



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: June 14, 2024

[REDACTED]
[REDACTED]
Bristol House Memory Care, LLC
[REDACTED]
[REDACTED]

RE: Bristol House Memory Care
2527 Bristol Road
Warrington, Pennsylvania 18976
License #: 144582

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection December 27, 2023, February 22, 2024, and April 9, 2024 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from June 14, 2024 to December 14, 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 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
82c	2	45	\$5	\$225	5 calendar days from mailing date of this letter
132e	2	45	\$5	\$225	5 calendar days from mailing date of this letter
231c	2	45	\$5	\$225	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 SECOND 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.

[REDACTED]

If you decide to appeal your SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]
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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* License #: *14458* License Expiration: *04/12/2024*
Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] 7 Email: [REDACTED]

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *03/19/2019* Issued By: *Warrington Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *94* Waking Staff: *71*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Monitoring* Exit Conference Date: *12/27/2023*

Inspection Dates and Department Representative

12/27/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *47*

Secured Dementia Care Unit

In Home: *Yes* Area: *Entire Home* Capacity: *48* Residents Served: *47*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *0*
Diagnosed with Mental Illness: *4* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *47* Have Physical Disability: *0*

Inspections / Reviews

12/27/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/03/2024*

Inspections / Reviews (*continued*)

02/06/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 02/02/2024
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/11/2024

02/13/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 02/11/2024
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 03/08/2024

05/14/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: 03/08/2024
Reviewer: [REDACTED] Follow-Up Type: Enforcement

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

Labels identifying resident medications for residents #1, #2, #3, and #4 were located outside the medication cart, unsecured and available to be viewed by passersby.

Plan of Correction

Accept [redacted] - 02/13/2024)

All MedTech's have been retrained by Director of Nursing on record confidentiality and HIPPA and how it may affect one person or multiple people on 1/10/2024.

Starting on Friday 1/12/2024 both RCC's will perform random confidentiality checks weekly for the duration of 2-months, Both RCC's were trained on its importance by Director of Nursing 1/11/2024.

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented ([redacted] - 03/21/2024)

51 - Criminal Background Check

2. 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 person A, hired on [redacted] 22, was not a Pennsylvania resident for two years, staff person license on date of hire was from the State of [redacted]. The home did not have the FBI clearance.

Repeated Violation: 3-21-23, 5-15-23

Plan of Correction

Accept [redacted] 02/13/2024)

A federal background check has been performed on Staff person A. Executive Director will resume the role of obtaining background checks and which is appropriate based on the residential status of the employee during the hiring process.

Executive Director will perform employee file audits weekly starting 1/10/2024 which will last for the duration of 3-months.

Business office Manager will perform weekly audits for the duration of 6-months on top of the Executive Director starting 2/01/2024 which will consist of a signature needed from business office manager stating Background checks, Social Security cards, Identification have all been received.

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented ([redacted] - 03/21/2024)

51 - Criminal Background Check (*continued*)

57c - 2 Hours/Day

3. Requirements

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 12-25, 26 and 12-27-23, there were 47 residents in the home, including 47 residents with mobility needs, requiring a total minimum of 94 hours of direct care service. On this date, only 82.5 hours of direct care staffing was provided.

Plan of Correction**Accept** (████) - 02/13/2024)

Resident Care Coordinator will be retrained on staffing requirements by Executive Director 1/26/2024. Executive Director will ensure staffing ratios is applied and looked at for the next six months. A monthly audit will be performed starting 1/26/2024 for the duration of 3-months. The Resident Care coordinator is responsible for developing the staff schedule, both RCC's are responsible to ensure staff call outs are covered per Job descriptions. The Executive Director is in charge of performing these monthly audits to ensure the schedules are covered.

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Implemented (████) - 03/21/2024)

57d - Waking Hours

4. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 12-25, 26 and 12-27-23, 94 hours of direct care was required. However, only 60 of the required hours, or 63.8 percent, were provided during waking hours.

Plan of Correction**Accept** (████) - 02/13/2024)

Resident Care Coordinator will be retrained on staffing requirements by Executive Director 1/26/2024. Executive Director will ensure staffing ratios is applied and looked at for the duration of six months. This will be done on a Monthly audit starting 1/26/2024 with Resident Care Coordinator. Executive Director to perform these Audits. Management to meet weekly to ensure staffing needs meet regulation is hiring is done on the basis of the staff needed and required. The RCC is responsible to developing the staff schedule. Both RCC's are responsible to ensure that call-outs are covered.

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Implemented (████) - 03/21/2024)

65a - FS Orientation 1st Day

5. 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 person A, whose first day of work was [redacted]-23, did not initial receiving orientation on the following topics:

- Evacuation procedures
- Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable
- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable
- The location and use of fire extinguishers
- Smoke detectors and fire alarms
- Telephone use and notification of emergency services

Repeated violation: 5-15-23

Plan of Correction

Accept [redacted] - 02/13/2024)

Resident Care coordinator has been retrained by the Executive Director on the importance of first day orientation and what it will consist of on 1/11/2024. Dementia Care coordinator will resume role on ensuring that proper documentation is provided by future employee/current employees starting on 1/12/2024. Executive Director will resume performing monthly audits beginning 1/12/2024 that will continue for the duration of 6-months. Bristol house has rebuilt the training program as of 1/26/2024 that will include Executive Director to sign off on completed training before Employee is able to start. The executive Director will Audit Files of the employee to ensure everything has been filled out properly with the Dementia Care Coordinator. Nursing Director to follow up for last day of training to ensure all training is complete with a Checklist that has been provided. Executive Director to have this form as well for non-nursing staff to keep separate from employee files.

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented [redacted] - 03/21/2024)

65c - Ancillary Staff Orientation

6. 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 Violation

Ancillary staff person A, whose first day of work was [redacted]-22, did not have a general orientation to her specific job functions.

Plan of Correction

Accept [redacted] - 02/13/2024)

Resident Care coordinator has been retrained on the importance of first day orientation and what it will consist of on 1/11/2024. Dementia Care coordinator will resume role on ensuring that proper documentation is provided by

65c - Ancillary Staff Orientation (continued)

future employee/current employees starting on 1/12/2024. Executive Director will resume performing monthly audits beginning 1/12/2024 that will continue for the duration of 6-months. Bristol house has rebuilt the training program as of 1/26/2024 that will include Executive Director to sign off on completed training before Employee is able to start. The executive Director will Audit Files of the employee to ensure everything has been filled out properly with the Dementia Care Coordinator. Nursing Director to follow up for last day of training to ensure all training is complete with a Checklist that has been provided. Executive Director to have this form as well for non-nursing staff to keep separate from employee files.

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented [redacted] - 03/21/2024)

65d - Initial Direct Care Training

7. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted]-23, began providing unsupervised ADL services on 10-25-23. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeated Violation: 3-21-23

Plan of Correction

Accept [redacted] - 02/13/2024)

Resident Care coordinator has been retrained on the importance of first day orientation and what it will consist of on 1/11/2024, All department approved direct training will take place even if employee is certified nursing assistant. Dementia Care coordinator will resume role on ensuring that proper documentation is provided by future employee/current employees starting on 1/12/2024. Executive Director will resume performing monthly audits beginning 1/12/2024 that will continue for the duration of 6-months.

Staff person B has completed the required department approved training course and passed the competency test on 1/13/2024. An audit will be performed upon date of start to ensure this test was passed as outlined in the New Training program, This competency test will be sent to employees to complete on Date of Hire prior to the Start Date, The Dementia Care Coordinator is now solely responsible to ensure this document is sent along with offer letter which will be contingent upon completing the department approved training course and passing the competency test. The Executive Director will audit when the certificate is obtained, the date of hire and start date of the employee, Executive Director will keep a scanned copy of each Certificate obtained along with date obtained.

Proposed Overall Completion Date: 01/26/2024

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented [redacted] - 03/21/2024)

82c - Locking Poisonous Materials

8. 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

Daylogic, "skin relief " Moisturizing lotion with a manufacture's label indicating "In case of accidental ingestion seek medical help or contact poison control", was unlocked, unattended, and accessible to resident #5 . Not all the residents of the home, including resident #5, have been assessed capable of recognizing and using poisons safely.

Repeated Violation: 3-21-23, 5-15-23

Plan of Correction

Accept [redacted] - 02/13/2024)

All MedTech's have been retrained and counseled on poisonous materials and keeping them locked away at all times when not in use of staff on 1/10/2024. Director of Nursing and Executive Director will check daily to ensure all poisonous materials are kept locked away including on the medication cart starting on 1/11/2024 for the duration of 3-months.

RCC's will now check rooms and carts daily to ensure no poisonous materials are left out, Followed by Medtech's. Vitality Hospice now provides training to staff as provided in this year's training. First Training date set for March 12th on the importance of keeping poisonous materials locked away and out of reach from the residents.

Proposed Overall Completion Date: 02/11/2024

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented [redacted] - 03/21/2024)

85a - Sanitary Conditions

9. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 12-27-23 at 2:46pm, the bathroom floor in room # [redacted] was stained with residue of feces.

Plan of Correction

Accept [redacted] - 02/13/2024)

All staff have been retrained on the importance of sanitary conditions and how to clean and sanitize each room to ensure its sanitary conditions be maintained on 1/11/2024 by Executive Director. Staff will clean the accident and Housekeeping will follow up to ensure it is sanitized thoroughly, starting on 1/11/2024 Houskeeper will double check all rooms to ensure they are sanitized thoroughly for the duration of 3-months by spending and extra 1hr on each side after first clean and sanitize. Executive Director to perform these audits weekly starting on 1/11/2024 for the duration of 3-months, these audits will consist of a checklist of sanitized areas, when they were last cleaned, any discrepancies with cleaning, any complaints from families and care staff.

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented [redacted] - 03/21/2024)

85d - Trash Receptacles

10. Requirements

85d - Trash Receptacles (continued)

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

On 12-27-23 at 11:41am there was a trash can full, uncovered, unattended trash can in the kitchenette area located near the dining room of the home.

Plan of Correction

Accept [REDACTED] - 02/13/2024)

All Staff have been retrained by Executive Director on ensuring the trash can is emptied in-between shift changes and covered at all times on 1/10/2024.

Housekeeper will check daily to ensure trash is removed and covered; Housekeeper will keep a daily log starting 1/11/2024 to ensure to is being upkept for the duration of 2-months.

Licensee's Proposed Overall Completion Date: 02/11/2024

Not Implemented [REDACTED] - 03/21/2024)

185a - Implement Storage Procedures

15. 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 #6 is prescribed Acetaminophen 650 mg suppositories as needed. On 12-27-23, the Acetaminophen 650 mg suppositories medication were not available in the home.

Repeated Violation-7-6-23, et al

Plan of Correction

Accept [REDACTED] - 02/13/2024)

Director of Nursing have counseled all MedTech's on performing daily audits to ensure all medication is on the cart at all times on 1/10/2024. Director of nursing will resume the responsibility of performing cart audits weekly starting 1/10/2024 for the duration of 3-months.

Proposed Overall Completion Date: 02/09/2024

Licensee's Proposed Overall Completion Date: 02/09/2024

Not Implemented [REDACTED] - 03/21/2024)

225a - Assessment 15 Days

16. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #7 was admitted on [REDACTED]-23 ; however, the resident's assessment was not completed until 11-17-23.

225a - Assessment 15 Days (continued)

Plan of Correction**Accept** [REDACTED] - 02/13/2024)

It has been noted between pharmacy and facility of admission intake error. Nursing Director will continue to use planned intake option but will however ensure that the correct intake date is updated upon moving in, Nursing Director will perform weekly audits to ensure paperwork is updated to match system starting 1/17/2024 for a duration of 3-months. This issue has been corrected again 1/17/2024. An Audit has been completed on all potential discrepancies and resolved on 1/17/2024 By Both Dementia Care coordinator and Nursing Director.

Licensee's Proposed Overall Completion Date: 02/09/2024

Not Implemented [REDACTED] - 03/21/2024)

231c - Preadmission Screening

17. 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

Resident #7 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]-23. However, the resident 7's written cognitive preadmission screening was completed on 11-14-23.

Repeated Violation-5-15-23

Plan of Correction**Accept** [REDACTED] - 02/13/2024)

It has been noted between pharmacy and facility of admission intake error. Nursing Director will continue to use planned intake option but will however ensure that the correct intake date is updated upon moving in, Nursing Director will perform weekly audits to ensure paperwork is updated to match system starting 1/17/2024 for a duration of 3-months. This issue has been corrected again 1/17/2024. An Audit has been completed on all potential discrepancies and resolved on 1/17/2024 By Both Dementia Care coordinator and Nursing Director.

Proposed Overall Completion Date: 02/09/2024

Licensee's Proposed Overall Completion Date: 02/09/2024

Not Implemented [REDACTED] - 03/21/2024)

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

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* License #: *14458* License Expiration: *04/12/2024*
Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *03/19/2019* Issued By: *Warrington Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *76* Waking Staff: *57*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Provisional* Exit Conference Date: *02/22/2024*

Inspection Dates and Department Representative

02/22/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *38*

Secured Dementia Care Unit

In Home: *Yes* Area: *All* Capacity: *48* Residents Served: *38*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *38*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *38* Have Physical Disability: *0*

Inspections / Reviews

02/22/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/15/2024*

Inspections / Reviews (*continued*)

03/20/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/15/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 03/25/2024

03/28/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/25/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/05/2024

05/14/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/05/2024

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

On 2/22/2024, there was no copy of the 2600 chapter regulations posted in a conspicuous and public place in the home.

Repeat violation: 3/21/2023.

Plan of Correction

Accept (redacted) - 03/20/2024)

The Executive Director has hung the 2600 chapter regulations in a conspicuous and public place in the home on 2/26/2024.

Executive Director will check bi-weekly to make sure the regulations are posted starting 2/26/2024 for the duration of 3-months.

Licensee's Proposed Overall Completion Date: 03/14/2024

Implemented (redacted) - 04/17/2024)

26a - Quality Management Plan

2. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not have a quality management plan on 2/22/2024.

Plan of Correction

Accept (redacted) - 03/28/2024)

Bristol House has now established and implemented a quality management plan in which all management will meet monthly starting 2/22/2024. The Quality management plan was re-developed by the business office manager, The business office manager is responsible for scheduling these meeting and ensuring that the home has a quality management plan. This meeting will take place the last Wednesday of each month. If a meeting is not held during the last Wednesday of each month, it will always be schedule for that last Thursday or Friday to ensure quality assurance of the building. This plan is indefinite as long as this policy is in place.

Proposed Overall Completion Date: 03/25/2024

Licensee's Proposed Overall Completion Date: 03/25/2024

Implemented (redacted) - 04/17/2024)

54a - Direct Care Staff

3. Requirements

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

54a - Direct Care Staff (continued)

does not have a high school diploma or GED from the United States, or active registry status on the Pennsylvania nurse aide registry.

Repeat violation: 3/21/2023, 5/15/23.

Plan of Correction

Accepted [redacted] 03/28/2024)

Direct Care Staff person A did start working with [redacted] to have High School Diploma transcribed on 2/23/2024. Bristol House in process of submitting Waiver for employee while we are waiting for [redacted] response and submission, unfortunately due to Employee being unable to perform job duties until the process is complete employee is no longer on our roster as of [redacted] 6/2024 until we are able to receive supporting documents. Business office manager was trained by executive Director to oversee HR process moving forward with understanding documents needed and documents we cant use on 3/6/2024. Business office manager has completed a complete Documentation audit on all employee files on 3/8/2024, The Business office manager will follow up with completing weekly audits for the duration of 2-months and after 2-months, the business office manager will complete monthly audits for the duration of 6 months beginning 6/8/2024.

Proposed Overall Completion Date: 03/25/2024

Licensee's Proposed Overall Completion Date: 03/25/2024

Implemented [redacted] - 04/17/2024)

65f - Training Topics

4. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self-administration training.
- 3. Care for residents with dementia and cognitive impairments.
- 4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
- 6. Safe management techniques.

Description of Violation

Direct care staff person B did not receive training in the following topics during training year 2023:

- Medication self-administration.
- Care for residents with dementia and cognitive impairments.
- Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
- Safe management techniques.

Plan of Correction

Accepted [redacted] - 03/20/2024)

Staff person B has been trained on topics listed as of 3/12/2024 by Both Director of Nursing and Executive Director. Executive Director to ensure Supervisors are in mandatory monthly meetings or trained separately within same month to ensure yearly training is upkeep. Executive Director to sign off on all training required during the year for supervisors starting 3/12/2024 and will keep on file as a monthly audit which will last for the duration of the year 2024.

Licensee's Proposed Overall Completion Date: 03/15/2024

Implemented [redacted] - 04/17/2024)

65f - Training Topics (*continued*)

65g - Annual Training Content

5. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff person B did not receive training in The Older Adult Protective Services Act, or in Falls and Accident Prevention, during training year 2023.

Plan of Correction

Accept (█) - 03/20/2024)

Staff person B has been trained on topics listed as of 3/12/2024 by Both Director of Nursing and Executive Director. Executive Director to ensure Supervisors are in mandatory monthly meetings or trained separately within same month to ensure yearly training is upkept. Executive Director to sign off on all training required during the year for supervisors starting 3/12/2024 and will keep on file as a monthly audit which will last for the duration of the year 2024.

Licensee's Proposed Overall Completion Date: 03/15/2024

Implemented (█) - 04/17/2024)

82c - Locking Poisonous Materials

6. 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 2/22/2024, at 10:51 am, a tube of Sensodyne fluoride toothpaste and a tube of Colgate whitening toothpaste were unlocked, unattended, and accessible to resident █ in room █. Both products featured manufacturer's labels warning, "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away." The residents of the home, including resident #1, have not been assessed as capable of recognizing and using poisons safely.

Repeat violation: 3/21/2023, 5/15/23

Plan of Correction

Accept (█) - 03/28/2024)

As of 3/12/2024 All Direct Care Staff has been retrained by Vitality Hospice and counseled on keeping poisonous materials locked away and the harm it can cause our residents if digested. RCC's have been counseled on 3/12/2024 by the executive Director on the importance of making sure to perform these audits as well as the Director of Nursing. Executive Director to resume daily audits which will now extend our audit duration from 3-months to 6-months.

Proposed Overall Completion Date: 03/25/2024

Licensee's Proposed Overall Completion Date: 03/25/2024

82c - Locking Poisonous Materials (continued)

Not Implemented [redacted] - 04/17/2024)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 2/22/24, at 10:10am, there was no form of hand drying in the ladies' bathroom.

Repeat violation: 3/21/2023.

Plan of Correction

Accept [redacted] - 03/28/2024)

As this is a repeated violation Executive Director is to take on the responsibility of ensuring that all Bathrooms have hand towels and toilet paper at all times. Executive Director will use two forms of paper towels to ensure we don't run out during the day. Business Office Manager to control daily audits on ensuring there is a form of hand drying at all times, if not [redacted] will be sure to restock. These daily audits will start on 2/28/2024 and will last for the duration of 4-months.

Our Immediate correction to this violation was to order more towels and looking to see if we can get a bigger paper towel dispenser. At the Current moment we have paper towels in the dispenser and an extra roll next to dispenser. Executive Director will check 3 times daily for the duration of 2-weeks to ensure this is being maintained.

Proposed Overall Completion Date: 03/25/2024

Licensee's Proposed Overall Completion Date: 03/25/2024

Not Implemented [redacted] - 04/17/2024)

85d - Trash Receptacles

8. 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

On 2/22/2024 at 9:55 am, two 32-gallon trash cans in the kitchen were not covered..

Repeat violation: 3/21/2023

Plan of Correction

Accept [redacted] - 03/28/2024)

Kitchen Staff has been trained by the Executive Director on the importance of keeping trash cans covered especially in the kitchen area. Head Chef counseled by Executive Director on making sure this is happening at all times. Executive Director to do random weekly checks starting on 2/28/2024 which will last for the duration of 3-months. Executive Director in process of purchasing trash cans with lids attached, this will happen prior to the 31st of the month of March, to ensure trash can lids cannot be removed from trash cans.

Licensee's Proposed Overall Completion Date: 03/25/2024

Not Implemented [redacted] 04/17/2024)

85d - Trash Receptacles (*continued*)

101j7 - Lighting/Operable Lamp

9. 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*On 2/22/2024, at 10:55 am, resident #1 did not have access to a source of light that could be turned on/off at bedside.**At 11:01 am, resident #2 did not have access to a source of light that could be turned on/off at bedside.***Plan of Correction****Accept** [REDACTED] - 03/20/2024)*As of 2/23/2024 both residents have access to a source of light that can be turned on/off at bedside. Resident care coordinator checked all rooms as well on 2/23/2024 to ensure all residents have access to a source of light that could be turned on/off at bedside, rooms rearranged to ensure residents have this access at all times. New operable lamps purchased to ensure we have extra in stock. Resident care coordinator will check rooms weekly to ensure each residents bedroom is arranged to ensure they can reach light at bedside and that light is operable. These weekly audits started 2/23/2024 and will last for the duration of 3-months,***Licensee's Proposed Overall Completion Date:** 03/15/2024**Implemented** [REDACTED] - 04/17/2024)

102j - Towels/Wash Cloths Access

10. Requirements

2600.

102.j. Towels and washcloths shall be in the possession of the resident in the resident's living space unless the resident has access to the home's linen supply.

Description of Violation*On 2/22/2024, at 10:53 am, towels and washcloths were not accessible to resident #1 in the bathroom of room [REDACTED].***Plan of Correction****Accept** [REDACTED] - 03/20/2024)*As of 2/23/2024 resident #1 in room [REDACTED] has clean towels and washcloths in her bathroom. Resident coordinator will also be responsible moving forward in making sure each resident has a Bath towel, washcloth, and hand towel in bathroom at all times. Resident care coordinator to ensure these items are replaced when taken out for laundry immediately. Director of Nursing to perform weekly audits to ensure RCC is keeping bathrooms stocked with towels and washcloths. These Audits will start 2/28/2024 and will last for the duration of 2-months.***Licensee's Proposed Overall Completion Date:** 03/15/2024**Implemented** [REDACTED] - 04/17/2024)

103d - Storing Food Off Floor

11. Requirements

2600.

103.d. Food shall be stored off the floor.

Description of Violation*On 2/22/2024, at 10:04 am, two five-gallon containers of water were stored on the floor in the emergency supply area.*

103d - Storing Food Off Floor (*continued*)**Plan of Correction**

Accept (████) - 03/20/2024)

As of 2/23/2024 the two five-gallon containers of water has been stored off the floor. Executive Director will be sure to check the emergency supply twice weekly to ensure that nothing is stored on the floor starting 2/23/2024 and the executive director will perform these audits for the duration of 2-months to ensure Food is being stored correctly. Chef to be responsible for these audits indefinitely starting 4/24/2024.

Licensee's Proposed Overall Completion Date: 03/15/2024

Implemented (████) - 04/17/2024)

130h - Inoperable Smoke Detector

12. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction

Accept (████) - 03/20/2024)

Executive Director has now implemented a procedure for when a smoke detector or fire alarm is inoperable. This implementation took place 3/12/2024 alongside Business Office Manager. Business office to upkeep Bristol house's procedures and policies and to add as we continue to grow. Executive to ensure this is happening by auditing the policies and procedures binder once a month starting 3/12/2024 for the duration of 3-months, to be sure it is being done correctly and to company's standard.

Proposed Overall Completion Date: 03/15/2024

Licensee's Proposed Overall Completion Date: 03/15/2024

Implemented (████) - 04/17/2024)

132c - Fire Drill Records

13. 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 written fire drill records for the drills conducted on 1/10/2023 at 1:45 pm, 1/19 at 7:30 pm, 2/15 at 10:42 am, and 2/22 at 3:16 pm do not include 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.

Plan of Correction

Accept (████) - 03/20/2024)

All management personnel have been trained by the Executive Director on the importance of documenting fire drills properly and maintaining the documentation on 2/28/2024. The executive Director will continue to perform

132c - Fire Drill Records (continued)

monthly audits which started on 1/10/2024 that will last for the duration of 6-months. This audit list's times the fire drill is performed, person who performed the fire drill, how long the drill lasted, how long the drill lasted and the date the audit and drill are performed.

Licensee's Proposed Overall Completion Date: 03/15/2024

Not Implemented [redacted] - 04/17/2024)

132e - Fire Drill Sleeping Hours

14. Requirements

2600.

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

Description of Violation

The last fire drill conducted during sleeping hours was on 3/23/2023 at 1:24 am. There were no overnight fire drills recorded from April to December of 2023.

Repeat violation: 3/21/2023

Plan of Correction

Accept [redacted] - 03/28/2024)

Overnight Fire Drill was performed in January of 2024. Executive Director now fully aware on how overnight drills operate with verbal conversation with fire inspector and training on fire drill regulations. Executive Director will resume control over performing Fire drills starting 01/01/2024 which will last for the duration of 12-months to ensure fire drills are being properly performed.

Another overnight fire drill was performed 3/22/2024. Executive Director will Ensure that another fire drill is performed 6-months from 3/22/2024. The next drill is to be performed on or before 9/22/2024. Fire drill audits will still be performed which started 01/01/2024 which will last for a duration of 12-months to ensure fire drills are being properly performed.

Licensee's Proposed Overall Completion Date: 03/25/2024

Not Implemented [redacted] - 04/17/2024)

143a - Emergency Medical Plan

15. Requirements

2600.

143.a. The home shall have a written emergency medical plan that includes the following:

Description of Violation

On 2/22/2024, the home did not have a written emergency medical plan.

Plan of Correction

Accept [redacted] - 03/28/2024)

A written medical emergency plan has been completed by the Business office manager and is now in effect as of 3/1/2024. This Medical plan consist of hospital source that will be used in the event of an emergency, Emergency Transportation to be used, an emergency staffing plan which includes contract with Clipboard health and has each resident medical and health information available at all times. This book will be checked monthly starting on 3/1/2024 to ensure it is being upkept as needed for the safety and security of our residents. This monthly check will last for the duration of 6-months to be sure it is upkept to meet state regulations.

Proposed Overall Completion Date: 03/25/2024

143a - Emergency Medical Plan (continued)

Licensee's Proposed Overall Completion Date: 03/25/2024

Not Implemented [redacted] - 04/17/2024)

185a - Implement Storage Procedures

17. 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 #3's glucometer was not calibrated to the correct time. On 2/22/2024, at 11:17 am the device read a time of 12:16 pm.

Repeat violation: 3/21/2023, 5/15/23.

Plan of Correction

Accept [redacted] - 03/20/2024)

Director of Nursing was counseled on the importance of training MedTech's to check daily and after use to ensure glucometers are calibrated to correct time by the executive Director, date and numbers taken are correct. Any Discrepancies must be noted and reported as an error. MedTech's to check for correct time with each use and report any discrepancies daily as of 2/23/2024, Director of Nursing to follow up every Friday starting 2/23/2024 for the duration of 6-months to ensure this is being understood and done correctly. Director of Nursing has also trained RCC's 2/23/2024 to calibrate glucometer and complete audit in the case that she is not in the building that Friday to keep audit in compliance.

Licensee's Proposed Overall Completion Date: 03/15/2024

Not Implemented [redacted] - 04/17/2024)

231c - Preadmission Screening

18. 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

Resident #2 was admitted to dementia care in the home on [redacted]/2022. However, the resident's written cognitive preadmission screening was completed on 12/8/22, more than 72 hours prior to admission. Also, the assessor did not complete the screening by selecting yes or no under "Based on this screening, I verify that the needs of this applicant require secured care due to Alzheimer's disease or other dementia."

Repeat violation: 5/15/2023

Plan of Correction

Accept [redacted] - 03/20/2024)

Based on this Finding the Executive Director will take over on how the chart auditing is being done. Executive Director has performed a massive binder Audit with the assistance of the management team to ensure nothing is missing on preadmission screenings. Moving forward this form will be completed during assessment of residents by Executive Director alongside Director of Nursing. Director of nursing has received written counsel on preadmissions and the importance of filling and checking off each box and on each line. Executive Director has also implemented

231c - Preadmission Screening (continued)

a checklist to take to admission screenings and with new move in policy if this form is not completed the move in does not happen until Business office has a scanned in PDF copy of the preadmission screening and move in checklist form and along with email to confirm preadmission is approved for completion by business office manager. Business office manager and Executive director has started this process on 3/5/2024 and this will last for the duration of 12-months with the understanding of no discrepancies during this new system.

Licensee's Proposed Overall Completion Date: 03/15/2024

Not Implemented [redacted] - 04/17/2024)

236 - Staff Training

19. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

The home did not have documentation that staff persons A and B, who provide direct care to residents with diagnoses of dementia, received six hours of training related to dementia care and services.

Plan of Correction

Accept [redacted] - 03/20/2024)

Staff person A is no longer on Bristol House roster until we are able to complete education guidelines. Staff person B has been trained on topics listed as of 3/12/2024 by Both Director of Nursing and Executive Director. Executive Director to ensure Supervisors are in mandatory monthly meetings or trained separately within same month to ensure yearly training is upkept. Executive Director to sign off on all training required during the year for supervisors starting 3/12/2024 and will keep on file as a monthly audit which will last for the duration of the year 2024.

Proposed Overall Completion Date: 03/15/2024

Licensee's Proposed Overall Completion Date: 03/15/2024

Not Implemented [redacted] - 04/17/2024)

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

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* License #: *14458* License Expiration: *04/12/2024*
Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *03/19/2019* Issued By: *Warrington Township*

Staffing Hours

Resident Support Staff: Total Daily Staff: *78* Waking Staff: *59*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Monitoring* Exit Conference Date: *04/09/2024*

Inspection Dates and Department Representative

04/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *39*

Secured Dementia Care Unit

In Home: *Yes* Area: *All* Capacity: *48* Residents Served: *39*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *39*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *39* Have Physical Disability: *0*

Inspections / Reviews

04/09/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/27/2024*

Inspections / Reviews (*continued*)

04/18/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/19/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/22/2024

04/19/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/19/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/23/2024

04/24/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/19/2024

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] 2024, at 9:00 am, there was an odor of urine in room [redacted] By 1:00 pm, the smell had lessened but was still present.

Plan of Correction

Accept [redacted] - 04/19/2024)

Smell was noted by housekeeper and marked down for afternoon deep cleaning. Room [redacted] a deep cleaning at 3:27PM, Housekeeper will continue to check rooms daily for the duration of 2-months with providing an extra day for deep cleaning for room [redacted]. Residents Care plan has been updated to state the frequency change on using the bathroom, Resident now requires assistance surrounding toileting use. DCS to assist throughout the day to ensure resident knows location of the bathroom.

Resident Care coordinator has updated the Care support plan on 4/12/2024.

Proposed Overall Completion Date: 04/18/2024

Licensee's Proposed Overall Completion Date: 04/18/2024

Not Implemented [redacted] - 04/24/2024)