pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BRISTOL HOUSE MEMORY CARE LLC**
LEGAL ENTITY

To operate **BRISTOL HOUSE MEMORY CARE**
NAME OF FACILITY OR AGENCY

Located at **2527 BRISTOL ROAD, WARRINGTON, PA 18976**
(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 **48**
(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 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 **February 21, 2025** until **February 21, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144580**

ISSUING OFFICER

DEPUTY SECRETARY

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

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing date: February 21, 2025

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

RE: Bristol House Memory Care
2527 Bristol Road
Warrington, Pennsylvania 18976
License #: 14458

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on August 15, 2024, October 17, 2024, and December 30, 2024, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

February 14, 2025

[redacted]
BRISTOL HOUSE MEMORY CARE LLC
[redacted]

RE: BRISTOL HOUSE MEMORY CARE
2527 BRISTOL ROAD
WARRINGTON, PA, 18976
LICENSE/COC#: 14458

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/15/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* **License #**: *14458* **License Expiration**: *12/14/2024*

Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*

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

Administrator

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

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*

Address: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Provisional, Monitoring* **Exit Conference Date**: *08/15/2024*

Inspection Dates and Department Representative

08/15/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *35*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Blue Jay/ Gold Finch* **Capacity**: *48* **Residents Served**: *35*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *35*

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

Have Mobility Need: *35* **Have Physical Disability**: *0*

Inspections / Reviews

08/15/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/07/2024*

Inspections / Reviews *(continued)*

09/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/15/2024*

09/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/15/2024*

02/14/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2024*

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

5a1 - DHS Access

1. Requirements

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

Description of Violation

On 8/15/2024, at 9:00 am, an agent of the Department, requested access to records. Staff person A could not provide access until staff person B arrived which was approximately 10:20 am.
On 8/15/24 an agent of the Department requested documentation of timecards for 8/9/2024, 8/10/2024, and 8/11/2024. The requested information was not provided until 8/16/2024 at 5:26 pm.

Plan of Correction ***Accept [redacted] - 09/10/2024)***

Effective 09/05/2024, all staff members were trained on the importance of providing immediate access to records and the procedures for doing so. Training included steps to ensure that any request from an agent of the Department is handled without unnecessary delay. The Executive Director will Implement a monitoring system to track and verify that documentation requests are fulfilled within the required timeframe. This system will include checks to ensure that all requests are processed promptly starting on 9/06/2024. The Executive Director will also Perform regular monthly internal audits starting 9/6/2024 to ensure compliance with documentation request requirements and address any issues promptly for the duration of 3-months.

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

Implemented ([redacted] - 02/14/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/2024, for resident 1 was not signed by the resident. There was no indication the resident was given the opportunity to sign the contract.

The resident-home contract, dated [redacted]2022, for resident 2 was not signed by the resident. There was no indication the resident was given the opportunity to sign the contract.

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Starting 09/12/2024 all new residents that are admitted to Bristol house Memory Care will have the opportunity to participate in their contract signing process. If the resident is unable to sign or put a mark it will be indicated by the POA that resident is unable to sign, and it will be initialed by the POA and the Executive Director.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented [redacted] 02/14/2025)

51 - Criminal Background Check

3. Requirements

2600.

51 - Criminal Background Check *(continued)*

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person C hired [redacted]/2024, did not have an acknowledgement that [redacted] has resided in PA for over 2 years. Staff person C has a work authorization permit issued [redacted]15/2023. There was no FBI clearance completed for staff person C.

Repeated Violation: 3/21/23, 5/15/23, 12/27/2023

Plan of Correction ***Accept [redacted] - 09/10/2024)***

Executive Director to review and update hiring policies to ensure they align with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15.
Executive director will on 9/10/2024 provide training to HR and relevant staff on the updated policies and procedures, emphasizing the importance of compliance with criminal history checks and documentation requirements. Executive Director will also Implement weekly audits of new hires to ensure that all required criminal history checks and documentation (including FBI clearances and residency acknowledgments) are completed before employment.
Maintain a checklist for each staff person to track the completion and verification of all required documents. These audits will begin on 9/10/2024 and last for the duration of 6-months following plan of correction.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented [redacted] - 02/14/2025)

52 - Hiring Staff

4. Requirements

2600.

52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

Description of Violation

Staff person D was hired on [redacted]2024, a background check was not completed until 7/31/2024.

Plan of Correction ***Directed [redacted] - 09/18/2024)***

Starting 09/12/2024 The Business office manager will create a new hire check list to ensure that all necessary paperwork and trainings is completed before start date. The Executive Director will sign off on the check list and will give the ok for the new staff member to start work.

Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall create a line item on the check list that will identify a staff persons official hire date and the staff persons first official day working in the home (including if just attending training in the home prior to performing actual job duties.) Tracking the dates in this manner will allow for accurate measuring of compliance with dates for trainings and documentation.

Directed Completion Date: *09/12/2024*

Implemented [redacted] - 02/14/2025)

53a - Qualifications

5. Requirements

2600.
53.a. The administrator shall have one of the following qualifications:
1. A license as a registered nurse from the Department of State.
2. An associate's degree or 60 credit hours from an accredited college or university.
3. A license as a licensed practical nurse from the Department of State and 1 year of work experience in a related field.
4. A license as a nursing home administrator from the Department of State.
5. For a home serving 8 or fewer residents, a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

Description of Violation

On 8/15/2024, the home was serving 35 of residents. Staff person E the administrator does not have a license from the Pennsylvania Department of State as a registered nurse, or a licensed practical nurse with one year of work experience in a related field, an associate's degree, 60 or more credits from an accredited college or university, or a license on file in the home.

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Starting 09/12/2024 the Business office manager will do a monthly staff chart audit to ensure that all necessary paperwork is up to date and not expired. The Executive Director will sign off on the audit stating that the audit was completed to its fullest. This will be an ongoing process.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented [redacted] - 02/14/2025)

54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

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

Repeat violation: 3/21/2023, 5/15/23, 2/22/2024

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Starting 09/12/2024 The Business office manager will create a new hire check list to ensure that all necessary paperwork and trainings is completed before start date. The Executive Director will sign off on the check list and will give the ok for the new staff member to start work.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented [redacted] - 02/14/2025)

62 - Contact List

7. Requirements

62 - Contact List *(continued)*

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person E, [redacted], maintains a list of staff persons that does not include all staff members.

Plan of Correction ***Accept [redacted] - 09/10/2024)***

Executive Director has established a procedure for updating the staff list on a regular basis (e.g., monthly) or as soon as changes occur.
Executive Director has retrained business office manager on 9/6/2024 on the importance of maintaining an accurate and complete staff list and the procedures for updating it. Executive Director to perform Bi-weekly audits on random employee files beginning 9/10/2024 which will last for the duration of 2-months.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented [redacted] - 02/14/2025)

65i - Training Record

9. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training for staff member D does not include date, source, length of each course and copies of any certificates received.

Plan of Correction ***Accept [redacted] - 09/10/2024)***

Business off manager to review and enhance record-keeping procedures to ensure all future training records are maintained in compliance with the regulations. Audits to be performed weekly starting 9/10/2024 for the duration of 3-months.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented ([redacted] - 02/14/2025)

82c - Locking Poisonous Materials

10. 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 8/15/2024 at 10:14am a broken container of Lysol wipes, with a manufacture's label indicating "Contact poison control if there is contact with eyes.", a red bottle of Peroxy HDox Red Dilution - with a manufacture's label indicating "Contact poison control if swallowed.", and a SureScents Lavender air fresher manufacture's label indicating "If inhaled call physician or poison control if you feel unwell." were observed unlocked, unattended, and accessible to residents' activity area kitchenette under the sink in an unlocked cabinet. The kitchenette door was unlocked, and the keys to the area were on a countertop accessible to residents.

82c - Locking Poisonous Materials (continued)

At 10:51 a stick of Lady Speed Stick invisible dry deodorant with a manufacture's label indicating "if swallowed contact poison control" was unlocked in the bedside table of room [redacted]

At 3:05 pm a stick of Dove deodorant manufacture's label indicating "if swallowed contact poison control" was in an unlocked bedside table in room [redacted]

Not all the residents of the home, have been assessed as capable of recognizing and using poisons safely.

Repeat Violation: 12/27/23, 2/22/24, 6/26/24

Plan of Correction ***Accept*** [redacted] ***09/18/2024)***

All management such as executive director, business office manager and resident care coordinator has removed all poisonous materials from accessible areas and securely locked them in a designated cabinet that is out of reach of residents. Ensure that all keys to these cabinets are kept in a secure location, inaccessible to residents. Starting on 9/12/2024 all residents personal care items will be placed in storage closets with named baskets and locked, Caregivers will be given access to retrieve such items daily and place back when finished caring for resident. Daily audits will continue with resident care coordinator checking rooms daily at 8:30am for any poisonous and hazardous materials for the duration of 4-months started 9/1/2024. Daily audits will continue, and monthly in-services will be conducted on this topic in the staff meetings. This will be an ongoing process. Last in-service was conducted on 09/05/2024.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented [redacted] ***- 02/14/2025)***

96b - First Aid Location

11. Requirements

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

On [redacted] */24, Staff person F, did not know the location of the first aid kit.*

Plan of Correction ***Accept (*** [redacted] ***- 09/10/2024)***

Director of Nursing to ensure that the location of the first aid kit is clearly identified and accessible. Confirm that it is stocked and properly maintained.
Director of nursing has Immediately informed all staff members, including Staff person F, of the first aid kit's location.
Director of Nursing has conducted a mandatory training session on 9/5/2024 at 2:30pm for all staff members on the location and use of the first aid kit. Include this information in the orientation for new hires.

Director of nursing has Implemented a procedure where staff are periodically asked about the location of the first aid kit to ensure they are aware. This can be included in regular staff meetings or check-ins starting 9/10/2024.
Director of Nursing to Maintain records of staff training and any check-ins related to first aid kit location awareness starting 9/10/2024 and will last for a duration of 2-months.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented ([redacted] ***- 02/14/2025)***

103c - Food Protected

12. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 8/15/2024 at 10:13 am there was an unsealed and partially open container of chocolate chip muffins stored in the activity room kitchenette cabinet.

Plan of Correction ***Accept [redacted] - 09/10/2024)***

Executive director to review and update food storage procedures to ensure that all food is stored in sealed containers to protect it from contamination.
Executive Director has conducted training for all relevant staff on 9/5/2024 on proper food storage practices, emphasizing the importance of keeping food sealed and stored in a clean environment.
Activities Director has implemented a daily inspection routine to check food storage areas and ensure that all food items are properly sealed and stored this start 9/5/2024 and will last for a duration of 4-months.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented [redacted]/14/2025)

132g - Fire Drills Days/Times

13. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills for the 7am-3pm shift between 1:14pm and 2:32 pm, and between 4:25pm and 4:47pm for the 3pm to 7pm shift. This is evidenced by drills held:
2/26/24 at 1:14pm, 3/5/24 at 2:32pm. 4/24/24 at 1:42 pm. 5/29/24 at 4:47pm. 6/21/24 at 1:39pm, and 7/31/24 at 4:25pm.

Plan of Correction ***Directed [redacted] - 09/18/2024)***

Starting 09/12/2024, all fire drills will be conducted monthly at various times throughout the day of each shift. The times will vary from month to month. This will be an ongoing process.

Directed Plan of Correction:
The administrator or designee shall audit the fire drill log monthly in the first week of each month to track or identify any repeating days/times/shifts etc to ensure drills are appropriately staggered. Additionally the administrator or designee shall provide in-service training regarding this regulation to the person responsible for conducting the fire drills. This in-service shall be completed prior to the next fire drill or within 15 business days of the receipt of this POC, which ever is sooner. Documentation of the training shall be kept and made available for department review.

Directed Completion Date: *09/12/2024*

Implemented [redacted] - 10/29/2024)

183e - Storing Medications

14. Requirements

183e - Storing Medications *(continued)*

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 8/15/2024 resident 3's Lorazepam .5 mg tablet blister pack the foil for pill 15 was punctured. Foil was taped over with two orange "direction change" stickers and pill was still in the pack.

Plan of Correction ***Accept[redacted] - 09/18/2024)***

Director of nursing has provided training to all med techs on 9/5/2024 on proper medication storage procedures, including how to handle and report compromised packaging. Emphasize the importance of maintaining the integrity of medications.
Director of nursing to perform weekly cart audits to ensure all training is implemented and ongoing starting 9/6/2024 for the duration of 2-months. An Audit sheet will be signed off by the Director of Nursing and the Med tech.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented ([redacted] - 02/14/2025)

184b - Labeling OTC/CAM

15. 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 8/15/2024, a bottle of Dermal Care wound cleanser belonging to resident 4 was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept[redacted] - 09/18/2024)***

on 9/5/2024 all medications were checked and rechecked by both director of nursing and resident care coordinator to ensure all OTC and CAM belonging to a resident is labeled and all MedTech's were trained on 9/5/2024 on the importance of properly labeling resident-specific medications. Include instructions on how to label medications correctly and the importance of adhering to labeling protocols. Director of nursing to perform daily checks to ensure all training is implemented and ongoing starting 9/6/2024 for the duration of 2-months. An audit sheet will be signed off by the Director of Nursing and the Med Tech. This will be an ongoing process.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented [redacted] - 02/14/2025)

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

On 8/15/2024, at 3:00 pm resident 5's glucometer was not calibrated to the correct date or time and read 9/14/2024 5:58pm.

185a - Implement Storage Procedures (continued)

Repeat violation: 2/22/2024

Plan of Correction ***Accept [redacted] 09/10/2024)***

Director of Nursing has immediately calibrated Resident 5's glucometer to the current date and time and verified that the glucometer is functioning correctly and providing accurate readings.
Director of nursing has Inspected all other glucometers and medical equipment to ensure they are calibrated correctly and reflect the accurate date and time.
Director of nursing has provided training to all Medtech's on 9/5/2024 on proper use, calibration, and maintenance of glucometers and other medical equipment. Director of nursing also emphasized the importance of accurate calibration and the procedures for reporting and addressing issues. Director of Nursing to perform weekly calibrations which will start 9/10/2024 and last for the duration of indefinitely as policy.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented [redacted] - 02/14/2025)

187d - Follow Prescriber's Orders

17. Requirements

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

Description of Violation

Resident 6 is prescribed Bupropion HCL 150 tablet, Carvedilol 25 mg, CBD gummies, Escitalopram 20 mg tablet, Furosemide 40 mg tablet, Gabapentin 300mg capsule, heel protector, Hydralazine 25mg tablet, Lisinopril 20 mg tablet, Potassium CL 10 meq Capsule and Vitamin d3 soft gel to be given at 9:00am. However, resident 6 was administered these medications on 8/7/2024 at 10:14 am.

Plan of Correction ***Accept [redacted] - 09/18/2024)***

Director of nursing had trained Medtech's on [redacted]/5/2024 on the importance of adhering to prescribed medication times and procedures. Include instructions on how to handle and document any deviations from the prescribed schedule.
Director of nursing has also scheduled regular refresher training sessions to ensure ongoing compliance with medication administration procedures.
Director of nursing has Implemented monthly audits of medication administration to ensure compliance with prescribed schedules beginning 9/5/2024 which will last for the duration of 3-months.

Licensee's Proposed Overall Completion Date: *09/12/2024*

Implemented ([redacted] - 02/14/2025)

190c - Record of Training

18. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person F does not include documentation of successful completion of the training

190c - Record of Training (continued)

. Home only has documentation of the most recent annual practicum which does not list original certification date, or recertification date.

Plan of Correction ***Directed (- 09/18/2024)***

Starting 09/12/2024 The Business office manager will create a new hire check list to ensure that all necessary paperwork and trainings is completed before start date. The Executive Director will sign off on the check list and will give the ok for the new staff member to start work.

Directed Plan of Correction:
Within 10 business days of the receipt of this Plan of Correction, the administrator or designee shall audit all medication training records for all staff to ensure all required documentation is completed accurately and filed appropriately. If any areas of non-compliance are observed, the documents will be corrected if appropriate, or the staff person shall receive remediation training to come into compliance within 5 calendar days of the audit. The administrator or designee shall audit med training documents monthly for 3 months, then quarterly thereafter to ensure compliance.

Directed Completion Date: *09/12/2024*

Implemented (- 02/14/2025)

231b - Medical Evaluation

19. Requirements

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

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on 2024; however, the resident's medical evaluation was completed on /2024.

Repeat Violation: 11/6/2023, 6/26/24

Plan of Correction ***Accept - 09/10/2024)***

Director of nursing has arranged for a new medical evaluation for Resident 1 as soon as possible which was completed, ensuring it is completed within the 60-day period prior to admission. This evaluation documents the resident's diagnosis of Alzheimer's disease or other dementia and the need for the Secure Dementia Care Unit. Director of nursing has provided training on 9/6/2024 to resident care coordinator on the requirements for medical evaluations prior to admission, including the need to document diagnoses and secure care unit requirements. Director of nursing to perform random weekly audits on 30% of residents starting 9/10/2024 which will last for the duration of 5-months and after monthly for the duration of 1-year.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Implemented (- 02/14/2025)

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

February 14, 2025

[redacted]
BRISTOL HOUSE MEMORY CARE LLC
[redacted]

RE: BRISTOL HOUSE MEMORY CARE
2527 BRISTOL ROAD
WARRINGTON, PA, 18976
LICENSE/COC#: 14458

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/17/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* **License #**: *14458* **License Expiration**: *12/14/2024*

Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*

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

Administrator

Name: [redacted]

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*

Address: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *10/17/2024*

Inspection Dates and Department Representative

10/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *48* **Residents Served**: *32*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

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

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

10/17/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/08/2024*

11/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/24/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/20/2024*

Inspections / Reviews *(continued)*

11/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/24/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/23/2024*

02/14/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/24/2024*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/2023, for resident #1 was not signed by the resident.
The resident-home contract, dated [redacted]/2024, for resident #2 was not signed by the resident.

Plan of Correction ***Accept [redacted] 11/15/2024)***

Violation occurred because community failed to obtain resident signature on resident home contract at time of admission, belief was that [redacted] could sign on behalf of the resident if resident was unable to sign.
Business Office Manager had residents 1 and 2 sign resident home contract on 11/7/2024.
On 11/9/24 New Administrator educated Interim Administrator and Business Office Manager and Sales Director on regulation and that all residents are to sign home contract and if unable to sign it must be noted and witnessed on home contract.
New Administrator hired [redacted]/24 completed audit on all Resident files on 11/8/24. All Resident Files are now in compliance.
To prevent further repeat violations, the Sales Director and Administrator will ensure all contracts are signed prior to or at time of admission effective 11/8/24. The Business Office Manager will perform monthly audit starting 12/01/24 utilizing Resident Business File Audit tool to ensure all regulatory paperwork is completed and signed upon admission for all new admissions.

Proposed Overall Completion Date: 11/11/2024

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

Implemented [redacted] - 02/14/2025)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff A, date of hire [redacted]/2024, has not held permanent residency in Pennsylvania for the two consecutive years prior to beginning employment; however, the home failed to run a FBI check.

Repeat Violation: 12/27/2023

Plan of Correction ***Accept ([redacted] - 11/15/2024)***

Violation occurred due to the Business Office Manager not being aware that Staff Person A did not hold Pennsylvania residency status for the past 2 year.
Staff Person A completed the FBI background through Identago on 11/7/2024.
Community will utilize background check form that will specifically ask for staff persons residency status during application process effective 11/11/2024.

51 - Criminal Background Check (continued)

The new Administrator educated the Business Office Manager on 11/10/24 on regulation 51 and the process to determine if new hire needs to have FBI Background clearance due to PA residency status.
Business Office Manager completed audit on all employee files on 11/10/24 to ensure proper background check/FBI clearance has been obtained for all staff.
Business Office Manager will ensure proper background checks are completed at time of hire utilizing new hire checklist effective 11/10/2024 and ongoing.
Administrator to audit all personnel files upon completion of new hire and sign off on new hire checklist effective 11/10/2024 and ongoing.

Proposed Overall Completion Date: 11/11/2024

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

Implemented [redacted] - 02/14/2025)

62 - Contact List

3. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person B, [redacted], does not update the staff list when hiring new employees and the staff list provided on 10/16/2024 did not include housekeeping staff A hired on [redacted] 2024 and maintenance staff C hired on 1[redacted]24.

Plan of Correction ***Accept[redacted] - 11/15/2024)***

Violation occurred because the prior Administrator failed to update the staff list upon new employees being hired.
Business Office Manager has updated the staff list on 11/7/2024 to reflect current staff. Agency Staff Binder Created for all supplemental Staff on 11/7/24.
On 11/7/24 Administrator provided education to the Business Office Manager regarding regulation 62 and the process/procedure for updating staff contact list upon new hire and to include supplemental/agency staff.
To prevent further violation effective 11/7/24 and ongoing the Business Office Manager will utilize new hire checklist to ensure all new hires including supplemental/agency staff have been added to the contact list of current staff.
The new administrator will audit staff contact list for accuracy monthly starting 11/7/24 and ongoing.

Proposed Overall Completion Date: 11/11/2024

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

Implemented [redacted] - 02/14/2025)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

63a - First Aid/CPR Training *(continued)*

Description of Violation

32 residents were present in the home on 10/14/2024 from 11PM~7 AM, on 10/13/24 from 7AM~3 PM, and on 10/11/24 from 11pm~7 AM; however, there was no staff person present in the home who was certified in first aid/CPR during these time periods.

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred because community failed to have procedure in place to ensure at least one staff person per shift held a valid CPR/First Aid Certification.
Business office manager audited all personnel files utilizing staff file audit tool to track all staff CPR/First Aid certification expiration dates. Audit completed on 11/10/24.
On 11/10/24 the Administrator provided education to the Business Office Manager regarding requirements for Regulation 63a and utilizing the staff file audit tool to track CPR/First Aid expiration dates to ensure compliance with the regulation.
Meeting with CPR/First Aid Instructor Scheduled for 11/11/24 and CPR/First Aid class to be scheduled to ensure all staff are CPR/First Aid. CPR/First Aid class to be held on 11/18/2024.
Meanwhile, Business office manager responsible for scheduling will ensure that at least 1 person per shift according to state requirements is CPR/First Aid Certified.
Administrator to review Employee File audit tool monthly effective 11/2024.

Proposed Overall Completion Date: 11/18/2024

Licensee's Proposed Overall Completion Date: *11/18/2024*

Implemented [redacted] - 02/14/2025)

65e - 12 Hours Annual Training

5. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person D received only 5.75 hours of annual training in training year 2023.

Plan of Correction ***Accept ([redacted] 11/19/2024)***

Violation occurred because prior Administrator failed to secure all training documentation for staff person D 2023 Training for Staff person D was unable to be located.
Business Office Manager to assign Relias Training/In person training to Staff person D to be completed by 11/30/24 to ensure that Staff person D has met the 12 hours of annual training per regulation 65e.
On 11/10/24 the Administrator Provided Education to Business Office Manager as to the annual training requirements for all staff per state regulations and utilization of the audit tool to track training hours monthly for all staff. On 11/10/24 the administrator educated staff person D as to his obligation to complete monthly training per requirements of regulation.
To prevent further violation, the Business Office Manager who will be responsible for ensuring compliance with training requirements per regulation effective 11/10/24 will audit monthly Relias training/in person training

65e - 12 Hours Annual Training (continued)

documentation to ensure staff completion and print Relias transcripts for training binder. Audit to be completed by 11/15/2024
The administrator effective 11/7/24 will do in person training will all personnel monthly according to annual training plan starting November 27th 2024 at homes monthly All Staff Meeting.
The administrator will review staff training audit tool monthly to ensure compliance with regulation effective 11/2024 and ongoing.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 02/14/2025)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
6. Safe management techniques.

Description of Violation

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

- *Medication self-administration training.*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Care for residents with dementia and cognitive impairments.*
- *Safe management techniques.*

Repeat Violation: 02/22/2024

Plan of Correction ***Accept [redacted] - 11/19/2024)***

Violation occurred because prior Administrator failed to secure all training documentation for staff person D 2023 Training for Staff person D was unable to be located.
Business Office Manager to assign Relias Training/In person training to Staff person D to be completed by 11/30/24 to ensure that Staff person D has met the 12 hours of annual training per regulation 65e.
On 11/10/24 the Administrator Provided Education to Business Office Manager as to the annual training requirements for all staff per state regulations and utilization of the audit tool to track training hours monthly for all staff. On 11/10/24 the administrator educated staff person D as to his obligation to complete monthly training per requirements of regulation.
To prevent further violation, the Business Office Manager who will be responsible for ensuring compliance with training requirements per regulation effective 11/10/24 will audit monthly Relias training/in person training

65f - Training Topics (continued)

documentation to ensure staff completion and print Relias transcripts for training binder. Audit to be completed by 11/15/2024
The administrator effective 11/7/24 will do in person training will all personnel monthly according to annual training plan starting November 27th 2024 at homes monthly All Staff Meeting.
The administrator will review staff training audit tool monthly to ensure compliance with regulation effective 11/2024 and ongoing.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] 02/14/2025)

65g - Annual Training Content

7. 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:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.

Description of Violation

Staff person D did not receive training in the following topics during training year 2023:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights*

Repeat Violation: 02/22/2024

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred because prior Administrator failed to secure all training documentation for staff person D 2023 Training for Staff person D was unable to be located.
The New Administrator provide training on 11/9/24 to Staff Person D on all topics outlined in annual training per regulation 65e to include Annual Fire safety by fire safety expert, Emergency Preparedness and Resident Rights.
On 11/10/24 the Administrator Provided Education to Business Office Manager as to the annual training requirements for all staff per state regulations and utilization of the audit tool to track training hours monthly for all staff. On 11/10/24 the administrator educated staff person D as to his obligation to complete monthly training per requirements of regulation.
To prevent further violation, the Business Office Manager who will be responsible for ensuring compliance with training requirements per regulation effective 11/10/24 will audit monthly Relias training/in person training

65g - Annual Training Content (continued)

documentation to ensure staff completion and print Relias transcripts for training binder. Audit to be completed by 11/15/2024

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented [redacted] - 02/14/2025)

81a - Accomodation

8. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home has not developed polices or procedures for use of bedside mobility devices. Residents #2 and #3 utilize bedside mobility devices.

Plan of Correction ***Directed [redacted] 11/19/2024)***

Violation occurred due to the community not having a bedside mobility device policy and procedure in place. Effective 11/7/2024 Administrator and Business Office Manager developed a home policy regarding the use of bedside mobility devices that follows the guidelines with state regulation 81a as outlined in the RGC 2600 regulations for a personal care home.
To prevent further violations community will only accept bedside mobility devices that meet the regulation and community policy. Community will educate families by 11/30/24 with literature as to the policy and what bedside mobility devices are acceptable.
Proposed Overall Completion Date: 11/30/2024

Directed Plan of Correction:

Immediately, the administrator or designee shall perform audits of resident rooms weekly for four weeks, then monthly to review for the presence of bedside mobility devices to ensure compliance with FDA guidelines, installation according to manufacturer's instructions, appropriateness of device, the resident's ability to use the device safely, and the physician/medical professional's recommendation for the use of the device. Any device found to be not compliant shall be secured or removed immediately.

Directed Completion Date: *12/21/2024*

Implemented [redacted] - 02/14/2025)

81b - Resident Personal Equipment

9. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

81b - Resident Personal Equipment *(continued)*

Description of Violation

Resident #2 has a bedside mobility device which is 10 inches wide and 20 inches high, exceeding the FDA guideline; however, the device is covered with a pillow case which comes loose when pulled up.

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred due to prior Director of Nursing not providing oversight as to the bedside mobility devices being utilized for residents to ensure they meet the FDA guidelines.
Resident #2 Bedside Mobility device has been removed effective 11/11/24 and to be replaced with FDA approved bedside mobility device and care planned accordingly by 11/22/24 pending family approval..
On 11/11/24 the Administrator educated the Resident Care Coordinator on regulation 81b and what is approved per regulation and home policy regarding mobility devices and the monthly audit process to be completed by the Resident Care Coordinator
To prevent further violations, the New Administrator to provide communication to all family members by 11/15/24, that all personal equipment and mobility devices need to be approved by homes Administrator and rehab provider to ensure it meets federal guidelines and resident safety per regulation prior to installation. Additionally, effective 11/11/24 the Resident Care Coordinator will do monthly room audits to ensure no unapproved bedside mobility devices have been installed on any resident bed. Administrator to review bedside mobility audit tool monthly effective 11/2024.

Proposed Overall Completion Date: 11/22/2024

Licensee's Proposed Overall Completion Date: *11/22/2024*

Implemented [redacted] - 02/14/2025)

82c - Locking Poisonous Materials

10. 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 10/17/2024 around 10:00 AM, the home's laundry room was unlocked, unattended, and accessible to residents. Present was a bottle of bleach, with a manufacture's label indicating "Keep out of reach of children...contact a poison control center or doctor immediately for treatment advice".

In the bathroom of resident room #102, a container of Suave deodorant was present with a warning label stating "call poison control if ingested".

Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 06/26/2024, 02/22/2024, 12/27/2024

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred because staff failed to secure poisonous materials in resident room during AM care on day of inspection.

82c - Locking Poisonous Materials (continued)

Administrator to provide training on regulation 82 C regarding poisonous materials to all staff starting 11/8/24 and completing the training by 11/27/24 at the homes All Staff Meeting.
Resident Care Coordinator continues to perform daily room sweeps to ensure all poisonous materials are secured and provide on the spot re-education/disciplinary action if items are found to be unsecured. Manager on Duty to perform daily room sweeps on weekend occurs daily and ongoing.
Administrator to review Poisonous Material Daily Room Check Audit sheets weekly effective 11/11/24 to ensure compliance.

Proposed Overall Completion Date: 11/27/2024

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented ([redacted] - 02/14/2025)

91 - Telephone Numbers

11. 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

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in Gold Finch nurse station.

Plan of Correction ***Accept [redacted] 11/15/2024)***

Violation occurred due to homes failure to assign staff to ensure emergency telephone numbers were posted near all community telephones.
Business Office Manager corrected immediately at time of inspection on 10/17/24 and posted the Emergency Telephone numbers in Goldfinch Nurses station.
To prevent further violations effective 11/11/24 the Resident Care Coordinator during daily rounds will ensure Emergency Numbers are posted at each phone station in the community.
Administrator will monitor weekly effective 11/11/24 to ensure Emergency Numbers remain posted.

Proposed Overall Completion Date: 11/11/2024

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

Implemented [redacted] - 02/14/2025)

96a - First Aid Kit

12. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the kitchen does not include an antiseptic and tweezers.

96a - First Aid Kit *(continued)*

Plan of Correction ***Accept (- 11/15/2024)***

Violation occurred because the home failed to have procedure in place for routinely checking first aid kits.
Interim ED replaced missing items in first aid kits on 11/6/24 and audited all first aid kits for compliance on 11/6/24
New Administrator Educated Resident Care Coordinator 11/11/24 regarding regulation 96a and utilizing monthly audit tool effective 11/11/24
To prevent further violations first aid kit audit tool will be utilized and the Resident Care Coordinator, and/or designees will do monthly audits to ensure compliance with regulation effective 11/11/2024.
The administrator will review audit tool monthly starting 11/11/24 to ensure compliance with regulation.

Proposed Overall Completion Date: 11/11/2024

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

Implemented (02/14/2025)

103h - Thawing Food

13. Requirements

2600.
103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

On 10/17/2024 at 12:07 PM, two cases of ground beef were being thawed in the service sink of the kitchen with no water in it.

Plan of Correction ***Accept (- 11/15/2024)***

Violation occurred because contracted Dining Service failed to ensure that the service sink was holding water for thawing the ground beef.
Administrator educated contracted dining service provider on 11/10/24 on the regulation, process and procedure regarding thawing meat.
To prevent further violations the administrator will do weekly routine sweeps of kitchen for 4 weeks to ensure proper thawing procedures are being followed starting 11/10/2024.

Licensee's Proposed Overall Completion Date: *12/02/2024*

Implemented - 02/14/2025)

107a - Emergency Preparedness

14. Requirements

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

Description of Violation

Staff person B, , does not have the emergency preparedness plan for the local municipality.

Plan of Correction ***Accept 11/15/2024)***

Violation occurred because prior Administrator did not have the emergency preparedness plan for the local

107a - Emergency Preparedness (continued)

municipality in which the home is located, in the home's Emergency Preparedness/Disaster binder.
New Administrator on 11/09/24 obtained the emergency preparedness plan for the local municipality in which the home is located, has read the plan and filed plan within the home's Emergency Preparedness Binder.
To prevent further violations the new Administrator will audit Emergency Binder bi-annually to ensure all documents per regulation are maintained effective 11/2024

Proposed Overall Completion Date: 11/11/2024

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

Implemented ([redacted] - 02/14/2025)

107b - Emergency Procedures

15. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include the following elements:

- *Contact information for each resident's designated person*
- *The home's plan to provide the emergency medical information for each resident that ensures confidentiality*
- *Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents*
- *Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs*
- *Alternate means of meeting resident needs in the event of a utility outage*

Plan of Correction ***Accept[redacted] - 11/15/2024)***

Violation occurred because prior Administrator did not update the homes emergency procedures and have them accessible in the emergency preparedness binder.
On 11/11/24 the Administrator and Business Office Manager reviewed documentation found relative to the Emergency Procedures and have updated them to reflect the missing components outlined in the violation for 107b.

107b - Emergency Procedures (continued)

To prevent further violations the new Administrator will audit Emergency Binder bi-annually to ensure all documents per regulation are maintained effective 11/2024.

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

Implemented [redacted] - 02/14/2025)

107d - Procedure Emergency Management Agency Submission

16. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home could not provide proof that the home's written emergency procedures had been submitted to the local emergency management.

Repeat Violation: 12/27/2023

Plan of Correction ***Directed [redacted] - 11/19/2024)***

Violation occurred because prior Administrator was not aware of the regulation.
New Administrator effective 11/7/24 contacted the homes Fire Protection and Life Safety consultant [redacted] with Atlantic Code Consultants on 11/11/24 to review home emergency preparedness plan and submit documentation to local emergency management by 11/22/24 as the homes Fire Protection and Life Safety consultant is currently out in the field until the week of 11/18/24.
To Prevent further violations Administrator will review home emergency preparedness plan, update plan accordingly and submit to local emergency management annually.
Proposed Overall Completion Date: 11/22/2024

Directed Plan of Correction:

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall create a tracking system to document and remind management staff of the dates when the emergency procedures are required to be submitted.

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall educate management staff responsible for the submission of documents to the EMA, as well as alternate management staff on the requirement to submit the emergency procedures annually, and the use of the tracking system.

Directed Completion Date: *11/29/2024*

Implemented [redacted] - 02/14/2025)

183e - Storing Medications

17. Requirements

2600.

183e - Storing Medications *(continued)*

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 10/17/2024 at 01:50 PM, an opened bottle of Latanoprost Ophthalmic Solution 0.005% was in the home's Gold Finch hall medication cart with an open date of 08/20/2024. According to the manufacturer's instructions, the eye drop should be discarded 6 weeks after opening.

Plan of Correction ***Accept ([redacted] - 11/15/2024)***

Violation occurred due to prior administrator who was also the director of nursing not having routine medication cart audits completed on med carts.
Resident Care Coordinator corrected violation at time of inspection on 10/17/24 by discarding the expired eye drops and reordered medication that arrive the evening of 10/17/24.
New Administrator educated Resident Care Coordinator on 11/11/24 and all med techs to be educated on regulation 183e Storage of Medication starting 11/11/24 and all training to be completed by 11/27/24.
To prevent further violations Resident Care Coordinator will perform weekly Med Cart Audits starting 11/18/2024. Administrator and Resident Care Coordinator will review med cart audit tool quarterly at quarterly Quality Assurance/Safety Meeting on 12/9/2024 to determine opportunities for additional med tech training.

Proposed Overall Completion Date: 11/27/2024

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented [redacted] - 02/14/2025)

187a - Medication Record

18. Requirements

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

Description of Violation

Resident #4 is prescribed Novolog Flexpen 100u/ml three times per day based on a sliding scale (200-250 = 2u, 251-200= 4u, 301-350 = 6u, 351-400 = 8u, >400 = 10u). The Medication Administration Record (MAR) indicates that this medication is administered (MAR) at 7:30am, 11:30am, and 4:30pm. However, the resident's October MAR does not indicate the insulin units administered on the following dates/times:

- *10/01/2024 at 4:30pm*
- *10/02/2024 at 4:30pm*
- *10/03/2024 at 4:30pm*
- *10/04/2024 at 7:30am and 4:30pm*
- *10/05/2024 at 7:30am, 11:30am and 4:30pm*
- *10/06/2024 at 7:30am, 11:30am and 4:30pm*
- *10/07/2024 at 11:30am and 4:30pm*
- *10/08/2024 at 4:30pm*
- *10/09/2024 at 11:30am and 4:30pm*
- *10/10/2024 at 11:30am and 4:30pm*

187a - Medication Record (continued)

- *10/11/2024 at 11:30am and 4:30pm*
- *10/12/2024 at 7:30am, 11:30am and 4:30pm*
- *10/13/2024 at 7:30am, 11:30am and 4:30pm*
- *10/14/2024 at 4:30pm*
- *10/15/2024 at 11:30am and 4:30pm*
- *10/16/2024 at 7:30am, 11:30am and 4:30pm and*
- *10/17/2024 at 4:30pm*

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred due to the prior Director of Nursing not recognizing that the dosage given for sliding scale insulin did not appear on the resident Medication Administration Record (MAR) for the resident.
On 11/05/24 the Resident Care Coordinator spoke to Quick Mar the Medication Administration Software tech department and to troubleshoot so that the dosage of sliding scale insulin given to residents on sliding scale insulin will show the medication administration record. It was appearing but has now disappeared Additional call to tech support for Quick mar place on 11/11/24 To be resolved by 11/15/24.
On 11/11/24 New Administrator educated the Resident Care Coordinator regarding the regulation and ensuring that dosages for those on sliding scale insulin are appearing on the Medication Administration Record
Resident Care coordinator and/or designee to review Medication Administration Record for all residents on sliding scale insulin weekly for 4 weeks starting 11/18/24 to ensure documentation meets the regulation. Administrator to review audit weekly starting 11/18/24 to ensure completion.

Proposed Overall Completion Date: 11/18/2024

Licensee's Proposed Overall Completion Date: *11/18/2024*

Implemented [redacted] - 02/14/2025)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #6 is prescribed Timolol Maleate 0.5% eye drop. However, this medication has not been administered to the resident since October 02, 2024 because the medication is not available in the home.

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred because prior Director of Nursing did not perform daily missed medication overview in quick mar the homes medication administration recording system.
The Resident Care Coordinator contacted Resident #6's physician on 10/18/24 and obtained new order for Resident 6's Timolol Maleate 0.5% eye drop. Resident #6's medication is now in house and being administered according to prescribers orders.

187d - Follow Prescriber's Orders (continued)

On 11/11/24 New Administrator educated the Resident Care Coordinator on regulation 187d and utilizing quick mar missed med report daily, to avoid further violations. Resident Care Coordinator to train All med-techs by 11/22/24 on reviewing the missed med dashboard prior to end of shift and to report all concerns/issues regarding medication to Resident Care Director immediately to be corrected.Training to include Following prescribers orders.

Administrator, Resident care coordinator and/or Director of Nursing to review missed med report weekly, and ongoing to ensure compliance effective 11/15/2024.

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented [redacted] - 02/14/2025)

20. Requirements

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

Description of Violation

Resident #4 is prescribed Novolog Flexpen 100u/ml three times per day based on a sliding scale (200-250 = 2u, 251-200= 4u, 301-350 = 6u, 351-400 = 8u, >400 = 10u). The Medication Administration Record (MAR) indicates that this medication is administered (MAR) at 7:30am, 11:30am, and 4:30pm. Additionally, the resident receives this medication, 8 units 3 times per day with meals. On 10/07/2024 at 8:11am, staff member E documented that the resident "refused to take meds, [redacted] the meds in his right front pants pocket". However, the MAR documents this medication as administered.

Resident #4 is prescribed Aspirin 81mg tablet, Divalproex Sodium 125mg, and Vitamin B1 100mg. On the following dates, Staff member E documented in the notes that the resident refused these medication and put them in the resident's right pocket. However, the MAR documents these medications as administered.

- *10/02/24 at 7:57am*
- *10/03/2024 at 7:48am*
- *10/04/2024 at 8:11am*
- *10/07/2024 at 8:00am*
- *10/09/2024 at 8:03am*
- *10/10/2024 at 8:06am*
- *10/11/2024 at 8:08-8:09am*
- *10/14/2024 at 8:06am*
- *10/16/2024 at 8:29am*
- *10/17/2024 at 7:55am*

Resident #5 is prescribed Oxycodone 5 mg 1/2 tab twice a day. This medication was not signed out on the narcotics control record at 07:30 AM on 10/11/2024. However, the resident's October Medication Administration Record indicates that this medication was administered by staff member E. There is no discrepancy in the narcotic pill count.

187d - Follow Prescriber's Orders (continued)

Resident #7 is prescribed Levothyroxine 75 MCG tablet in the morning; however, the resident was not administered this medication on 10/07/2024.

Plan of Correction ***Directed [redacted] - 11/19/2024)***

Violation occurred because Med tech did not observe resident taking their prescribed medication and or did not dispence medication per prescribers orders.
On 11/11/24 New Administrator educated the Resident Care Coordinator on regulation 187d and utilizing quick mar missed med report daily, to avoid further violations. Resident Care Coordinator to train All med-techs by 11/22/24 on regulation and policy that all residents receiving medications must be observed taking the medication to properly document medication as being administered, proper narcotic log procedures to including both quick mar and log book documentation, following prescribers orders and reviewing the missed med dashboard orders prior to end of shift and to report all concerns/issues regarding medication to Resident Care Director immediately to be corrected.
Med tech training to include Following prescriber orders
Administrator, Resident care coordinator and/or Director of Nursing to review missed med report and Narcotic log weekly, and ongoing to ensure compliance effective 11/15/2024.
Proposed Overall Completion Date: 11/30/2024

Directed Plan of Correction:

In addition to the home's plan above, starting within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall observe a medication pass for each staff weekly for four weeks, then monthly for six months. Documentation of observations shall be retained and provided to the department.

Directed Completion Date: *12/21/2024*

Implemented ([redacted]/14/2025)

190a - Completion Medication Course

21. Requirements

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

Description of Violation

Staff person D, whose most recent annual practicum was completed [redacted]1/2023, administered Esitalopram 20 MG, Ezetimibe 10 MG, and etc. to resident #7 on 10/12/2024 and 10/13/2024.

The home could not provide staff person F's medication administration training record, who administered Levothyroxine 75 MG tablet to #7 at 6:00 AM on 10/2, 10/8, 10/9, 10/13, 10/14, 10/15, 10/16/2024.

Plan of Correction ***Accept ([redacted] 11/15/2024)***

Violation occurred due to prior Administrator not securing Staff Person D's Med tech Paperwork within the Med tech binder.
New Administrator upon cleaning out prior administrators desk found and secured Staff Person D's Annual

190a - Completion Medication Course (continued)

Practicum completed 02/2024
On 11/11/24 Administrator educated the Business Office Manager on proper procedures for maintaining records and on ensuring compliance with regulation 190a.
Effective 11/11/24 Business Office Manager will maintain Med Tech binder and audit quarterly for compliance effective 11/24. Additionally the Administrator will review med tech binder at Quarterly Quality and Safety Meeting effective at next quality and safety meeting on 12/9/24.

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

Implemented [redacted] - 02/14/2025)

190b - Insulin Injections

22. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person D, who has not completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to resident #6 at 8 PM on 10/01,10/04, 10/06,10/09, 10/15, 10/16/2024.

Staff person F, who has not completed a Department-approved diabetes patient education program within the past 12 months, checked resident #6's blood glucose level at 06:00 AM on 10/04, 10/08, 10/09, 10/11/10/13, 10/14, 10/16 10/17/2024.

Plan of Correction ***Accept ([redacted] - 11/15/2024)***

Violation occurred because prior administrator did no secure documentation for staff person D. Staff person D's Diabetic Training Certificate could not be located.
New Administrator has scheduled Staff person D for Diabetic training with a certified diabetic trainer to be held on 11/15/24 and will include training for all med techs.
On 11/11/24 Administrator educated the Business Office Manager on proper procedures for maintaining records and on ensuring compliance with regulation 190a.
Effective 11/11/24 Business Office Manager will maintain Med Tech binder and audit quarterly for compliance effective 11/24. Additionally the Administrator will review med tech binder at Quarterly Quality and Safety Meeting effective at next quality and safety meeting on 12/9/24.

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented [redacted] 02/14/2025)

234a - Admission Support Plan

23. Requirements

2600.

234a - Admission Support Plan *(continued)*

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted]/2024. However, the resident's initial support plan was completed on 03/15/2024.

Repeat Violation: 06/26/2024

Plan of Correction ***Accept [redacted]/15/2024)***

Violation occurred because the resident care coordinator at the time did not complete support plan with the 72 hours of admission.
Resident Care coordinator complete resident Support Plan on
On 11/11/24 the Administrator educated the resident care coordinator as to the regulations regarding Resident Support Plans being completed within 72 hours of admission.
To prevent further violation. Administrator will review all Support Plans effective 11/11/24 for all new admissions to ensure time completion

Proposed Overall Completion Date: 11/11/2024

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

Implemented[redacted] - 02/14/2025)

234b - Support Plan Needs Elements

24. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [redacted]024, for resident #2 does not address the use of a bedside mobility device.
The support plan, dated [redacted]024, for resident #3 does not address the use of half-rails on the bed.

Plan of Correction ***Accept [redacted]/15/2024)***

Violation occurred due to prior Director of Nursing did not care plan appropriately and accurately to needs of the resident for use of bedside mobility device.
Resident care coordinator obtained documentation from Physical Therapist with Fox Rehab on 11/11/24 as to why the resident needs the use of a bedside mobility device for resident #2 and resident #3 and will do an addendum to Resident #2 and #3 care plan to be completed by 11/13/24.
Administrator educated the Resident Care Coordinator on 11/11/24 as to the proper documentation/addendum to the support plan requirements per regulation 234a
Administrator and/or Director of Nursing will provide quarterly review effective 12/24 to ensure addendums are added for those who may have started using bedside mobility devices after 11/11/24.

Proposed Overall Completion Date: 11/13/2024

Licensee's Proposed Overall Completion Date: *11/13/2024*

234b - Support Plan Needs Elements *(continued)*

Implemented [redacted] - 02/14/2025)

236 - Staff Training

25. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secured Dementia Care Unit (SDCU), did not have any training in dementia care during the 2023 training year.

Repeat Violation: 02/22/2024

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Violation occurred because prior Administrator failed to secure all training documentation for Staff Person D 2023 Training for Staff person D was unable to be located.
On 11/10/2024 New Administrator Educated the Business Office Manager and the Resident Care Coordinator on the training requirements per regulation and procedures going forward to ensure staff training meets regulation requirements and process for maintaining such records.
Business Office Manager to audit staff training binder and Relias training to ensure staff completion and print Relias transcripts for training binder starting 11/10/24 audit to be completed by 11/15/24.
New Administrator and or Designee effective November 27th 2024 at All Staff Meeting will do in person training with all personnel monthly according to annual training plan and documentation to be secured and retained in Yearly Staff Training binder.
Effective 11/10/24 Business office person will perform quarterly audit on staff training transcripts to ensure compliance with regulations. Initial Audit to start 11/10/24 and to continue quarterly to ensure by year end all staff have the required training per state regulation. Business office manager will alert the Administrator as to any staff members who have not completed necessary training requirements.

Proposed Overall Completion Date: 11/27/2024

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented [redacted] - 02/14/2025)

252 - Record Content

26. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #3's record does not include a photograph of the resident that is no more than 2 years old. The one on file was dated [redacted]/2022.

Plan of Correction ***Accept ([redacted] 11/15/2024)***

Violation occurred because the community failed to have procedure in place for updating resident profile pictures.

252 - Record Content (continued)

New Administrator obtained current picture of Resident #3 on [redacted]4 and it was added to residents Record on 11/9/24.
On 11/11/2024 the Administrator educated the Business office manager and the Resident Care Coordinator on regulation 252 and the importance of having a current photo of resident within the resident record.
Resident Care Coordinator to Audit Resident Medical Charts and complete audit by 11/15/24. Updated Photos to be secured for each resident and placed in medical chart to be completed by 11/22/2024.
Resident Care Director and/or Designee will ensure that updated resident photos are completed annually in November each year and document on Resident Photo Audit tool when completed.
The administrator will review audit tool annually effective December 2024 for compliance.

Proposed Overall Completion Date: 11/22/2024

Licensee's Proposed Overall Completion Date: *11/22/2024*

Implemented [redacted] 02/14/2025)

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

February 14, 2025

[redacted], [redacted]
BRISTOL HOUSE MEMORY CARE LLC
[redacted]

RE: BRISTOL HOUSE MEMORY CARE
2527 BRISTOL ROAD
WARRINGTON, PA, 18976
LICENSE/COC#: 14458

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/30/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* **License #**: *14458* **License Expiration**: *12/14/2024*

Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*

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

Administrator

Name: [redacted]

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*

Address: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *12/30/2024*

Inspection Dates and Department Representative

12/30/2024 - On-[redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *48* **Residents Served**: *32*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *31*

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

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

12/30/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/23/2025*

01/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/24/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/19/2025*

Inspections / Reviews *(continued)*

01/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/24/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/31/2025*

02/14/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/24/2025*

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

183c - Refrigerated Meds Locked

1. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 12/30/24 at approximately 2pm, the door to a staff office was left unlocked in the secure unit. A bottle of Milk of Magnesia and discontinued cough syrup were found unlocked and unattended on the desk.

Plan of Correction ***Accept ([redacted] 01/14/2025)***

Violation occurred because Director of Nursing and Resident Care Coordinator failed to properly secure the door to their office where medication was being held prior to being destroyed.
On 1/13/2025 Executive Director Educated the Director of Nursing and Resident Care Coordinator on the regulation 183c and 183e for proper storage of medication and promptly destroying expired medications.
Director of Nursing educated medication technicians on 1/9/25 on regulation and proper procedures relative to regulation 183c and 183e of the RCG.
To prevent further violations locking mechanism on Nursing Office Door will be replaced with automatic lock mechanism so that door when closed will automatically lock. Door Handle ordered and to be replaced by 1/20/2025.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented [redacted] - 02/14/2025)

183e - Storing Medications

2. 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 12/30/24, The following medication cards were observed to have a punctured blister foil with the medication still present in the spot:

- *Resident #1's Solifenacin 5mg tab in slot #14*
- *Resident #2's Acetaminophen 325mg tab in slot #1*

Plan of Correction ***Accept [redacted] - 01/21/2025)***

Violation occurred due to possible overcrowding of medication cart whereas corners of Blister pack card are puncturing the backs of other blister pack cards.
On 1/9/2025 Medication technicians were educated on regulation 183c and 183e and the process of destroying medications if punctured blister foil is discovered with medication still intact.
To prevent further violations Med Cart audits to be conducted weekly to inspect all blister packs to ensure the blister foil is intact. Med Cart Audits to be completed Weekly Effective 1/13/2025 and ongoing by Med Techs.
Effective 1/13/2025 Weekly audits to be completed by Director of Nursing and/or Resident Care Coordinator to ensure continued compliance. Audits to continue for 8 weeks starting week of 1/13/2025

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *01/15/2025*

Implemented [redacted] - 02/14/2025)