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

June 2, 2025

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

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/29/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BELLE REVE SENIOR LIVING CENTER* **License #**: *22513* **License Expiration**: *05/15/2025*

Address: *404 EAST HARFORD STREET, MILFORD, PA 18337*

County: *PIKE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL BELLE REVE OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/31/2022* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *121* **Waking Staff**: *91*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/29/2025*

Inspection Dates and Department Representative

04/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *86* **Residents Served**: *79*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *40* **Residents Served**: *39*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *79*

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

Have Mobility Need: *42* **Have Physical Disability**: *0*

Inspections / Reviews

04/29/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/26/2025*

05/27/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/01/2025*

Inspections / Reviews *(continued)*

06/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2025*

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

65g - Annual Training Content

1. 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:

Description of Violation

Staff person A did not receive training in Fire safety by a fire safety expert or staff trained by FSE during 2024 training year.

Plan of Correction ***Accept (- 05/27/2025)***

Immediate Corrective Action:
The fire expert completed training with Staff A on 5/5/25.

Additional Corrective Actions:
The Business Office Director will audit all employee files to verify annual fire safety training was completed by 6/1/25. The fire expert will provide any needed fire safety training by 6/15/25.

Ongoing Quality Assurance Actions:
A monthly audit will be completed by the Business Office Director to track and verify annual fire safety training, starting 6/1/25. Ongoing compliance and findings from the monthly audits will be reviewed as part of the Quarterly QA Meetings, beginning 6/1/25.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented (- 06/02/2025)

185a - Implement Storage Procedures

2. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1's glucometer displayed a reading on 4/20/25 at 6:12 P.M. of 343. Resident's Medication administration record had no documentation of a reading for the 4:00 P.M. scheduled reading.

Plan of Correction ***Accept (- 05/27/2025)***

Immediate Corrective Action:
On 4/29/25, Resident #1's physician and family were made aware of the error, and it was reported to the department on 4/30/25. The physician made no changes or recommendations to the resident's plan of care.

Additional Corrective Actions:
All Med Techs will complete the Shift Change Responsibility form at the change of each shift, which includes verification the glucometer and MARs match. Any discrepancies will be reported immediately to the Wellness Nurse or Executive Director. A weekly audit will be completed by the Wellness Nurse to confirm the Shift Change Responsibility form is being completed, beginning 6/1/25.

Ongoing Quality Assurance Actions:

185a - Implement Storage Procedures (continued)

The Wellness Nurse will have ongoing compliance and findings from the weekly glucometer and MAR checks to be reviewed as part of the Quarterly QA Meetings, beginning 6/1/25.

Licensee's Proposed Overall Completion Date: *06/01/2025*

Implemented ([redacted] - 06/02/2025)

187d - Follow Prescriber's Orders

3. Requirements

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

Description of Violation

Resident #1 has an order to receive 4 units of Humulin N injectable U-100KWP when resident's blood glucose reading is 150-200. On 4/25/25 resident #1's glucometer documented a reading of 181. However, the resident's medication administration record documented the resident was administered 10 units of Humulin N injectable U-100KWP.

Resident #2 has an order to receive 4 units of Humalog 100 u/ml kwikpen before meals. However, the resident's medication administration record documented the resident was administered 15 units of Humalog on 4/22/25 at 4:00 P.M. and 18 units of Humalog on 4/25/25 at 4:00P.M..

Resident #2 has an order to receive 16 units of Humalog 100u/ml kwikpen when resident's blood glucose reading is 301-350.
On 4/14/25 resident #2's 4:00P.M. glucometer documented a reading of 303. However, the resident's medication administration record documented the resident was administered 25 units of Humalog on 4/14/25 at 4 P.M..

Resident #2 has an order to receive 18 units of Humalog 100u/ml kwikpen when resident's blood glucose reading is 351-400.
On 4/22/25 resident #2's 4:00 P.M. glucometer reading documented 379. However, the resident's medication administration record documented the resident was administered 4 units of Humalog on 4/22/25 at 4:00 P.M..

On 4/25/25 resident #2's 4:00 P.M. glucometer reading documented 364. However, the resident's medication administration record documented the resident was administered 4 units of Humalog 4/25/25 at 4:00 P.M..

Plan of Correction ***Accept ([redacted] - 05/27/2025)***

Immediate Corrective Action:
On 4/29/25 Resident #2's physician and family were made aware of the errors, and they were reported to the department on 4/30/25. The physician made no changes or recommendations to the resident's plan of care.

Additional Corrective Actions:
The Wellness Nurse will audit all residents' charts who require a sliding scale for insulin to assure the required units match the prescriber's order for the month of May by 6/6/25. Any errors will be reported to the physician, family, and department by 6/6/25. A weekly audit will be completed by the Wellness Nurse to identify any residents whose insulin units required are documented correctly to match the prescriber's orders starting 6/6/25.

187d - Follow Prescriber's Orders (continued)

Ongoing Quality Assurance Actions:
The Wellness Nurse will have ongoing compliance and findings from the weekly glucometer and MAR checks to be reviewed as part of the Quarterly QA Meetings, beginning 6/1/25.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented ([redacted] - 06/02/2025)

225c - Additional Assessment

4. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's assessment, dated [redacted] indicates the resident uses an enabler bar the assessment does not indicate if there are any risks associated with the device, the resident's ability to use the device safely for the intended purpose

Plan of Correction ***Accept ([redacted] - 05/27/2025)***

Immediate Corrective Action:
The Occupation Therapist will identify and document in Resident #3's support plan if they may use a bedside mobility device safely without any associated risks by 6/1/25.

Additional Corrective Actions:
The Occupation Therapist will audit all residents' charts for those with bedside mobility devices to ensure the required documentation for resident use, associated risk or safety is documented in the resident's support plan by 6/6/25, per regulatory guideline and HSL policy. A monthly audit will be completed by the Wellness Nurse to identify any residents who desire a bedside mobility device are seen by the Occupation Therapist to assure the required documentation for resident use, associated risk or safety is documented in the resident's support plan starting 6/6/25.

Ongoing Quality Assurance Actions:
All residents with bedside mobility devices will be reviewed during care plan meetings, to ensure all appropriate people are involved in the discussion for the need of the device, and to ensure all required questions and concerns have been addressed. The Wellness Nurse will have ongoing compliance and findings from the monthly bedside mobility device audit to be reviewed as part of the Quarterly QA Meetings, beginning 6/1/25.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented ([redacted] - 06/02/2025)