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

October 23, 2023

[redacted], SENIOR VICE PRESIDENT - BEHAVIORAL HEALTH
SALISBURY BEHAVIORAL HEALTH LLC
[redacted]

RE: SALISBURY BEHAVIORAL HEALTH LLC
1075 EASTON ROAD
ROSLYN, PA, 19001
LICENSE/COC#: 12820

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/14/2023 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: *SALISBURY BEHAVIORAL HEALTH LLC* **License #**: *12820* **License Expiration**: *10/26/2023*

Address: *1075 EASTON ROAD, ROSLYN, PA 19001*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SALISBURY BEHAVIORAL HEALTH LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/12/1998* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *14* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/14/2023*

Inspection Dates and Department Representative

07/14/2023 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *13* **Residents Served**: *13*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *5*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *13*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

07/14/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/11/2023*

09/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/03/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/11/2023*

Inspections / Reviews *(continued)*

10/02/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/06/2023*

10/23/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2023*

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

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 [redacted] at [redacted] the white board located in the kitchen had written information about resident #1's medication information and medical procedures in a public area of the home. The information read as follows:
ATTN: [resident #1's initials]- Must take Novolog and Tresiba 15 minutes before ALL MEALS"

The home serves 13 residents. No other resident shares these initials.

Plan of Correction ***Accept [redacted] - 09/06/2023)***

Immediately on [redacted] the information about resident 1 was erased and removed from the white board in the kitchen. On [redacted] a staff meeting was held where the administrator reviewed the privacy violation 42s with staff. Moving forward the program administrator will complete monthly walk threes and checks to ensure that staff are adhering to the residents right to privacy. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented ([redacted] - 10/23/2023)

44g - Telephone Number

2. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is not posted in a conspicuous and public place in the home. The number posted for the local ombudsman was incorrect and invalid for the ombudsman program.

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

Immediately on [redacted] the correct new local ombudsman contact information was updated and posted in a conspicuous and public place in the home. Moving forward the program administrator will complete monthly checks and walk threes to ensure the correct most current contact telephone numbers are posted. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented ([redacted] - 10/23/2023)

54a - Direct Care Staff

3. Requirements

54a - Direct Care Staff *(continued)*

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 09/08/2023)***

On [redacted] a request for waiver of regulation was submitted to the Bureau of Human Services Licensing. Please see attached completed request. The administrator informed HR of the 52a Requirements violation. Moving forward HR will notify the administer immediately if they need to complete a request for waiver for a direct care staff person when applicable.
Updated On 7-17-23 HR reviewed all current staff files to ensure that their education and credentials are present and meet requirements. All staff are compliant besides staff person A that we received the Violation for. Staff person A that has a Bachelor degree from Liberia is not providing direct care services as of 7-15-23. [redacted] current job duties only include house keeping until [redacted] waiver is approved. Affective 7-15-23 HR has implemented that during the hire process to ensure that all new hires have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. If HR finds they do not, HR will notify the program administrator before moving forward with the hire process. The administrator will then decide not to hire or if a request for waiver is needed. If a request for Waiver is needed the Administrator will ensure the new hire does not provide direct care services and their job duties are only house keeping.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 10/23/2023)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7-14-23, the [redacted] tablet 1 mg blister pack, pill #25 for resident #2 had a broken seal covered with clear tape.

Plan of Correction ***Directed (- 09/22/2023)***

A staff meeting was held on 7-22-23 were the administrator reviewed the Sanitary Conditions violation 85a with staff. Moving forward there are stickers for reinforcing the back of the cards that can be obtained directly from the pharmacy. Staff will obtain these stickers and keep a stock pile in the med cart for future sealing issues. Staff will also be more careful to handle the medication card when distributing meds and when pulling the card out and returning the card to the med cabinet. The administrator will conduct monthly checks of the residents medication. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.
Update 9-7-23 To ensure immediate safety and enclosure of medication in case of punctured blisterbacks, the pharmacy provides blister covers (commonly called "bandaids") from our healthcare vendors, which ensure protection to the unit dose in the blister. Please see attached letter from our Pharmacy that explains what the pharmacy blister covers are and how they ensure safe sanitary conditions. If you still deem that the use of the pharmacy issued blister covers are an unacceptable plan. We will immediately put in place a plan for staff to

85a - Sanitary Conditions (continued)

return the entire pack to the pharmacy to be repacked.

Directed Plan of Correction [redacted] 9/22/23:

Directed Completion Date: *09/07/2023*

Implemented ([redacted] - 10/23/2023)

88a - Surfaces

5. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The following surfaces were of concern on 7-14-23:

- *The bathroom floor on the second floor was a slipping hazard due to the wet floor.*
- *The window in room #13 was not in good repair. The window was inoperable due to a broken handle.*

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

Immediately on 7-14-23 the maintenance engineer was notified and came over to the site. The window in room #13 was repaired on 7-21-23 when the part for the new window handle came in. The bathroom floor was immediately mopped and dried by the direct care staff. Moving forward staff will conduct hourly bathroom checks to ensure the bathrooms are hazard free. The administrator will conduct monthly checks and walk threes to ensure the facility bathroom, residents room, and building are clean, in good repair and free of hazard. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented ([redacted] - 10/23/2023)

96a - First Aid Kit

6. 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 in the home does not include : googles, scissors and tweezers.

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

On 7-17-23 the program manager purchased googles, scissors, and tweezers and restocked the first aid kit. On 7-22-23 a staff meeting was held where the administrator reviewed the First aid kit violation 96a. with staff. Moving forward the program administrator will conduct monthly checks of the first aid kit to ensure the first aid kit is fully stocked. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented ([redacted] - 10/23/2023)

101j1 - Mattress Fire Retardant

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

The box spring located in room# 13 was covered with the original plastic.

Plan of Correction ***Accept (- 09/06/2023)***

Immediately on the original plastic was removed from the box spring. A staff meeting was held on where the administrator reviewed the mattress fire retardant violation 101j. with staff. Moving forward the administrator will conduct monthly checks and walk threes of the residents beds to ensure a solid foundation and fire retardant mattress is in good repair and supports the resident. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented (- 10/23/2023)

103g - Storing Food

8. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There were 3 unlabeled, undated Tupperware containers located in the pantry containing the following:

- *Cheerios Cereal*
- *Life Cereal*
- *Raisin Brand Cereal*

Plan of Correction ***Accept (- 09/06/2023)***

Immediately on 7-14-23 the three unlabeled, undated Tupperware containers in the pantry where labeled and dated appropriately. A staff meeting was held on 7-22-23 were the administrator reviewed the storing food violation 103g. with staff. Moving forward the administrator will conduct monthly checks and walk threes of the kitchen and pantry to ensure the food containers are properly stored, sealed, dated and labeled correctly. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented (- 10/23/2023)

132e - Fire Drill Sleeping Hours

9. Requirements

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

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

The last fire drill conducted during sleeping hours was on [redacted] at [redacted]

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

A sleeping hour fire drill was conducted by the program manager on 7-17-23. The administrator educated the program manager of the approiate fire drill sleeping hours and the 132e. violation. Moving forward the administrator will conduct quarterly sleeping hour fire drills to ensure two are held every six months. Please see attached sleeping hour fire drill

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented [redacted] - 10/23/2023)

133.2 - Exit Signs Direction

10. Requirements

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

On 7-14-23, the home served 13 residents. The exit signs located in the second floor hallway did not have a direct visual line to the nearest exit. The exit sign did not indicate the direction of travel to the nearest exits.

Plan of Correction ***Accept [redacted] - 09/06/2023)***

Immediately on 7-14-23 the maintenance engineer was notified and came over to the site. [redacted] corrected the exit signs to indicate the direction of travel to the nearest exits. Moving forward the administrator will conduct monthly checks and walk threes of the facility to ensure the exit signs are visible and indicate the direction of travel. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented [redacted] - 10/23/2023)

144c1 - Smoking Area Guidelines

11. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area located under the home was not fire safe. The receptacle was missing a lid to assist with smoldering a fire, and had a plastic container inside the receptacle where cigarette butts were deposited. The ground around the picnic table and receptacle had over one hundred cigarette butts littering the area.

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

Immediately the designated smoking area located under the home was swept and cleaned by the direct care staff.

144c1 - Smoking Area Guidelines (continued)

The administrator ordered a new fire proof receptacle that was delivered on 7-29-23 and replaced the old one. At the staff meeting held on 7-22-23 the administrator reviewed the smoking area guidelines violation 144c1. with staff. Moving forward the Direct care staff will conduct hourly designated smoke area checks to ensure the area is clean and the fire proof receptacles are in good repair and condition. The hourly checks started on 8-1-23 and will continue for 90 days. After the 90 days it will convert to a daily shift check per shift for the foreseeable future. Please see the the attach hourly designated smoking check form.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented [redacted] - 10/23/2023)

183e - Storing Medications

12. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The pharmacy label for resident # 3's [redacted] does not include the date the medication was opened. According to the manufacturer's instructions, this medication should be discarded 13 months after opening the foil pouch, when the dose counter reaches 0, or after the expiration date, whichever comes first.

Plan of Correction ***Accept [redacted] - 09/06/2023)***

A staff meeting was held on 7-22-23 were the administrator reviewed the Storing Medications Violation 183e with staff. Moving forward there are stickers available to adhere to each inhaler and insulin that staff should adhere upon opening the medication. Staff will scribe the opening date and determine and scribe the use by date indicated on the product or pharmacy sticker. Staff will ensure there is always ample stock of these stickers available. The administrator will conduct monthly checks of the residents medication. The monthly checks started on 8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented [redacted] - 10/23/2023)

185a - Implement Storage Procedures

13. 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 Violation

Resident # 4 is prescribed [redacted]. However, on [redacted], this medication was not available in the home. The medication is located at the outpatient clinic.

Plan of Correction ***Accept [redacted] - 10/02/2023)***

A staff meeting was held on 7-22-23 were the administrator reviewed the Implement Storage Procedures Violation 185a with staff. The medication is not available in the home due to the fact there is no staff on the premises to administer the medication. The mediation is to be administered by a doctor or nurse only and the mediation is therefore kept in the doctor and nurse's clinic until it is needed.
updated 9-7-23 Medications not administered in the home will not be on the Medication Administration Record.

185a - Implement Storage Procedures (continued)

Therefore Resident # 4 prescribed [redacted]. that [redacted] receives at the doctor's office is no longer listed on [redacted] MAR.

Licensee's Proposed Overall Completion Date: *09/07/2023*

Implemented [redacted] - 10/23/2023)

187a - Medication Record

14. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident # 3 is prescribed [redacted]. However, resident's #3's medication administration record does not indicate the diagnosis or purpose for these medications.

Resident #4 is prescribed [redacted]. However, resident's #4's medication administration record does not indicate the diagnosis or purpose for these medications.

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

A staff meeting was held on 7-22-23 were the administrator reviewed the Medication Record Violation 187a with staff. Prior to approving a medication staff will ensure that the diagnosis is entered as determined and indicated by the doctor's prescription and or pharmacy label. The administrator will conduct monthly checks of the residents medication. The monthly checks started on
8-1-23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented ([redacted] - 10/23/2023)

187c - Refusal of Medication

15. 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

On the following dates of [redacted], resident #1 refused to take utilize the [redacted] Replenish scheduled use of 8:00am. The home did not report this too the prescriber within 24 hours.

Plan of Correction ***Accept ([redacted] 09/06/2023)***

A staff meeting was held on 7-22-23 were the administrator reviewed the Refusal of Medication Violation 187c with staff. Moving forward Internal medication error forms will be utilized to document and track refusals and the completed form will be faxed to the facility nurse, prescribing doctor and other entities as indicated on the form. Staff will ensure these forms are completed and submitted to the respected entities upon a resident refusing to take a

187c Refusal of Medication (continued)

prescribed medication. The administrator will conduct monthly checks of the residents medication. The monthly checks started on 8 1 23 and will continue for six months. After that they will be conducted quarterly. Please see attached monthly checklist.

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented ([redacted] - 10/23/2023)

221b - Activity Types

16. Requirements

2600.
221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

The home's activities program does not include structured times for activities that involve the social, physical, intellectual and recreational activites.

Plan of Correction ***Accept ([redacted] - 09/06/2023)***

Immediately on 7 17 23 the program manager included the structured times for the activities on the activity calendar. On 7 22 23 a staff meeting was held where the administrator reviewed the Activity Types violation 221b with staff. Moving forward the program manager will ensure the program provides social, physical, intellectual and recreational activities in a planned, coordinated and structured manner with the scheduled times listed for the residents to plan accordingly.
Please see attached

Licensee's Proposed Overall Completion Date: *08/10/2023*

Implemented [redacted] - 10/23/2023)