVE SENIOR LIVING CENTER* **License #:** *22513* **License Expiration:** *06/25/2024*

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: *660 SENTRY PARKWAY, SUITE 220, BLUE BELL, PA, 19422*

Phone: [redacted] **Email:** [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:** *98* **Waking Staff:** *74*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *06/14/2023*

Inspection Dates and Department Representative

06/13/2023 - On-Site: [redacted]

06/14/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *86* **Residents Served:** *64*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *3rd Floor* **Capacity:** *40* **Residents Served:** *22*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *64*

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

Have Mobility Need: *34* **Have Physical Disability:** *0*

Inspections / Reviews

06/13/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/17/2023*

07/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/31/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/31/2023*

09/13/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/31/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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 most recent License Inspection Summary from 4/20/2022 was kept behind the greeter's desk and not conspicuously posted in the home.

Plan of Correction ***Accept (- 07/21/2023)***

What: The most recent License Inspection Summary from 4/20/22 was kept behind the greeter's desk and not conspicuously posted in the house.
Who/When/How: The Executive Director (ED) corrected immediately in the presence of licensing inspector on 6/14/23. The binder will remain located on the shelf that houses the kiosk where all visitors sign in.
Ongoing: The Business Office Manager will conduct monthly Quality Assurance audits of License Inspection Summary beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented - 09/13/2023)

42b - Abuse

2. 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

Resident 1 pushed Resident 2 to the ground. This resulted in Resident 2 being taken to the hospital with and admitted with

Plan of Correction ***Accept (- 07/21/2023)***

What: Resident 1 pushed Resident 2 to the ground. This resulted in Resident 2 being taken to the hospital with and admitted with
Who: The Memory Care Director or Executive Director will continue to assess behavioral concerns prior to all move ins.
When: At time of move in and ongoing.
How: Resident 1 has had no incidents of aggressive behavior since this incident. Staff continue to engage residents in programming to reduce idle time and complete regular rounds in the neighborhood. Staff will continue to report changes in any residents' behavior in communication log.
Ongoing: All incidents will be documented and reviewed at quarterly QA meetings. Memory Care Director and Executive Director will review communication log daily to review reported changes in behavior or status of residents.

Repeat Violation 3-9-23

Licensee's Proposed Overall Completion Date: *07/21/2023*

Not Implemented (- 09/13/2023)

63a - First Aid/CPR Training

3. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The home had a census of 61 residents on 5/28/2023 but only has verification of 1 staff member trained in first aide and certified in obstructed airway techniques and CPR in the home from 4am-7am on 5/28/2023.

Plan of Correction ***Accept [redacted] - 07/21/2023)***

What: The home had a census of 61 residents on 5/28/2023 but only has verification of 1 staff member trained in first aide and certified in obstructed airway techniques and CPR in the home from 4am-7am on 5/28/2023.
Who: Clinical Care Coordinator will schedule CPR and first aid classes at least quarterly to maintain as many certified staff members as possible.
When: This was corrected at time inspection.
How: When Clinical Care Coordinator is creating the staff schedule, they will cross reference the list of certified staff and the current census.
Ongoing: The Resident Care Director will conduct monthly Quality Assurance audits of CPR certified staff and staff schedule beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Not Implemented [redacted] - 09/13/2023)

65a - FS Orientation 1st Day

4. 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:

Description of Violation

Staff Member A was hired [redacted]/2023. The home has verification that the required 1st day orientations were completed but there is no date listed to verify that it was done timely.

Plan of Correction ***Accept ([redacted] - 07/21/2023)***

What: Staff Member A was hired [redacted]/2023. The home has verification that the required 1st day orientations were completed but there is no date listed to verify that it was done timely.

Who: The Business Office Manager will continue to utilize Orientation Checklist.
When: This was corrected at time of inspection.
How: The Business Office Manager will review the first day Orientation Checklist to ensure all aspects of the document are completed for all new hires before filing.
Ongoing: The Business Office Manager will conduct monthly Quality Assurance audits of first day training documentation beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Directed: Please audit all staff records to ensure overall compliance with this regulation.
Please provide proof of audit. 7-21-23 [redacted]

Licensee's Proposed Overall Completion Date: *07/31/2023*

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

Implemented (- 09/13/2023)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

The public restroom on the 2nd floor had a garbage can with no lid.

Plan of Correction ***Accept (- 07/21/2023)***

What: The public restroom on the 2nd floor had a garbage can with no lid.
Who/When/How: The Maintenance Director corrected this at the time of inspection on 6/13/2023 by placing a lid on the garbage can.
Ongoing: The Maintenance Director will conduct weekly Quality Assurance audits of bathroom trashcan lids beginning August 1, 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 09/13/2023)

91 - Telephone Numbers

6. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

Emergency telephone numbers were not posted near the landline telephone in room of Resident

Plan of Correction ***Accept (- 07/21/2023)***

What: Emergency telephone numbers were not posted near the landline telephone in room of Resident .
Who/What/How: The Clinical Care Coordinator placed emergency telephone numbers near the telephone in room of Resident on 7/19/23.
Ongoing: The Resident Life Director will conduct weekly Quality Assurance audits of emergency telephone numbers beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented - 09/13/2023)

103i - Outdated Food

7. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

There was an unlabeled and undated plastic container with ice cream in the freezer located in the 2nd floor TV lounge area.

Plan of Correction ***Accept ([redacted] - 07/21/2023)***

What: There was an unlabeled and undated plastic container with ice cream in the freezer located in the 2nd floor TV lounge area.
Who/What/How: The Executive Director (ED) removed the unlabeled and undated food item on 6/13/23.
Ongoing: The Resident Life Director will conduct weekly Quality Assurance audits of the common area refrigerator beginning August 1, 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented [redacted] - 09/13/2023)

132a - Monthly Fire Drill

8. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

There is no documentation showing that a fire drill was completed in May 2022.

Plan of Correction ***Accept [redacted] - 07/21/2023)***

What: There is no documentation showing that a fire drill was completed in May 2022.
Who: The Executive Director will train the maintenance team on regulatory requirements pertaining to fire drills.
When: Training to be completed by 8/11/23.
How: The Maintenance Director will ensure monthly fire drills are conducted. Unannounced monthly fire drills will be conducted on varying days at varying times, including 1 fire drill every 6 months during night time hours. Documentation will reflect number of residents present in the home and evacuated.
Ongoing: The Executive Director will conduct monthly Quality Assurance audits of the fire drill log beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented [redacted] - 09/13/2023)

132c - Fire Drill Records

9. 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 log incorrectly documented the number of residents in the home during fire drills completed 12/2022, 1/2023, 2/2023, 3/2023, and 4/2023 by counting residents that were out of the facility at the time of the drill.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept [redacted] - 07/21/2023)***

What: The fire drill log incorrectly documented the number of residents in the home during fire drills completed 12/2022, 1/2023, 2/2023, 3/2023, and 4/2023 by counting residents that were out of the facility at the time of the drill.
Who: The Executive Director will train the maintenance team on regulatory requirements pertaining to fire drills.
When: Training to be completed by 8/11/23.
How: The Maintenance Director will ensure monthly fire drills are conducted. Unannounced monthly fire drills will be conducted on varying days at varying times, including 1 fire drill every 6 months during night time hours. Documentation will reflect number of residents present in the home and evacuated.
Ongoing: The Executive Director will conduct monthly Quality Assurance audits of the fire drill log beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented [redacted] - 09/13/2023)

132e - Fire Drill Sleeping Hours

10. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

A fire drill was not completed during night-time hours during the 6-month period from 12/2022 through 5/2023.

Plan of Correction ***Accept [redacted] - 07/21/2023)***

What: A fire drill was not completed during night-time hours during the 6-month period from 12/2022 through 5/2023.
Who: The Executive Director will train the maintenance team on regulatory requirements pertaining to fire drills.
When: Training to be completed by 8/11/23.
How: The Maintenance Director will ensure monthly fire drills are conducted. Unannounced monthly fire drills will be conducted on varying days at varying times, including 1 fire drill every 6 months during night time hours. Documentation will reflect number of residents present in the home and evacuated.
Ongoing: The Executive Director will conduct monthly Quality Assurance audits of the fire drill log beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented [redacted] - 09/13/2023)

132g - Fire Drills Days/Times

11. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

132g - Fire Drills Days/Times *(continued)*

Description of Violation

The home held fire drills on the same day of the month for 3 consecutive months 2/20/23, 3/20/2023, and 4/20/2023.

Plan of Correction ***Accept (- 07/21/2023)***

What: The home held fire drills on the same day of the month for 3 consecutive months 2/20/23, 3/20/2023, and 4/20/2023.
Who: The Executive Director will train the maintenance team on regulatory requirements pertaining to fire drills.
When: Training to be completed by 8/11/23.
How: The Maintenance Director will ensure monthly fire drills are conducted. Unannounced monthly fire drills will be conducted on varying days at varying times, including 1 fire drill every 6 months during night time hours. Documentation will reflect number of residents present in the home and evacuated.
Ongoing: The Executive Director will conduct monthly Quality Assurance audits of the fire drill log beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented (- 09/13/2023)

183b - Meds and Syringes Locked

12. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

Resident 3 self-administers their own medications. At the time of inspection on 6/14/23, the medications were found unlocked in a cabinet in an unlocked room.
Repeat violation 4/20/2022.

Plan of Correction ***Accept - 07/21/2023)***

What: Resident 3 self-administers their own medications. At the time of inspection on 6/14/23, the medications were found unlocked in a cabinet in an unlocked room.
Who/When: The Maintenance Director repaired lock on Resident 3's cabinet on 6/16/23.
How: Resident 3 was educated on in the importance of medication storage and keeping medications locked. The lock was replaced and new key provided to ensure it is functioning properly.
Ongoing: The Resident Care Director will conduct weekly Quality Assurance audits of medication storage procedure for all residents in the home who self-administer their own medications beginning August 1, 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 09/13/2023)

185a - Implement Storage Procedures

13. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 Violation

Resident 4's glucometer indicated a blood glucose reading of 102 at [redacted] am on [redacted] /2023. The MAR was documented for the corresponding date and time with a reading of 109.

Plan of Correction ***Accept [redacted] - 07/21/2023)***

What: Resident 4's glucometer indicated a blood glucose reading of 102 at [redacted] am on [redacted] /2023. The MAR was documented for the corresponding date and time with a reading of 109.
Who/When/How: Med techs will complete the change of shift responsibility checklist, including comparing compare glucometer to electronic MAR to ensure accuracy of documentation beginning July 19, 2023.
Ongoing: The Resident Care Director will conduct monthly Quality Assurance audits of glucometers versus MAR beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented [redacted] - 09/13/2023)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident 4 has an order to receive 4 units of insulin when their blood glucose level is between 150-200. On [redacted] /2023 at [redacted] am their blood glucose reading was 170 but they received 0 units of insulin.
Repeat violation 1/23/2023.

Plan of Correction ***Accept ([redacted] - 07/21/2023)***

What: Resident 4 has an order to receive 4 units of insulin when their blood glucose level is between 150-200. On [redacted] /2023 at [redacted] am their blood glucose reading was 170 but they received 0 units of insulin. The med error was reported to the department on 6/13/23 following identification of the error during inspection.
Who: The Resident Care Director (RCD) will provide reeducation to med tech who made the error.
When: Training to be completed by 8/11/23.
How: Med tech involved will be reeducated on sliding scales, documentation, and administering insulin as ordered.
Ongoing: The Resident Care Director will conduct monthly Quality Assurance audits of diabetic resident MARs beginning September 2023. Findings and trends will be reviewed at the QA meetings.

Directed: Training indicated below shall be completed immediately. Please send proof of training. 7-21-23
[redacted]
How: Med tech involved will be reeducated on sliding scales, documentation, and administering insulin as ordered.

Licensee's Proposed Overall Completion Date: *08/11/2023*

187d - Follow Prescriber's Orders *(continued)*

Implemented ([redacted] - 09/13/2023)