pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BENSALEM PCH LLC**
LEGAL ENTITY

To operate **ALLEGRIA AT THE OAKS**
NAME OF FACILITY OR AGENCY

Located at **6400 HULMEVILLE ROAD, BENSALEM, 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 **95**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 48**

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 **January 7,** **2025** until **July 7,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **143672**

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.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 7, 2025

[redacted]
Executive Director
Bensalem PCH, LLC
6400 Hulmeville Road
Bensalem, Pennsylvania 19020

RE: Allegria at the Oaks
License #: 143672

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection February 28, 2024, April 29, 30, and May 13, 2024, and August 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 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 January 7, 2025 to July 7, 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)
42(b)	II	70	$5	$350	5 calendar days from mailing date of this letter

[redacted]

201	III	70	$3	$210	15 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.

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

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

[redacted]

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ALLEGRIA AT THE OAKS* **License #:** *14367* **License Expiration:** *06/19/2024*

Address: *6400 HULMEVILLE ROAD, BENSALEM, PA 19020*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BENSALEM PCH LLC*

Address: *6400 HULMEVILLE ROAD, BENSALEM, PA, 19020*

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *10/18/2018* **Issued By:** *Bensalem Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *125* **Waking Staff:** *94*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *04/30/2024*

Inspection Dates and Department Representative

04/29/2024 - On-Site: [redacted]
04/30/2024 - On-Site:
05/13/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* **Residents Served:** *75*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Evergreen* **Capacity:** *48* **Residents Served:** *35*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *73*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *50* **Have Physical Disability:** *1*

Inspections / Reviews

04/29/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/07/2024*

06/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/02/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/18/2024*

06/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/02/2024*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/03/2024*

09/26/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/02/2024*

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

On 4/30/2024, at 10:48 am, a binder marked "North Summit, South Summit, and Terrace Narcotic Log Book," containing diagnoses, prescriptions, and other medical information about residents, was unlocked, unattended, and accessible on a medication cart on the first floor.

Plan of Correction ***Accept ([redacted] 06/28/2024)***

Immediately, April 30, 2024, the med tech on duty was instructed by the DRS to remove the narcotic book and [redacted] took the book to the locked nursing medication room.
On May 2, 2024, the DRS and the ADRS gave an in-service to the nursing staff (LPNs and med techs) which included letting them know that the narcotic books cannot be left on top of the med cart or anywhere that they would be unattended and accessible to others. Narcotic books must be secured and locked in the med cart when not in use.
Starting May 3, 2024, the narcotic count binders have been stored in the medication cart which is locked when not in use.
The DRS/designee will spot check the med cart daily 5 times a week for 4 weeks beginning the week of June 24, 2024 (ending July 19, 2024) to ensure narcotic book is stored properly and not left unattended. After that the DRS will be responsible for spot checking each med cart once a week.
The DRS and ADRS are responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Not Implemented ([redacted] - 09/25/2024)

26a - Quality Management Plan

2. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's quality management plan calls for the executive director and department heads to meet weekly. However, minutes show the meetings were held biweekly in April 2024, on 4/11 and 4/25.

Plan of Correction ***Accept ([redacted] 06/12/2024)***

The Executive Director amended the Quality Assurance Plan on May 7, 2024. As recommended by the inspector, the frequency of the Quality Assurance Meeting was changed to once a year. For the other components the word, "usually" was added. The word "usually" was further clarified to mean that the meetings indicated are held in the time frame indicated; however, circumstances may require a meeting to be postponed or cancelled.
The Executive Director is responsible for ongoing compliance with the plan, notably ensuring that the Quality Assurance Meeting is held at least annually.

26a - Quality Management Plan *(continued)*

Licensee's Proposed Overall Completion Date: *06/06/2024*

Implemented [redacted] 09/25/2024)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 4/10/24 at 11:00 am, in the dining room of the secure dementia care unit, resident #1 slapped resident #2 in the face and attempted to pull resident #3's leg. The incident was the last in a series of violent episodes involving resident #1, beginning 9/4/23. The home did not update resident #1's support plan to address a need for agitation until 12/15/23. The plan was for staff to redirect and offer one-to-one support as necessary. However, resident #1 did not receive one-to-one support.

On [redacted], the home sent resident #1 to the hospital for an evaluation of the resident's change in mental status. On [redacted], staff person A told the hospital social worker assigned to resident #1 that the home would not allow the resident to return due to the resident's aggressive behaviors. On [redacted] staff person B sent resident #1's designated person a letter giving 30-days' notice of discharge. On [redacted] staff person C sent a second letter making the discharge immediate effective [redacted] the day resident #1 went to the hospital. The letters cited the resident's aggressive behaviors as the reason for the discharge, but the home had not followed the plan to address the resident's behavior. The home did not obtain a physician's certification or permission from the Department of Human Services to discharge the resident earlier.

Hospital records indicate that the resident was stable and ready for discharge on [redacted]. The home refused to accept the resident back. From [redacted] resident #1 remained in the hospital unnecessarily, as the resident's family and social worker sought new living arrangements. During this time, doctors noted that the resident had been stabilized, was "pleasantly confused," with "no evidence of any acting-out behavior recorded."

Repeat Violation: 5/2/23 et al.

Plan of Correction ***Accept [redacted] - 06/28/2024)***

REQUEST FOR WITHDRAWAL OF VIOLATION 3 (42.b)

Respectfully, I would like to request that the violation, listed as #3 for regulation 2600.42.b be reconsidered and withdrawn.
The reasons for this are as follows:
Some of the information in the Description of the Violation is inaccurate:
? "The home did not update resident #1's support plan…" the support plan was updated in September 2023 and December 2023
? "Resident #1 did not receive one-to-one support." Resident #1 did receive 1:1 support as needed, and that is what was written in the RASP
? "The home did not follow the plan to address the resident's behavior."
In fact, the staff did respond to the resident's behavior as indicated in the plan.
? "The home refused to accept the resident back." The Description further indicates that the resident was stable and

42b - Abuse (continued)

ready for discharge on [redacted] and that [redacted] was "pleasantly confused" with "no evidence of any acting-out behavior recorded." This information was never conveyed to us. Therefore, since it was not conveyed there was no point in which we definitively said we would not be taking the resident back. In fact, had we known this information it would have factored into our decision-making process. The discharge process for resident #1 was being coordinated by our DRS, [redacted] and the social worker at [redacted] MSW. Due to the discrepancies in the Description of the Violation, we reached out to [redacted] stated that "no one from here called Allegria on [redacted] to my knowledge. I certainly did not. We did not have a d/c date for [redacted]" "I am not sure what happened on [redacted] but that didn't come from our end." In the process of the discharge planning our DRS communicated to the SW that we believed that our setting was not the best for resident #1 at this point, We were working with the SW and the family to determine how [redacted] needs could best be met.

We were told by the Supervisor, [redacted] via a phone conversation on May 30, 2024, prior to the due date for the POC of June 7, 2024 (with [redacted] also on the call) that all of the violations re resident #1 stemmed from the fact that we "refused to take the resident back." In regard to 3, the "abusive action" was not taking [redacted] back. As noted above, we were never informed about the change in the resident's behavior, or that [redacted] was ready for discharge. And the SW with whom our DRS was working corroborates this fact. No one from [redacted] ever asked us to take [redacted] back, so how could we have refused to do so. And further, resident #1 did not suffer at the [redacted] Hospital as far as we know, nor was [redacted] in any danger while there. So, it is not apparent how it was abusive. It could be argued that it was actually beneficial for [redacted] in that there was additional time to more fully address [redacted] issues. And as noted above by the [redacted] social worker: "We did not have a d/c date for [redacted] on [redacted]

Procedurally, it seems that we should have been informed at the Exit Interview on April 30, 2024, that there were violations in this area. We did not know about these violations until we received the LIS that included them. We were told at the Exit Interview if there were to be any additional violations, the supervisor would let us know.

POC

The Executive Director reviewed the process for discharge or transfer with DRS and ADRS on May 21, 2024. The process will include the following: at the LOC meeting, which is usually held weekly, all residents are reviewed. The ED/designee will ensure that summaries of resident issues are kept after each LOC meeting. If it is determined that there are indications that any resident's care is exceeding our capacity to meet [redacted] needs, the ED will convene a meeting with the DRS, ADRS and any other appropriate staff members to review any resident who is at risk of discharge. The At-Risk Form will be initiated, setting the process in motion. This meeting will be convened on a case-by-case basis. If indicated that the resident is indeed at risk of discharge, the DRS, ADRs or ED/designee will reach out to the family and the PCP to apprise them of the situation and to schedule a Care Conference. If it is determined that the resident truly needs a higher level of care that cannot be provided here, a 30-day notice of intent to discharge will be issued. As of June 1, 2024, and going forward only the ED/designee may issue a 30-day notice; or in the case of the need for an immediate discharge, the ED/designee will ensure that a certification of a physician or the Department is secured.

On June 6, 2024, the ED reviewed with the DRS and the ADRS the policies relating to discharge and transfer, as well as change of condition. Policy J-170 and F-130.

This process was communicated to the managers at the Managers Meeting on May 30, 2024, by the Executive Director.

On May 31, 2024, the DRS and the ADRS educated the nursing supervisors re: discharge or transfer of residents; the residents right to remain in the home; also, the rights of residents not to be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

The ED has changed the timing of the annual training on Resident Rights and Abuse/Neglect from October to July

42b - Abuse (continued)

2, 2024. This mandatory training will be presented by the DRS, ADRS and the ED to all staff.
Competencies regarding resident rights will be assessed through a post test, given by the DRS immediately after the training. Additionally, each manager will be assigned and educated by the DRS, ADRS, ED to follow up with the members of their staff via an individual interview to ensure adequate comprehension and understanding. The interview process will take place from July 8, 2024 until August 2, 2024.
Going forward beginning September 2024, each manager will be responsible to conduct a random abuse /resident rights audit drill at their regular staff meeting at least quarterly for one year. The results of this drill will be documented and sent to the ED for review, who will follow up on any issues identified.
The Executive Director is responsible for ongoing compliance.

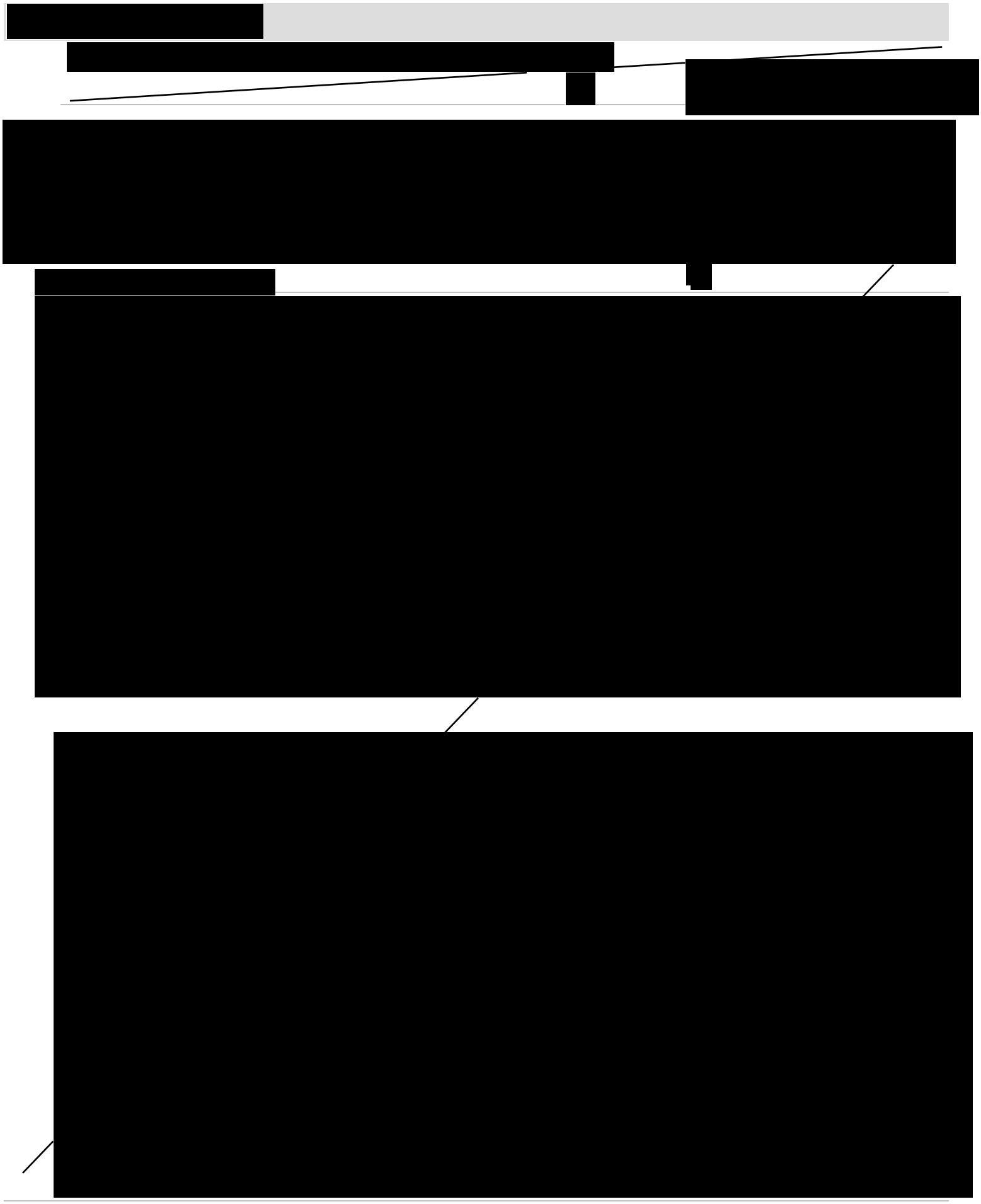
Licensee's Proposed Overall Completion Date: *08/02/2024*

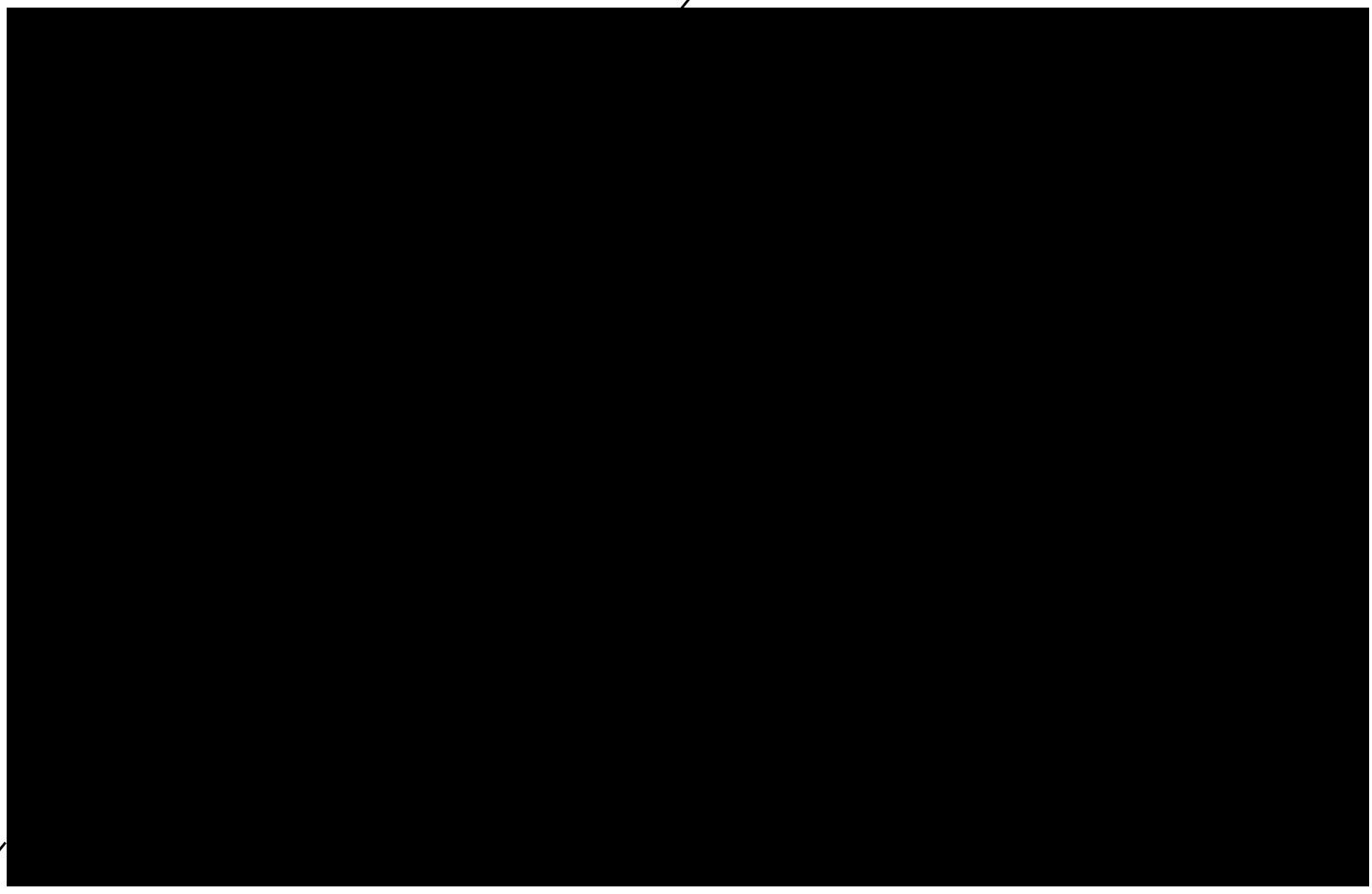
Not Implemented (09/26/2024)

[redacted]

Withdrawn 12/13/24

[redacted]





[redacted]

6. Requirements

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

Description of Violation

On 4/30/2024 at 10:19 am, there was feces left in the toilet bowl in room 31, a room shared by two residents. The toilet was previously clogged and was in need of cleaning.

Plan of Correction ***Accept ([redacted] - 06/28/2024)***

Immediately, the housekeeper was notified that the toilet needed cleaning in room 31. The housekeeper came and cleaned the toilet.
Going forward, in addition to their other duties, the aids who make rounds every two hours will check the toilet and also ensure that each resident has pillows, bed linens and blankets that are clean and in good repair. The aids were given an in-service on this on May 8, 2024, by the DRS and ADRS. The aid is to report issues to the charge nurse, manager, or supervisor on duty. Housekeepers were instructed by the Director of Housekeeping on June 3, 2024, that on their a.m. and p.m. rounds to each room in addition to their other duties they are to check the toilet for cleanliness and check that each resident has pillows, bed linens and blankets that are clean and in good repair. Housekeepers are to report issues to the Director of Housekeeping.
The DRS and Director of Housekeeping are responsible for their individual staffs' monitoring of the rooms.
Beginning the week of July 1, 2024, the routine room checks done twice a week by the Maintenance Assistant, and the routine room checks done once a week by the Managers will include checking the toilet for cleanliness and ensuring that there are clean pillows, bed linens and blankets for each bed. These room checks are ongoing.
The Director of Maintenance is responsible for ongoing compliance of room checks.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented [redacted] - 09/26/2024)

91 - Telephone Numbers

7. 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 the morning of 4/29/2024, there were no emergency telephone numbers, including the nearest hospital and fire department, on or by the common telephone in the conference room.

Plan of Correction ***Accept [redacted] 06/12/2024)***

The Emergency Telephone Number list was replaced immediately by the Director of Maintenance on Apr. 29, 2024.
Going forward the Director of Maintenance will check the phone lists in the common areas, using a checklist, on a daily basis, for 4 weeks beginning May 6, 2024, and weekly thereafter.
The phone lists in the residents' rooms are already on the checklist for room compliance. Each room is checked for the indicated items twice a week by the Maintenance Assistant and once a week by a manager. The Director of Maintenance is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/06/2024*

Implemented ([redacted] 09/26/2024)

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 4/29 and 4/30/2024, the door on room 47 had a broken lock and could not be locked from the inside.

Plan of Correction ***Accept [redacted] 06/28/2024)***

The resident had not communicated that the lock was broken. Rather [redacted] was asking for a different type of lock that is not used in this facility.
The week of May 6, 2024, the Director of Maintenance installed a new lock in the door of room 47. This was verified by the DHS inspector on May 13, 2024, when [redacted] returned for a second visit.
Beginning July 1, 2024, the Maintenance Director will keep a dated log of all resident requests for maintenance services. This log will be reviewed weekly with the Executive Director. This process will be ongoing.
Beginning July 1, 2024, the Maintenance Director will add to the room check forms used by the Maintenance Assistant twice a week and the Managers once a week the following: "Functioning lock is in place on resident room door." This process is ongoing.
The Director of Maintenance is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented [redacted] 09/26/2024)

101j3 - Bed/Linens/Pillows/Blankets

9. Requirements

2600.

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 4/30/2024 at approximately 10:30 am, the bed for resident #5 in room [redacted] had no pillow case.

Plan of Correction ***Accept [redacted] - 06/28/2024)***

Immediately, an aide was told to get a pillowcase for resident #5's pillow.
Going forward, in addition to their other duties the aids who make rounds every two hours will check the toilet and also ensure that each resident has pillows, bed linens and blankets that are clean and in good repair. The aids were given an in-service on this on May 8, 2024, by the DRS and ADRS. The aid is to report issues to the charge nurse, manager, or supervisor on duty. Housekeepers were instructed by the Director of Housekeeping on June 3, 2024, that on their a.m. and p.m. rounds to each room in addition to their other duties they are to check the toilet for cleanliness and check that each resident has pillows, bed linens and blankets that are clean and in good repair. Housekeepers are to report issues to the Director of Housekeeping.
The DRS and the Director of Housekeeping are responsible for their individual staffs' monitoring of the rooms.
Beginning the week of July 1, 2024, the routine room checks done twice a week by the Maintenance Assistant, and the routine room checks done once a week by the Managers will include checking the toilet for cleanliness and ensuring that there are clean pillows, bed linens and blankets for each bed.
The Director of Maintenance is responsible for ongoing compliance of room checks.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/26/2024)

171b5 - First Aid Kit

10. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 4/29/2024, the first aid kit in the bus used to transport residents did not include eye coverings, a thermometer, or scissors.

Plan of Correction ***Accept [redacted] 06/12/2024)***

It was discovered that the root cause of this violation was that the new First Aid Kit had not been checked when it was ordered and placed in the bus. An assumption was made that since it was new it included all items required. The missing items, eye coverings, a thermometer and scissors were added to the First Aide Kit on the bus by the Director of Maintenance on May 2, 2024.
All bus drivers were informed by the Director of Maintenance during the week of May 6, 2024, to ensure that the First Aid Kit's security tag is intact prior to taking the bus for an event.
Going forward beginning the week of May 28, 2024, the Director of Maintenance will check the First Aid Kit after each use of the bus. The Director of Maintenance will monitor the First Aid Kit on the bus, as well as all First Aid Kits throughout the building to ensure that the security tags are in place. This will be an ongoing process which will be

171b5 - First Aid Kit (continued)

added to the weekly preventive maintenance schedule, done weekly beginning May 28, 2024. The Director of Maintenance will replace any items discovered to be missing from the First Aid Kits and is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/06/2024*

Implemented [redacted] 09/26/2024)

201 - Positive Interventions

11. 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

Resident #1's assessment and support plan, dated [redacted], was amended on 12/15/23 to indicate a severe problem with agitation. The support plan says, "Staff will re-direct and offer 1:1 [one-to-one] support as needed." However, the home did not provide the one-to-one support called for in the resident's support plan.

Resident #1 has an advancing case of dementia, leading to a series of violent incidents. The first occurred on 9/4/23, when resident #1 had an altercation with resident #2, resulting in a scratch to resident #2's face. There were further instances of resident #1 being difficult or combative with staff or residents on 12/21/23, 1/14/24, 1/17/24, 3/5/24, and 3/27/24. There was no 1:1 assigned following these incidents.

On 4/10/24, resident #1 slapped resident #2 and attempted to pull resident #3's leg, the home sent resident #1 to the hospital for evaluation on [redacted]. The home issued a 30-day discharge notice on [redacted] stating the reason for discharge is "we are unable to manage [resident #1]'s aggression in a way we feel comfortable."

Repeat Violation: 5/2/23 et al.

Plan of Correction ***Accept [redacted] 06/28/2024)***

REQUEST FOR WITHDRAWAL OF VIOLATION 11 (201)

Respectfully, I would like to request that the violation, listed as #11 for regulation 2600.201 be reconsidered and withdrawn.
The reasons for this are as follows:
Some of the information in the Description of the Violation is inaccurate:
? "The home did not update resident #1's support plan..." the support plan was updated in September 2023 and December 2023
? "Resident #1 did not receive one-to-one support." Resident #1 did receive 1:1 support as needed, and that is what was written in the RASP
? "The home did not follow the plan to address the resident's behavior."
In fact, the staff did respond to the resident's behavior as indicated in the plan.
? "The home refused to accept the resident back." The Description further indicates that the resident was stable and

201 - Positive Interventions (continued)

ready for discharge on [redacted] and that [redacted] was "pleasantly confused" with "no evidence of any acting-out behavior recorded." This information was never conveyed to us. Therefore, since it was not conveyed there was no point in which we definitively said we would not be taking the resident back. In fact, had we known this information it would have factored into our decision-making process. The discharge process for resident #1 was being coordinated by our DRS, [redacted] and the social worker at [redacted] MSW. Due to the discrepancies in the Description of the Violation, we reached out to [redacted] stated that "no one from here called Allegria on [redacted] to my knowledge. I certainly did not. We did not have a d/c date for [redacted] on [redacted]" "I am not sure what happened on [redacted] but that didn't come from our end." In the process of the discharge planning our DRS communicated to the SW that we believed that our setting was not the best for resident #1 at this point, We were working with the SW and the family to determine how [redacted] needs could best be met.

We were told by the Supervisor [redacted] via a phone conversation on May 30, 2024, prior to the due date for the POC of June 7, 2024 (with [redacted] also on the call) that all of the violations re resident #1 stemmed from the fact that we "refused to take the resident back." In regard to 3, the "abusive action" was not taking [redacted] back. As noted above, we were never informed about the change in the resident's behavior, or that [redacted] was ready for discharge. And the SW with whom our DRS was working corroborates this fact. No one from [redacted] ever asked us to take [redacted] back, so how could we have refused to do so. And further, resident #1 did not suffer at the [redacted] Hospital as far as we know, nor was [redacted] in any danger while there. So, it is not apparent how it was abusive. It could be argued that it was actually beneficial for [redacted] in that there was additional time to more fully address [redacted] issues. And as noted above by the [redacted] social worker: "We did not have a d/c date for [redacted] on [redacted]"

Procedurally, it seems that we should have been informed at the Exit Interview on April 30, 2024, that there were violations in this area. We did not know about these violations until we received the LIS that included them. We were told at the Exit Interview if there were to be any additional violations, the supervisor would let us know.

POC

When the incident occurred on April 10 immediately, staff intervened to separate residents who were being aggressive, to use re-direction and to closely monitor the aggressor, not leaving [redacted] unsupervised. Planning was set in motion immediately to have the resident evaluated in a behavioral health setting, (admission actually took place [redacted]

Immediately the ED conferred with the DRS and the ADRS in regard to the need for the approval of the PCP and/or The Department in order to execute an immediate discharge. The DRS and ADRS were notified of the fact that the ED would be giving further directives in regard to the discharge/transfer process.

By August 2, 2024, the DRS and ADRS will give a full in-service to the nursing department staff concerning the procedures and techniques for addressing residents exhibiting aggressive behavior or disruptive behavior of any kind. This will include the use of positive interventions to modify or eliminate a behavior that endangers the resident or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, de-escalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

At the September, October and November 2024 nursing staff meetings the techniques will be reviewed. This will be followed by a discussion of potential scenarios requiring such interventions, coupled with a discussion of how the staff members would address the situations.

The Executive Director reviewed the process for discharge or transfer with DRS and ADRS on May 21, 2024. The process will include the following: at the LOC meeting, which is usually held weekly, all residents are reviewed. The ED/designee will ensure that summaries of resident issues are kept after each LOC meeting. If it is determined that

201 - Positive Interventions (continued)

there are indications that any resident's care is exceeding our capacity to meet [redacted]eeds, the ED will convene a meeting with the DRS, ADRS and any other appropriate staff members to review any resident who is at risk of discharge. The At-Risk Form will be initiated, setting the process in motion. This meeting will be convened on a case-by-case basis. If indicated that the resident is indeed at risk of discharge, the DRS, ADRs or ED/designee will reach out to the family and the PCP to apprise them of the situation and to schedule a Care Conference. If it is determined that the resident truly needs a higher level of care that cannot be provided here, a 30-day notice of intent to discharge will be issued. As of June 1, 2024, and going forward only the ED/designee may issue a 30-day notice; or in the case of the need for an immediate discharge, the ED/designee will ensure that a certification of a physician or the Department is secured.

On June 6, 2024, the ED reviewed with the DRS and the ADRS the policies relating to discharge and transfer, as well as change of condition. Policy J-170 and F-130
This process was communicated to the managers at the Managers Meeting on May 30, 2024, by the Executive Director
On May 31, 2024, the DRS and the ADRS educated the nursing supervisors re: discharge or transfer of residents; the residents right to remain in the home; also, the rights of residents not to be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Proposed Overall Completion Date: 11/30/2024

[redacted]

[redacted]

227

13. 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 did not sign their support plan dated [redacted] There was no indication on the form that the resident either declined or was unable to sign the support plan, nor that the resident declined or was unable to participate in the development of the support plan.

Repeat Violation: 5/2/23 et al and 8/17/23 et al.

Plan of Correction ***Accept ([redacted] 06/28/2024)***

The medical receptionist, under the direction of the DRS, is responsible for checking the chart of every resident each

227g -Support Plan Signatures (continued)

month. On May 31, 2024, the DRS re-trained the medical receptionist regarding [redacted] checking of the required signatures. The medical receptionist was informed that if there is no signature of a resident, then there must be an indication on the form that the resident either declined or was unable to sign the support plan or that the resident declined or was unable to participate in the development of the support plan. Prior to filing the RASP in the chart, and then during the regular checking of the residents' charts done monthly, the medical receptionist will ensure that the proper signatures are present or if not, that there is an indication as to why not. (eg.: "resident unable to sign.") Beginning July 1, 2024, the DRS or ADRS will randomly check 5 charts a month to review the RASP, checking for signatures of the resident and/or indications why it is not signed, the annual indication on the chart of the continued need for SMCU, as well as assuring RASPs are properly dated and updated—i.e. the initial, annual and significant change RASP's are in place. This process will be ongoing.
The DRS is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented [redacted] - 09/26/2024)

228b - Discharge or Transfer

14. Requirements

2600.
228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

On [redacted] the home sent a letter to a family member of resident #1 providing a 30-day notice of discharge. On [redacted] the home sent the family member a second letter declaring the discharge immediate effective [redacted] the day resident #1 went to the hospital for evaluation. The home did not obtain certification from a physician or the Department for an early discharge.

Plan of Correction ***Accept [redacted] 06/12/2024)***

The Executive Director reviewed the process for discharge or transfer with the DRS and ADRS on May 21, 2024. At the LOC meeting, which is usually held weekly, all residents are reviewed. If it is determined that there are indications that any resident's care is exceeding our capacity to meet [redacted] needs, the DRS, ADRs or ED/designee will reach out to the family for a care conference, and to apprise them of the situation. If it is determined that the resident needs a higher level of care that cannot be provided here a 30-day notice of intent to discharge will be issued. As of June 1, 2024, and going forward only the ED/designee may issue a 30-day notice; or in the case of the need for an immediate discharge, the ED/designee will ensure that a certification of a physician or the Department is secured. On May 31, 2024, the DRS and the ADRS educated the nursing supervisors re: immediate removal from the home. On June 6, 2024, the ED reviewed with the DRS and the ADRS the policies relating to discharge and transfer, as well as change of condition. Policy J-170 and F-170.
This process was communicated to the managers at the Managers Meeting on May 30, 2024, by the Executive Director. The Executive Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/06/2024*

228b - Discharge or Transfer *(continued)*

Implemented [redacted] 09/26/2024)

231f - Assessed Annually

15. Requirements

2600.
231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident #6 was assessed as needing admission to the Secure Dementia Care Unit (SDCU) on [redacted] but the resident's continuing need for memory care has not been assessed in more than a year. Resident #4's [redacted] assessment did not address the resident's care in the SCDU.

Plan of Correction ***Accept [redacted] - 06/28/2024)***

The medical receptionist, under the direction of the DRS, is responsible for checking the chart of every resident each month. In May 2024 the DRS educated the medical receptionist that [redacted] is to include in [redacted] monthly chart review the checking of the RASP to ensure that the continued need for SMCU is included. The medical receptionist also checks each RASP for completeness prior to filing it in the chart.
On May 2, 2024, the DRS and the ADRS educated the nursing staff (LPNs and med techs) on the requirement to indicate on the annual RASP the continued need for SMCU.
Beginning July 1, 2024, the DRS or ADRS will randomly check 5 charts a month to review the RASP, checking for signatures of the resident and/or indications why it is not signed, the annual indication on the chart of the continued need for SMCU, as well as assuring RASPs are properly dated and updated—i.e. the initial, annual and significant change RASP's are in place. This process will be ongoing.
The DRS is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented [redacted] - 09/26/2024)

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

Facility Information

Name: *ALLEGRIA AT THE OAKS* **License #:** *14367* **License Expiration:** *06/19/2024*

Address: *6400 HULMEVILLE ROAD, BENSALEM, PA 19020*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BENSALEM PCH LLC*

Address: *6400 HULMEVILLE ROAD, BENSALEM, PA, 19020*

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *10/18/2018* **Issued By:** *Bensalem Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *116* **Waking Staff:** *87*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *08/01/2024*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* **Residents Served:** *70*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Grove* **Capacity:** *36* **Residents Served:** *34*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *67*

Diagnosed with Mental Illness: *14* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *46* **Have Physical Disability:** *0*

Inspections / Reviews

08/01/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/02/2024*

Inspections / Reviews *(continued)*

09/09/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/23/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/23/2024*

09/26/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/23/2024*

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

82c - Locking Poisonous Materials

1. 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

Antifungal Cream, with a manufacturer's label indicating "In case of accidental ingestion contact a physician or Poison Control Center right away", was unlocked, unattended, and accessible to residents in Memory Care room [redacted] Not all the residents of the home, including resident 1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] 09/09/2024)***

1. It was discovered that the antifungal cream had just been used and left unsecured by the hospice nurse, who was still in the room. The Director of Residential Services instructed the hospice nurse to secure the antifungal cream.
On August 27, 2024, the Executive Director sent a memo to all hospices that service the community advising them that all items which potentially may be harmful to a resident must be locked in the closet in the bathroom and may not be left unsecured. In addition, the same notice will be posted in the rooms of all hospice residents, both current and new, by the Director of Residential Services by 9/6/24 and going forward.
The Director of Residential Services is responsible for on-going compliance.

The routine room checks, which began May 2024 will be continued and are on-going. These room checks are done twice a week by the Maintenance Assistant, and once a week by one of the Managers. The Director of Maintenance is responsible for the on-going compliance regarding room checks.

Licensee's Proposed Overall Completion Date: *09/06/2024*

Not Implemented ([redacted] 09/26/2024)

101j3 - Bed/Linens/Pillows/Blankets

2. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 8/1/2024 at 11:30 am the bed for resident 2 had a pillow that was wrapped in plastic and had no pillow case.

Plan of Correction ***Accept [redacted] 09/09/2024)***

2. The PCA was immediately directed by the Director of Maintenance to ensure that the pillowcase was put on the pillow.
It was discovered that the PCA had brought the pillowcase to the room earlier, but the resident was asleep and so left the pillowcase there, waiting to put it on the pillow until the resident woke up. Also, the resident was sleeping on three pillows. It was only the bottom pillow that was without a pillowcase. The one [redacted] was lying on and the one in the middle both had pillowcases.
During the week of August 26, 2024, the PCA's were re-trained about the need to ensure that the pillowcases are

101j3 - Bed/Linens/Pillows/Blankets (continued)

on the pillows. If a pillowcase needs to be changed, it must be immediately replaced, even if the resident is sleeping. The Director of Residential Services is responsible for on-going compliance.

The routine room checks, which began May 2024 will be continued and are on-going. These room checks are done twice a week by the Maintenance Assistant, and once a week by one of the Managers. The Director of Maintenance is responsible for the on-going compliance regarding the room checks.

Licensee's Proposed Overall Completion Date: *09/06/2024*

Not Implemented [redacted] 09/26/2024)

102i - Soap Dispenser

3. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 8/1/2024 at 11:25 am, there were two unlabeled bars of soap in the bathroom of shared room 16.

Plan of Correction ***Accept [redacted] 09/09/2024)***

3. A lead care manager has been assigned by the Executive Director on August 30, 2024, to monitor the labeling compliance. The monitoring will begin the week of September 9, 2024. This includes the labeling of personal care items, including soap containers and toothbrush containers, doors, closets, towel racks, bathroom door hooks, and bathroom cabinets in shared rooms. The lead care manager will have the following duties:
Train PCA's to check each of their shared rooms daily for proper labeling, using the Labeling Checklist.
Ensure that each PCA on day shift is checking each day.
Review Labeling Checklists daily for compliance.
Use Sharpie to mark residents' names on personal care items.
Labels are made by the receptionist. Inform the receptionist if labels are missing.
Spot check 5 shared rooms on Personal Care and 5 shared rooms on Memory Care weekly for compliance.
Follow up with PCA's when non-compliance is detected
Report bi-weekly to the Director of Residential Services on on-going compliance.
During periods of extended absence from the community check with Director of Residential Service for appointment of a substitute.
The Director of Residential Services is responsible for on-going compliance.

The routine room checks, which began May 2024 will be continued and are on-going. These room checks are done twice a week by the Maintenance Assistant, and once a week by one of the Managers. The Director of Maintenance is responsible for the on-going compliance regarding room checks

102i - Soap Dispenser (continued)

Licensee's Proposed Overall Completion Date: *09/13/2024*

Not Implemented ([redacted] - 09/26/2024)

103d - Storing Food Off Floor

4. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 8/1/2024 at 1:00 pm, a large box of frozen beef was stored on the floor in the kitchen's walk in freezer.

Plan of Correction ***Accept [redacted] 09/09/2024)***

4 The Culinary Director immediately placed the box back on the shelf where it had been stored.
It was discovered that the box had been placed on the floor by the cook who was taking out what [redacted] needed for the meal, and [redacted] had not yet placed the box back on the shelf.
On August 26, 2024, all dietary staff were re-educated by the Culinary Director that "food shall be stored off the floor." 2600.103 (d)
Also, on August 26,2024 the cooks were instructed by the Culinary Director that when taking food items from storage to be used for a meal, the box, if removed from the shelf, should be placed on a kitchen cart, while removing the food items. Once the food has been retrieved, the box with any remaining food in it is to be placed on the shelf again right away for continued storage.
The Culinary Director is responsible for on-going compliance.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Not Implemented ([redacted] - 09/26/2024)

183e - Storing Medications

6. Requirements

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

Description of Violation

On 8/1/2024 resident 3's prescription of Atorvastatin 20 mg tablet had a puncture on the back of spot 11, with the tablet still in the spot.

On 8/1/2024 at 10:03 am, the following was found in the medication cart prescribed to resident 4:

- *a Novolog 70/30 Flex Pen with an open date of 4/5/2024*
- *an open, undated Humulin Pen*

Plan of Correction ***Accept [redacted] 09/09/2024)***

Immediately, the blister pack was removed from the med cart by the med tech who wasted the medication.

Also, the med tech immediately removed expired Novolog Flex Pen and the undated Humulin pen from the med cart.

During the week of August 26, 2024, the med techs/nurses were re-educated by the Director of Residential Services on the following:

183e - Storing Medications (continued)

:
--Expired meds must be removed from the med cart
--When blister backs are punctured the medication must be destroyed and the pharmacy notified that a replacement is needed
--All meds must be properly labeled, including name of resident and date opened, this includes OTC and CAM
In March 2024 a designated med tech was assigned by the Director of of Residential Services to begin on-going monitoring of the med carts to audit for the following:
Cart clean, free of trash and personal items.
Bulk items are not sticky.
Glucometers are labeled (glucometer and case)
Insulin pens are dated
Eye, ear, nose drops/spray are labeled with date opened.
All expired meds are removed (use stickers to label expiration date).
Medications are removed for any resident on LOA or discharged.
Nebulizer foil packaging and nebulizers labeled with date opened.
8 oz. cups are available.
Water and applesauce dated, if applicable.
Narcotic count is correct.
All order medication is present.
These audits have proven to be effective and will continue with the same med tech monitoring the carts going forward.
It was discovered that this designated med tech was on vacation for an extended period of time, out of the country. Going forward, should a similar situation occur, the designated med tech will confer with the Director of Residential Services, prior to her departure about appointing a substitute. The designated med tech will train the substitute prior to [redacted] *departure. The Director of Residential Services will inform the med tech of this responsibility by August 30, 2024. The Director of Residential Services is responsible for on-going compliance.*

Licensee's Proposed Overall Completion Date: *08/30/2024*

Not Implemented ([redacted] 09/26/2024)

184b - Labeling OTC/CAM

7. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 8/1/2024, an antibacteirial eye compress treatment pack belonging to resident 5 was in the North Summit Medication Cart and was not labeled with the resident's name.

Plan of Correction ***Accept [redacted] 09/09/2024)***

Immediately, the med tech labeled the antibacterial eye compress treatment

184b - Labeling OTC/CAM (continued)

pack with the resident's name, verifying the correct resident.
During the week of August 26, 2024, the med techs/nurses were re- educated by the Director of Residential Services on the following:

--Expired meds must be removed from the med cart
--When blister backs are punctured the med must be destroyed and the pharmacy notified that a replacement is needed
--All meds must be properly labeled, including name of resident and date opened, this includes OTC and CAM

In March 2024 a designated med tech began on-going monitoring of all med carts having been appointed by the Director of Residential Service to audit for the following:
Cart clean, free of trash and personal items.
Bulk items are not sticky.
Glucometers are labeled (glucometer and case)
Insulin pens are dated
Eye, ear, nose drops/spray are labeled with date opened.
All expired meds are removed (use stickers to label expiration date).
Medications are removed for any resident on LOA or discharged.
Nebulizer foil packaging and nebulizers labeled with date opened.
8 oz. cups are available.
Water and applesauce dated, if applicable.
Narcotic count is correct.
All order medication is present.
These audits have proven to be effective and will continue with the same med tech going forward.

It was discovered that this designated med tech was on vacation for an extended period of time, out of the country. Going forward, should a similar situation occur, the designated med tech will confer with the Director of Residential Services, prior to [redacted] departure about appointing a substitute. The designated med tech will train the substitute prior to [redacted] departure. The Director of Residential Services will inform the med tech of this responsibility by August 30, 2024. The Director of Residential Services is responsible for on-going compliance.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Not Implemented ([redacted] 09/26/2024)