pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CARE HSL BELLE REVE OPCO LLC**
LEGAL ENTITY

To operate **BELLE REVE SENIOR LIVING CENTER**
NAME OF FACILITY OR AGENCY

Located at **404 EAST HARFORD STREET, MILFORD, PA 18337**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **86**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 15, 2024** until **May 15, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **225130**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: May 15, 2024

[redacted]
Care HSL Belle Reve OPCO LLC
[redacted]

RE: Belle Reve Senior Living Center
404 East Harford Street
Milford, Pennsylvania 18337
License #: 225130

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on February 27, 2024 and February 28, 2024 and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

April 30, 2024

[redacted]
CARE HSL BELLE REVE OPCO LLC
[redacted]

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

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/27/2024, 02/28/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BELLE REVE SENIOR LIVING CENTER* **License #**: *22513* **License Expiration**: *04/02/2024*

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: [redacted]

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *03/20/2001* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *2* **Total Daily Staff**: *101* **Waking Staff**: *76*

Inspection Information

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

Reason: *Provisional, Incident, Interim* **Exit Conference Date**: *02/28/2024*

Inspection Dates and Department Representative

02/27/2024 - On-Site: [redacted]

02/28/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *86* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd Floor* **Capacity**: *40* **Residents Served**: *29*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*

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

Have Mobility Need: *29* **Have Physical Disability**: *2*

Inspections / Reviews

02/27/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2024*

03/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/29/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/30/2024*

Inspections / Reviews *(continued)*

04/30/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/29/2024*

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

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 home did not have a copy of Chapter 2600 (pink book) posted in a conspicuous and public place in the personal care home.
Repeat Violation-6-13-23 et al.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Actions: The Chapter 2600 pink book was placed in the Lobby near the Visitor Kiosk on 2/28/24, and is now chained to the wall.

Additional Corrective Actions: Staff at the Front Desk will visually confirm the Chapter 2600 pink book is present in the Lobby, on a daily basis, beginning by 3/21/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be confirmed monthly by the Business Office Director, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment.

5a1 - DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On the day of the inspection, the administrator did not provide immediate access to the residents' records. Department Representatives requested the records at approximately 10:45am. The records were not provided until 1:00pm and the Resident Contracts were not included in the files.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Actions: The electronic record vendor company was informed of the glitch in the system that prevented us from retrieving the 2023 resident agreements. The Vice President of Operations was able to work with TabulaPro (EHR) on 2/27/24 to correct the error so that this will not be an issue in the future.

Additional Corrective Actions: The Executive Director will audit all Resident Records to ensure the Resident Agreements are in place in the electronic file. This will be completed by 3/29/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be audited by the Executive Director each month, with findings reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

5a1 - DHS Access *(continued)*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

17 - Record Confidentiality

3. 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

The License Inspection Summaries dated 8/3/23 and 8/23/23 were posted in the lobby of the home with the Resident Privacy Coding pages attached.

Plan of Correction ***Accept[redacted] - 03/21/2024)***

Immediate Corrective Actions: The Privacy Coding Pages were removed by the Lead Licensing Representative on 2/28/24.

Additional Corrective Actions: Staff at the Front Desk will visually confirm the Chapter 2600 Licensing Inspection Summaries are present in the Lobby Binder with no Privacy Coding Pages, on a daily basis. This will begin by 3/21/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be confirmed monthly by the Business Office Director, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

25b - Contract Signatures

4. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident # 8's contract, dated [redacted]/14/23, was not signed by the resident and there was no documentation that the resident was offered to sign the contract.

Plan of Correction ***Accept[redacted] - 03/21/2024)***

Immediate Corrective Actions: Resident #8's signature was obtained by the Executive Director 2/28/24.

Additional Corrective Actions: The Executive Director will audit all Resident Records to ensure the Resident Agreements are in place and signed. This will be completed by 3/29/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be audited by the Executive Director each month, with findings reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

25b - Contract Signatures *(continued)*

Licensee's Proposed Overall Completion Date: *03/29/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachments

41a - Complaint w/o Retailiation

5. Requirements

2600.
41.a. Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter. Retaliation includes discharge or transfer from the home.

Description of Violation

There is no documentation to verify that resident #8 was educated on [redacted] residents' rights.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Actions: Resident #8's signature was obtained on the Resident Agreement by the Executive Director 2/28/24. The Agreement includes the education on resident rights.

Additional Corrective Actions: The Executive Director will audit all Resident Records to ensure the Resident Agreements are in place and signed, to include education on resident rights. This will be completed by 3/29/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be audited by the Executive Director each month, with findings reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Evidence of Completion ***Implemented [redacted] 04/30/2024)***

Please see attachments

51 - Criminal Background Check

6. 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

The records for Staff person "B", hired [redacted]/21, did not contain a Criminal History Check.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Business Office Director obtained the Criminal History Check for Staff Person B on 3/19/24.

Additional Corrective Actions: The Business Office Director will audit all staff records to ensure Criminal History Checks are completed and in the file. This will begin by 3/29/24.

Ongoing Quality Assurance Actions: The Business Office Director will audit a sample of employee records each month. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

51 - Criminal Background Check *(continued)*

Evidence of Completion ***Implemented [redacted] 04/30/2024)***

Please see attachments

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Staff person "B", hired [redacted]/21, did not receive annual training in 2023 for the following required topics: (1) Medication self-administration training and
(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: Staff Person B did receive all required trainings, in all required topics. The full training record was not provided at the time of the inspection, but has been obtained and verifies training was completed on October 31, 2023 and December 1, 2023.

Additional Corrective Actions: The Business Office Director will audit a sample of staff records each month, including verification of progress of annual training requirements. This will begin by 4/1/24.

Ongoing Quality Assurance Actions: The Executive Director will print a community training report each month, to be reviewed with the Quality Assurance Operations Manager to create an action plan for any delinquent trainings. This will begin in April 2024. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/01/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

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

The trash can in the kitchenette located on the 3rd floor was overflowing with trash, preventing the lid from being able to close properly.

Plan of Correction ***Accept [redacted] 03/21/2024)***

Immediate Corrective Action: The Housekeeper on duty immediately emptied the trash upon finding it, on 2/27/24, and ensured the lid was secure.

Additional Corrective Actions: The Maintenance Director will complete a Daily Walk Through of the building, per

85d - Trash Receptacles (continued)

the Maintenance Standards Manual, to include ensuring trash is removed and lids are secured. In addition, Housekeepers will empty trash at least daily in common areas while providing housekeeping services. These tasks will begin by 3/29/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be monitored by the Maintenance Director as part of the Quality Assurance Task List, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachments

107a - Emergency Preparedness

9. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home did not have an Emergency Preparedness Plan posted on the first floor that was accessible to residents and staff.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Maintenance Director updated the Emergency Binder, which includes the emergency preparedness plan for the municipality. This was completed on 2/27/24 and the Emergency Binder was placed in the Lobby on 2/28/24.

Additional Corrective Actions: Staff at the Front Desk will visually confirm the Emergency Binder is present in the Lobby, on a daily basis, beginning by 3/21/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be confirmed monthly by the Business Office Director, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

121a - Unobstructed Egress

10. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The Exit Door leading to the outside near resident room [redacted] required excessive force to open, preventing immediate egress from the facility.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The door was cleaned and serviced to ensure it was operable on 3/25/24.

Additional Corrective Actions: The Maintenance Director will monitor all exterior exit doors as part of the Daily Walk Through defined in the Maintenance Standards Manual to ensure they are operable and in good condition. This will begin by 3/29/24 .

Ongoing Quality Assurance Actions: Compliance with this regulation will be monitored by the Maintenance Director as part of the Quality Assurance Task List, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

125a - Combustible Storage

11. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

An excessive amount of lint was behind the dryers in the laundry room on the second floor, posing a potential fire hazard.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Housekeeper on duty removed all lint, and cleaned the area behind and around the dryer. This was completed on 2/27/24.

Additional Corrective Actions: In addition to removing lint from the lint catcher after each use, Housekeeping staff will be trained to monitor laundry areas for lint behind and around dryers after each cycle of laundry. Training will be completed by 3/30/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be monitored by the Maintenance Director as part of the Quality Assurance Task List and Daily Walk Through, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

132e - Fire Drill Sleeping Hours

12. Requirements

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

Description of Violation

The home's most recent overnight fire drill was conducted 2/2/24 at 1:45am. The overnight fire drill before that was

132e - Fire Drill Sleeping Hours (continued)

conducted 7/8/23 at 2:15am, more than 6 months previous.
Repeat Violation-6/13/23 et al.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Maintenance Team was trained on 3/21/24 by the Executive Director on regulatory requirements related to fire drills during sleeping hours.

Additional Corrective Actions: The schedule for fire drills is maintained in TELS, the building management platform, which includes preventative maintenance and fire drills, as required by regulation. The Executive Director will create and monitor the schedule for fire drills and provide Outlook Calendar reminders to the Maintenance Director regarding scheduled drills. This is effective 3/20/24.

Ongoing Quality Assurance Actions: The fire drill schedule and implementation of drills will be reviewed as part of the Quarterly QA process. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Evidence of Completion ***Implemented ([redacted] 04/30/2024)***

Please see attachment

141a 1-10 Medical Evaluation Information

13. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #8's medical evaluation, dated [redacted]5/23, does not include documentation of the resident's cognitive status.

Plan of Correction ***Accept[redacted] 03/21/2024)***

Immediate Corrective Action: An audit of all resident records will be completed by the Executive Director to ensure all DME forms are fully complete, accurate, and up to date. Physicians will be contacted as needed regarding any needed changes to DME forms. This will be completed by 4/2/24.

Additional Corrective Actions: Staff will be trained to follow a system in which either the Wellness Nurse or Clinical Care Coordinator will obtain completed DME forms. The Resident Care Director or Memory Care Director will complete the 30-Day Audit Tool to ensure they are complete, accurate, and updated before submitting to the

141a 1-10 Medical Evaluation Information (continued)

resident record. This training will be completed and the system will be in place by 4/2/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be reviewed by the Resident Care Director each month as part of the Quality Assurance Review. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning April 2024.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

181c - Self-administration Assessment

14. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #16 is not assessed to self -administer medications. On the day of the inspection, Department Rep. noted a bottle of Extra Strength Tylenol 500mg., Preparation H and a tube Calmoseptine Cream in the drawer of their bedside table. A bottle of Nature Made Vitamin C Gummies 250mg. was also noted on the counter in the resident's room.

Plan of Correction ***Accept [redacted] 03/21/2024)***

Immediate Corrective Action: All medications were immediately removed from the room on 2/28/24 by the Medication Technician. The resident and family were educated by the Clinical Care Coordinator regarding storage of medications on 2/28/24. A reminder to monitor resident rooms for medications was sent out to all staff in the Communication Log on 3/19/24.

Additional Corrective Actions: At the next Town Hall meetings for residents, proper medication storage policies will be reviewed. At the next staff meeting, the need to be vigilant for medications in resident rooms will be reviewed. These meetings will be held by 3/29/24.

Ongoing Quality Assurance Actions: A sample of resident rooms are inspected every quarter by the Clinical Care Coordinator, to ensure each room meets regulatory guidelines. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

182c - Medication Administration

15. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

182c - Medication Administration *(continued)*

Description of Violation

On 2/9/24, Staff "A" did not follow proper medication administration procedures when staff "A" did not ensure that Resident #1 placed the medication in their mouth from the medication cup.

Plan of Correction ***Accept [redacted] 03/21/2024)***

Immediate Corrective Action: The medication error was reported to the physician, designated person, and BHSL on 2/9/24. There were no new orders nor were there any adverse effects.

Additional Corrective Actions: Staff Member A was removed from the medication cart on 2/9/24, after reviewing the proper procedures. There was no additional action as the staff person was leaving employment in less than a week.

Ongoing Quality Assurance Actions: The Clinical Care Coordinator is the Medication Train The Trainer, and will continue to complete Medication Observations as required each year for all Medication Technicians. Medication training, oversight, and concerns will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/20/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

No attachment, staff no longer employed.

185a - Implement Storage Procedures

16. 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 #2's glucometer was not calibrated to the correct time.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: All glucometers were checked by 3/13/24 to ensure that dates and times are correct. This was completed by the Wellness Nurse.

Additional Corrective Actions: Weekly audits are completed by the Wellness Nurse to ensure glucometers are calibrated, beginning 3/13/24. This will be documented in the Audit Binder.

Ongoing Quality Assurance Actions: Findings, patterns, and trends will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/20/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

187a - Medication Record

17. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

187a - Medication Record *(continued)*

Description of Violation

Resident #3 was administered PRN Haloperidol on 2/20/24 at 12:01pm and 2/20/24 at 4:12am that was documented on the controlled drug record sheet. However, neither of these medication administrations were documented on the MAR.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Medication Technician responsible for the documentation error was removed from the medication cart on 2/21/24. As the staff person had already given notice to end employment, no other action was taken.

Additional Corrective Actions: All Medication Technicians were educated to ensure medications are accounted for on both the controlled drug count sheet and that the administration of the medication is recorded on the MAR. This was completed by the Resident Care Director on 3/27/24.

Ongoing Quality Assurance Actions: All Medication Technicians will review the Medication Dashboard at change of shift to ensure all medication alerts have been addressed. The Resident Care Director and Memory Care Director will review the Medication Dashboard at least once daily, and the Wellness Nurse will audit a sample of MARS each week. Findings will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/27/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident # 4 is on a sliding scale that begins at 200. Resident # 4's MAR was documented with a blood glucose reading of 186 on 1/29/24 at 11am. The resident was administered 2 units of Novolog.
Resident #7 was given the incorrect dose of insulin on 1/15/24 and 1/22/24 by 2 different med techs. Through investigation, med techs were removed from the med cart and retrained on medication and retrained on diabetic medications.
Repeated Violation-6/13/23 et al., 10/23/23, 11/30/23 et al., 1/24/24.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Medication Technicians were removed from the Medication Cart and retrained. The physicians and designated persons were notified, and a reportable incident form was submitted to BHSL. This was all completed by 2/15/24.

Additional Corrective Actions: The Clinical Care Coordinator is the community's Medication Train The Trainer and will complete quarterly Medication Administration Observations for all Medication Technicians for the next six months, through October 2024. The Resident Care Director will complete monthly education sessions as reminders of proper medication administration procedures with all Medication Technicians through October 2024. Trainings will begin by 4/2/24.

187d - Follow Prescriber's Orders (continued)

Ongoing Quality Assurance Actions: Additional Medication Administration Train The Trainer and Practicum Observer certifications will be obtained as the new Resident Care Director and Wellness Nurse are hired, to provide additional resources for education and oversight. The Resident Care Director and Memory Care Director will review the Medication Dashboard at least once daily, and the Wellness Nurse will audit a sample of MARS each week. Findings will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

190a - Completion Medication Course

19. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Resident # 17 is prescribed Trulicity injection 1.5/0.5 ML (1.5 mg) once weekly. Review of Resident #17's Medication Administration Record indicates that the injection was administered by med techs on 2/1/24. 2/8/24, 2/15/24 and 2/22/24. The home does not have a waiver which allows for Medication Technicians to administer this medication.

Plan of Correction ***Accept ([redacted] - 03/21/2024)***

Immediate Corrective Action: The medication was discontinued by the physician on 2/29/24. Insulin was increased for the resident to meet their needs.

Additional Corrective Actions: The Wellness Nurse will monitor new prescriptions to ensure appropriate personnel and training, per regulations, are available to meet resident needs, effective 3/13/24. The Resident Care Director will audit a sample of MARs and physician orders each month to provide additional oversight.

Ongoing Quality Assurance Actions: Findings, patterns, trends, and concerns will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/20/2024*

Evidence of Completion ***Implemented [redacted] 04/30/2024)***

Please see attachment

191 - Resident Right to Refuse

20. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

There is no documentation to verify that resident [redacted] was educated on [redacted] to refuse medications.

Plan of Correction ***Accept[redacted] - 03/21/2024)***

Immediate Corrective Actions: Resident #8's signature was obtained on the Resident Agreement by the Executive

191 - Resident Right to Refuse (continued)

Director 2/28/24. The Agreement includes the education on resident rights.

Additional Corrective Actions: The Executive Director will audit all Resident Records to ensure the Resident Agreements are in place and signed, to include education on resident rights. This will be completed by 3/29/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be audited by the Executive Director each month, with findings reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

201 - Positive Interventions

21. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On 1/23/24, Resident #9 slapped Resident # 10's back when resident #10 attempted to remove Resident # 9's hand from [redacted]r chair. Per staff interviews, Resident #9 has a history of hitting residents when [redacted] gets in residents' personal space and the resident attempts to remove Resident #9. The home has failed to prevent Resident # 9's behaviors effectively.

Plan of Correction ***Accept [redacted] 03/21/2024)***

Immediate Corrective Action: Resident #9 was redirected and Resident #10 had no injuries nor was [redacted] in distress following the incident. All physicians and designated persons were notified of the event, and a reportable incident form was submitted to BHSL. All direct care, activities, and housekeeping staff will be educated related to social distancing and personal space by 4/2/24.

Additional Corrective Actions: Resident #9 had one to one supervision for waking hours, effective 2/29/24 until he was placed in a higher level of care on 3/20/24.

Ongoing Quality Assurance Actions: Any time challenging behaviors or care needs occur, they will be reviewed by the Clinical Care Team. Staff will receive any appropriate training to meet the needs of the residents, and assistance will be provided to find placement when a higher level of care is needed. The Executive Director will be responsible for oversight of this regulation. Compliance will be reviewed at Quarterly Quality Assurance Meetings, beginning April 2024.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

224a - Preadmission Screen Form

22. Requirements

224a - Preadmission Screen Form *(continued)*

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident # 11 was admitted to the facility on [redacted]/23. The resident's Preadmission Screening was completed on 12/5/23, which exceeds the timeframe required by this regulation.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The Preadmission Screening was completed within 30 days prior to admission to the personal care home, per regulatory guideline. The cognitive screening was completed prior to the 72 hour guideline for memory care admission. This cannot be corrected, having been found following admission, but the assessment of memory care needs is accurate.

Additional Corrective Actions: The Resident Care Director or Wellness Nurse will complete preadmission screenings, and cognitive screenings when needed. The Executive Director will provide additional oversight to review these forms before they are submitted to the resident record, to ensure compliance with both 224a and 234a. This will be effective 3/15/24.

Ongoing Quality Assurance Actions: A sample of resident records will be reviewed each month by the Resident Care Director, as part of the Quality Assurance Review. Findings will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/20/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

225a - Assessment 15 Days

23. 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 #12's assessment and support plan do not include the date on which they were finalized.

Plan of Correction ***Accept [redacted] 03/21/2024)***

Immediate Corrective Action: An audit of all resident records will be completed by the Executive Director to ensure all RASPs are properly dated. This will be completed by 4/2/24.

Additional Corrective Actions: Staff will be trained to follow a system in which either the Wellness Nurse or Clinical Care Director will complete the RASPs. The Resident Care Director or Memory Care Director will review them to ensure they are complete, accurate, and updated before submitting to the resident record. This training will be completed and the system will be in place by 4/2/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be reviewed by the Resident Care Director each month as part of the Quality Assurance Review. Findings will be reviewed at the Quarterly Quality Assurance

225a - Assessment 15 Days (continued)

Meetings, beginning April 2024.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Evidence of Completion ***Implemented [redacted] 04/30/2024)***

Please see attachment

227d - Support Plan Medical/Dental

24. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident # 5 had an unwitnessed fall. The resident suffered a substantial bruise to the face and a lump to the forehead. The resident was sent to the ER. Upon return, the resident was placed on increased supervision for safety. No addendums were added to RASP to indicate what the home was doing to ensure the residents safety.

Resident # 13 utilizes an enabler bar. The resident's assessment and support plan (RASP) dated 11/29/23 does not include documentation of the following as required:
• If a cover is required to meet FDA guidelines
• Risks associated with the device

Resident # 11 utilizes an enabler bar. The resident's RASP does not include documentation of the following as required:
• The specific need for the device
• Any risks associated with the device
• The resident's ability to use the device safely for the intended purpose
• If a cover is required to meet FDA guidelines

Resident # 14 was involved in an unwitnessed altercation with resident # 15, during which Resident #14 grabbed Resident #15's arm after Resident #15 wandered into Resident #14's room, leaving 2 small bumps on [redacted] arm. Resident #14's RASP, dated 11/30/23 was not updated with the steps the home took to manage Resident #14's behaviors following the incident, including the dates when he/she was placed on 1-to-1 supervision and was subsequently taken off supervision, and that medication adjustments were made after the incident occurred.
Repeat Violation-8/23/23 et al., 10/23/23, 11/30/23 et al.

Plan of Correction ***Accept [redacted] 03/21/2024)***

Immediate Corrective Action: RASP updates for Residents 11 and 13 were completed and reviewed with BHSL Licensing Representatives on 2/28/24. The RASP for Residents 5 was updated on 2/19/24. The RASP for Resident 14 was updated with notes reflecting the care need changes and supports put in place on 3/13/24.

Additional Corrective Actions: Clinical Care Meetings will be held daily, beginning 3/14/24. The Clinical Care Team will consist of the Executive Director, Resident Care Director, Memory Care Director, Wellness Nurse, and Clinical Care Coordinator. These meetings will focus on reviewing care need changes, hospitalizations, incidents and other events involving residents.

227d - Support Plan Medical/Dental (continued)

Ongoing Quality Assurance Actions: A summary and overview of Clinical Care Meetings will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/20/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

227g -Support Plan Signatures

25. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #6's RASP was updated at the request of the department, and it was finalized on 12/8/23. However, the resident did not sign the RASP until 1/4/24.

Resident #12's assessment and support plan (RASP), undated, was not signed by the resident and there was no documentation that the resident refused to or was unable to sign the RASP.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: The signature on the RASP for Resident 6 was obtained and cannot be changed. The RASP for Resident 12 was updated to obtain their signature on 3/15/24. An audit of all resident records will be completed by the Executive Director to ensure all RASPs are properly signed. This will be completed by 4/2/24.

Additional Corrective Actions: Staff will be trained to follow a system in which either the Wellness Nurse or Clinical Care Director will complete the RASPs. The Resident Care Director or Memory Care Director will review them to ensure they are complete, accurate, updated, and signed before submitting to the resident record. This training will be completed and the system will be in place by 3/29/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be reviewed by the Resident Care Director each month as part of the Quality Assurance Review. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning April 2024.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment

231b - Medical Evaluation

26. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #5 was admitted to SDCU on [redacted]24. Resident #5's most recent DME dated 12/19/23, does not indicate the

231b - Medical Evaluation (continued)

resident needs a secured dementia unit.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

Immediate Corrective Action: This DME cannot be corrected as the resident is no longer residing here. An audit of all resident records will be completed by the Executive Director to ensure all DME forms are fully complete, including the need for a secured dementia unit when applicable. Physicians will be contacted as needed regarding any needed changes to DME forms. This will be completed by 4/2/24 .

Additional Corrective Actions: Staff will be trained to follow a system in which either the Wellness Nurse or Clinical Coordinator will obtain completed DME forms. The Resident Care Director or Memory Care Director will review them to ensure they are complete, accurate, and updated to include the need for a secured dementia unit when applicable before submitting to the resident record. This training will be completed and the system will be in place by 3/29/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be reviewed by the Resident Care Director each month as part of the Quality Assurance Review. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning April 2024.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Evidence of Completion ***Implemented [redacted] - 04/30/2024)***

Please see attachment