



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **JUNIPER VILLAGE AT BENSLEM OPERATIONS LLC**
LEGAL ENTITY

To operate **JUNIPER VILLAGE AT BUCKS COUNTY SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **3200 BENSLEM BOULEVARD, BENSLEM, PA 19020**
(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 **60**
(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 21**

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 **August 2, 2024** until **February 2, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142461**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING 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.



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 2, 2024

[REDACTED]
Executive Director
Juniper Village at Bensalem Operations, LLC
[REDACTED]

RE: Juniper Village at Bucks County Senior Living
3200 Bensalem Boulevard
Bensalem, Pennsylvania 19020
License #: 142461

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection January 8, 2024 and April 1, 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 REVOKES your certificate of compliance 142460 dated November 30, 2023 to November 30, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated November 30, 2023 to November 30, 2024 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 2, 2024 to February 2, 2025.

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	II	40	\$5	\$200	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 FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

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

, Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Room 631, Health and Welfare Building
 625 Forster Street
 Harrisburg, Pennsylvania 17120


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:



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

Facility Information

Name: JUNIPER VILLAGE AT BUCKS COUNTY SENIOR LIVING License #: 14246 License Expiration: 11/30/2024
Address: 3200 BENSALEM BOULEVARD, BENSALEM, PA 19020
County: BUCKS Region: SOUTHEAST

Administrator

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

Legal Entity

Name: JUNIPER VILLAGE AT BENSALEM OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 04/28/1983 Issued By: PA L&I

Staffing Hours

Resident Support Staff: 60 Total Daily Staff: 138 Waking Staff: 104

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 01/08/2024

Inspection Dates and Department Representative

01/08/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 60 Residents Served: 44

Secured Dementia Care Unit

In Home: Yes Area: Wellspring Capacity: 21 Residents Served: 16

Hospice

Current Residents: 11

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 44
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 34 Have Physical Disability: 0

Inspections / Reviews

01/08/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/04/2024

02/07/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/12/2024

02/14/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 03/29/2024

07/16/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2024

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 1/8/2023, a copy of the chapter 2600 regulations was not posted in a conspicuous and public place in the home.

Plan of Correction

Directed (████) - 02/14/2024)

Administrator will be posted in a binder containing Chapter 2600 regulations in a conspicuous and public place in the home by 2/9/2024. Once posted, the binder will not be removed from the home.

Directed Plan of Correction 2/14/24 █████

Starting within 30 days of the receipt of the acceptable plan of correction, the administrator will check monthly to ensure that all required postings are present and posted conspicuously in a public place in the home.

Proposed Overall Completion Date: 02/09/2024

Directed Completion Date: 03/14/2024

Implemented (████) - 06/21/2024)

65g - Annual Training Content

2. 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).

Description of Violation

Staff person A did not receive training in The Older Adult Protective Services Act during training year 2023.

Plan of Correction

Directed (████) - 02/14/2024)

Personal care wellness associates will have their training completed by 2/29/2024. Director of Wellness and/or designee will conduct monthly audits to show that associate monthly trainings are being completed as soon as POC is accepted.

Directed Plan of Correction 2/14/24 █████

Within 30 days of the receipt of the acceptable plan of correction, the administrator shall ensure that Staff A is trained on all required topics.

Within 20 days of the receipt of the acceptable plan of correction, the administrator or designee shall conduct an audit of all employee training records to ensure the requirements of 65g are present.

Starting 30 days after the receipt of the acceptable plan of correction, the administrator or designee shall conduct quarterly audits to ensure employee training is being completed according to the annual training plan, and in accordance with 2600.65g.

65g - Annual Training Content (continued)

Proposed Overall Completion Date: 02/29/2024

Directed Completion Date: 03/14/2024

Implemented (████) - 06/21/2024)

82c - Locking Poisonous Materials

3. 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 1/8/2024 at 9:00am, a bottle of hand sanitizer, with a manufacturer's label warning, "Keep out of reach of children", was unlocked, unattended, and accessible to residents at the front door of the home's secure dementia care unit. Residents of the unit, including resident #1, have been assessed incapable of recognizing and using poisons safely.

Repeat violation: 10/16/23

Plan of Correction

Accept (████) - 02/14/2024)

Administrator will conduct in service with director care staff by 2/14/2024 on keeping items labeled "Please keep out of reach of children; please contact the poison control center" inaccessible to residents. Administrator will audit weekly x2 then monthly x2 after accepted date of POC

Licensee's Proposed Overall Completion Date: 02/14/2024

Not Implemented (████) - 04/04/2024)

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/8/2024 at 10:17 am, there were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the common shower room on the second floor.

Plan of Correction

Accept (████) - 02/14/2024)

Administrator will educate environmental service director on regulation 2600.85.a. to ensure that all common shower rooms are kept stocked with sanitary means for hand drying by 2/14/2024. Audit will be conducted by administrator weekly x2 then monthly x2 after accepted date of POC

Licensee's Proposed Overall Completion Date: 02/14/2024

Not Implemented (████) - 06/21/2024)

91 - Telephone Numbers

5. Requirements

2600.

91 - Telephone Numbers (continued)

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

Description of Violation

On 1/8/2024, there were no emergency telephone numbers to the nearest hospital, fire department, etc. on or by the telephone in room 217.

Plan of Correction

Directed () - 02/14/2024)

Audit will be completed by administrator by 2/29/2024 to ensure that all rooms will have emergency telephone numbers posted in the room. Upon move in of new resident, the room will be inspected to ensure numbers are posted by associates of the home.

Directed Plan of Correction 2/14/24 ()

Starting 30 days after the receipt of the acceptable plan of correction, the administrator or designee with audit telephones in the home quarterly to ensure presence of emergency telephone numbers.

Proposed Overall Completion Date: 02/29/2024

Directed Completion Date: 03/14/2024

Not Implemented () - 04/04/2024)

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 1/8/2024 at 11:31 am, the temperature in the main-kitchen freezer was 7 degrees Fahrenheit.

Plan of Correction

Directed () - 02/14/2024)

The walk-in freezer will be monitored for temperature fluctuations. Doors will be kept closed even during the receiving and storage process of deliveries. Dining Director will remind staff to keep the doors closed at all times, and signage will be posted to act as a reminder. Maintenance request will be placed by 2/9/2024 to see if anything can be done to drop the holding temperature of the freezer.

Directed Plan of Correction 2/14/24 ()

Within 30 days of the receipt of the accepted plan of correction, the administrator or designee shall educate staff involved in the storage and preparation of food on food safety requirements.

Starting within 30 days of the receipt of the acceptable plan of correction, the administrator or designee shall conduct weekly freezer temperature audits for 4 weeks, then monthly for 6 months.

Proposed Overall Completion Date: 02/09/2024

Directed Completion Date: 03/14/2024

103f - Refrigerator/Freezer Temps (continued)

Not Implemented () - 04/04/2024

107c - Food/Water 3 Day Supply

7. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1/8/2024, the home served 44 residents, requiring 132 gallons of emergency drinking water. However, the home had only 90 gallons.

Plan of Correction

Directed () - 02/14/2024

Dining director ordered 50 additional gallons of water and will be added to the existing supply by 2/2/24.

Directed Plan of Correction 2/14/24 ()

Starting 30 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit emergency water supply monthly to ensure sufficient supply.

Proposed Overall Completion Date: 02/09/2024

Directed Completion Date: 03/14/2024

Not Implemented () - 06/21/2024

130h - Inoperable Smoke Detector

8. 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 and smoke detector policy do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction

Directed () - 02/14/2024

Home does have policy that indicated what procedure will be implemented when a smoke detector or fire alarm is inoperable. See below:

"When smoke detectors or fire alarms become inoperable safety, checks will be made every 15 minutes to ensure the building is free of any fire emergency. Safety checks will continue until the smoke detectors and/or fire alarms are repaired and back on-line within no longer than 48 hours. -REFER TO FIRE WATCH LOG, FIRE WATCH DOCUMENTATION, FIRE WATCH LOG"

The root cause of why this was unavailable at the time was because a different policy regarding smoke alarms was provided to the surveyor.

Directed Plan of Correction 2/14/24 ()

130h - Inoperable Smoke Detector (continued)

Within 30 days of the receipt of the acceptable plan of correction, all staff involved in the operation and maintenance of the home shall be trained in the location of the inoperable smoke detector policy by the home's administrator.

Proposed Overall Completion Date: 02/09/2024

Directed Completion Date: 03/14/2024

Implemented (█ - 06/21/2024)

132a - Monthly Fire Drill**9. Requirements**

2600.

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

Description of Violation

The home did not provide records of unannounced fire drills held during the months of February, April, June, October or December of 2023.

Plan of Correction

Directed (█ - 02/14/2024)

Facility can't retroactively correct. No resident was harmed in this deficient practice. The root cause of fire drills not being done monthly was turnover in maintenance department resulted in documentation being misplaced. If a fire drill was done, the documentation was placed in an unknown area. Maintenance director educated on the monthly fire drill requirement by 2/14/2024. Fire drills will be done monthly going forward.

Directed Plan of Correction 2/14/24 █

Within 30 days of receipt of the accepted plan of correction: The administrator shall monitor all fire drills and the fire drill records to ensure a fire drill is conducted at least once a month and is documented on a fire drill record which includes all information required by 2600.132c. The administrator shall maintain a copy of the records.

Proposed Overall Completion Date: 02/14/2024

Directed Completion Date: 03/14/2024

Not Implemented (█ - 06/21/2024)

132c - Fire Drill Records**10. 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 home's fire drill records for 2023 do not include the number of residents evacuated, the times each fire drill occurred, or the routes taken.

132c - Fire Drill Records (continued)

Repeat violation: 9/15/2022

Plan of Correction

Directed (████) - 02/14/2024)

Administrator will educate maintenance director on the requirements for fire drill paperwork by 2/14/2024. Paperwork will be reviewed by Administrator when monthly fire drills will be complete.

Directed Plan of Correction 2/14/24 (████)

Within 30 days of receipt of the accepted plan of correction: The administrator will monitor all fire drills and the fire drill record to ensure a fire drill is conducted at least once a month and is documented on a fire drill record which includes all information required by 2600.132c. All staff persons completing the fire drill record will be educated regarding the required information for the fire drill record.

Proposed Overall Completion Date: 02/14/2024

Directed Completion Date: 03/14/2024

Not Implemented (████) - 06/21/2024)

132e - Fire Drill Sleeping Hours

11. Requirements

2600.

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

Description of Violation

Interviews with residents indicated fire drills are being held during the day. The home did not record the times of fire drills in the home's 2023 logs.

Plan of Correction

Directed (████) - 02/14/2024)

Administrator will educate maintenance director on the overnight fire drill every 6 months requirement by 2/14/2024. Audit will be done after 6 months to ensure that overnight fire drill is done.

Directed Plan of Correction 2/14/24 (████)

Within 30 days of receipt of the accepted plan of correction: The home will conduct a sleeping hour fire drill for the next two consecutive months and at least one sleeping hour fire drill every six months thereafter.

Immediately: The administrator will monitor the fire drill record on a monthly basis to ensure a sleeping hour fire drill is conducted at least every six months and all residents are evacuated to a public thoroughfare or to a fire-safe area within the time specified in writing by a fire safety expert within the past year.

Proposed Overall Completion Date: 02/14/2024

Directed Completion Date: 03/14/2024

Not Implemented (████) - 06/21/2024)

162c - Menus Posted

12. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 1/8/2024, the home's posted menu only covered the period through 1/14, six days in advance.

Repeat violation: 9/15/2022 et al.

Plan of Correction

Directed ([REDACTED] - 02/14/2024)

2 weeks menus will be posted at all times with signage indicating "this week's menu" and "next week's menu" above the appropriate week. The menus are cyclical, so there are 5 weeks in print at all times. The current and next week will need to be posted by dining aides and identified so that residents are able to tell which is the current week.

Directed Plan of Correction 2/14/24 [REDACTED]

Starting within 30 days of the receipt of the acceptable plan of correction, the administrator shall check the home at least weekly to ensure menus are posted in accordance with regulation 2600.162(c).

Proposed Overall Completion Date: 02/09/2024

Directed Completion Date: 03/14/2024

Not Implemented ([REDACTED] - 06/21/2024)

183b - Meds and Syringes Locked

14. Requirements

2600.

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

Description of Violation

On 1/4/2023 at approximately 2:30pm, staff person B left a cart containing residents' medications unlocked and unattended while retrieving medications from the refrigerator in the medication room.

Plan of Correction

Directed ([REDACTED] - 02/14/2024)

The staff member involved was individually counseled by the Director Wellness as to the requirement and reasoning for the medication carts to be locked at all times when not in use. The staff member verbally acknowledged understanding of the matter. Wellness director will hold inservice on 2/14/2024 to review with all nursing staff the state regulations and corporate policy regarding the expectations of staff during medication administration.

Directed Plan of Correction 2/14/24 [REDACTED]

Within 30 day of receipt of the plan of correction, all staff persons shall be educated on the required locked storage of medications, proper labeling of medications, disposal of expired medications and the home's policy and procedures for the safe and secure storage of medications and controlled substances by the administrator or designee. Documentation of the education will be provided to the department.

183b - Meds and Syringes Locked (continued)

Starting 30 days from the date of the receipt of the acceptable plan of correction, the administrator shall check the home at least weekly to ensure prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Proposed Overall Completion Date: 02/14/2024

Directed Completion Date: 03/14/2024

Not Implemented (████ - 06/21/2024)

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

The home's glucometer log for resident #3 shows an evening blood sugar reading on 1/4/2024 of 295 mg/dl. However, the history display on resident #3's glucometer shows the reading was 292.

Plan of Correction

Accept (████ - 02/14/2024)

Wellness Director counseled individual staff member involved on the importance of accuracy in all documentation. Audit will be conducted by Wellness director x2 weekly then x2 monthly as soon as POC is accepted.

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

Not Implemented (████ - 06/21/2024)

187d - Follow Prescriber's Orders**17. Requirements**

2600.

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

Description of Violation

Resident #2 is prescribed 25 MCG Synthroid oral tablets, which the resident takes each morning at 6:00 am. This medication was not administered on 12/17/2023 and 12/31/23. There were no notes present on the Medication Administration Record to indicate why the medication was not administered on these dates.

Plan of Correction

Directed (████ - 02/14/2024)

Wellness director will hold inservice on 2/14/2024 will review both state regulations and corporate policy regarding the correct procedures for documenting missed or refused doses of medications.

Directed Plan of Correction 2/14/24 █████

Immediately: The administrator or designee shall review all occurrences of medication errors to ensure all regulatory reporting requirements in accordance with regulations 2600.16(c) and 2600.188 have been met.

187d - Follow Prescriber's Orders (continued)

Within 30 days of receipt of the plan of correction, the administrator or designee shall conduct an audit of prescription orders and medications weekly for four weeks then biweekly for all residents, to ensure proper documentation of medication administration, following the orders of the prescriber and reporting medication errors.

Proposed Overall Completion Date: 02/14/2024

Directed Completion Date: 03/14/2024

Not Implemented (████ - 06/21/2024)

227g -Support Plan Signatures**18. Requirements**

2600.

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

Description of Violation

The assessor of Resident #4's Residential Assessment-Support Plan (RASP), dated ██████████, did not sign and date it.

Repeat violation: 9/15/2022 et al.

Plan of Correction

Directed (████ - 02/14/2024)

A review of all resident charts will be completed by the DOW and medical concierge to assure all documentation is complete and all required signatures obtained. Complete review expected completion date is 2/28/2024.

Directed Plan of Correction 2/14/24 ██████████

Within 30 days of the receipt of the acceptable plan of correction, the administrator or designated staff person shall review all current and newly completed support plans to ensure completion including signatures of those involved in the development of the plan.

Within 30 days of the receipt of the acceptable plan of correction, all staff persons involved with the completion of support plans shall be educated on the proper completion of support plans including the required signature of persons involved with the development of support plans by the administrator. Documentation of education will be provided to the department.

Proposed Overall Completion Date: 02/28/2024

Directed Completion Date: 03/14/2024

Not Implemented (████ - 06/21/2024)

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

Facility Information

Name: JUNIPER VILLAGE AT BUCKS COUNTY SENIOR LIVING License #: 14246 License Expiration: 11/30/2024
Address: 3200 BENSALEM BOULEVARD, BENSALEM, PA 19020
County: BUCKS Region: SOUTHEAST

Administrator

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

Legal Entity

Name: JUNIPER VILLAGE AT BENSALEM OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 04/28/1993 Issued By: PA L&I

Staffing Hours

Resident Support Staff: Total Daily Staff: 62 Waking Staff: 47

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Monitoring Exit Conference Date: 04/01/2024

Inspection Dates and Department Representative

04/01/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 60 Residents Served: 40

Secured Dementia Care Unit

In Home: Yes Area: Wellspring Capacity: 21 Residents Served: 13

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 40
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 22 Have Physical Disability: 0

Inspections / Reviews

04/01/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/15/2024

04/18/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/09/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/23/2024

04/25/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 06/03/2024

06/21/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

82c - Locking Poisonous Materials (continued)

Licensee's Proposed Overall Completion Date: 05/13/2024

Not Implemented () - 06/21/2024

91 - Telephone Numbers

3. Requirements

2600.

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

Description of Violation

On 4/1/2024 at approximately 12:15 pm, there were no telephone numbers for the nearest hospital, police or fire department, ambulance, poison control, local emergency management agency, or personal care home complaint hotline on or by the common telephone at the front desk. There were also no emergency phone numbers posted in rooms 103 or 204.

Plan of Correction

Accept () - 04/25/2024

Emergency phone numbers were hung in all resident rooms and near telephones on 4/12/2024. Administrator or designee will audit monthly x3 to ensure emergency phone numbers are at least in the common area by the telephone. Audit will begin 30 days after POC acceptance date.

Proposed Overall Completion Date: 05/31/2024

Licensee's Proposed Overall Completion Date: 05/31/2024

Not Implemented () - 06/21/2024

103f - Refrigerator/Freezer Temps

4. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/1/2024 at approximately 12:05 pm, there were two thermometers in the main-kitchen freezer. One indicated a temperature of 10 degrees Fahrenheit, while the other read 15 degrees Fahrenheit.

Plan of Correction

Accept () - 04/25/2024

Maintenance request was put into electronic maintenance ticket system by the Administrator on 4/23/2024. Dining director or designee will audit freezer temperatures daily to ensure compliance with regulation for a month starting 30 days after POC acceptance date.

Proposed Overall Completion Date: 05/31/2024

Licensee's Proposed Overall Completion Date: 05/31/2024

Not Implemented () - 06/21/2024

132d - Evacuation

5. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's log indicates that during the fire drill on 2/29/2024 at 3:50 pm, there were 28 residents in personal care, but only 24 were evacuated.

Plan of Correction

Accept (█) - 04/25/2024

Fire drill log in question was not the yearly fire drill done by a fire safety expert. A root-cause analysis was conducted by the Administrator to determine why not all residents were evacuated from the area. The finding was that four resident rooms are located beyond the fire doors. Education will be done with environmental service associate that is delegated monthly fire drill task by the Administrator on how to properly document when conducting fire drills by 4/23/2024. Fire drill and logs will be monitored by the administrator to ensure that all residents are evacuated if possible and if not have it stated on the log the reasoning to why they were not.

Proposed Overall Completion Date: 05/31/2024

Licensee's Proposed Overall Completion Date: 05/31/2024

Not Implemented (█) - 06/21/2024

185a - Implement Storage Procedures

6. 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 #5 is prescribed one .5-MG Alprazolam tablet three times a day as needed, and one 10-MG Methylphenidate HCL tablet three times a day. On 4/1/2024 at 12:30 pm, the home's narcotics logs indicated there were 73 Alprazolam tablets remaining when there were 71, and 32 Methylphenidate tablets when there were only 30.

Resident #5 is prescribed one .5-MG Alprazolam tablet three times a day as needed, and one 10-MG Methylphenidate HCL tablet three times a day. On 4/1/2024 at 12:30pm, staff member B was in the process of administering one of each to resident #5. Staff B did not sign out the retrieval of these medications on the controlled substances record.

The resident's morning doses of these medications, administered at approximately 9:00 am, had not been signed out of the controlled substances records.

Plan of Correction

Accept (█) - 04/25/2024

Education will be conducted during staff meeting with LPN and Med Techs by the Director of Wellness on signing out controlled substances at the time of the medication administration on 4/26/2024. Control substance logs will be audits weekly x4 by the Director of Wellness to ensure all narcotics are being signed out. Audit will being 30 days after POC acceptance date.

Proposed Overall Completion Date: 05/31/2024

185a - Implement Storage Procedures (*continued*)

Licensee's Proposed Overall Completion Date: 05/31/2024

Not Implemented ([REDACTED] - 06/21/2024)