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

August 26, 2025

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

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/10/2025 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**: *05/15/2026*

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**: *134* **Waking Staff**: *101*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/10/2025*

Inspection Dates and Department Representative

07/10/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *86* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *unit* **Capacity**: *40* **Residents Served**: *40*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *52* **Have Physical Disability**: *0*

Inspections / Reviews

07/10/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/04/2025*

08/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/22/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/22/2025*

Inspections / Reviews *(continued)*

08/26/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/22/2025*

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

42b - Abuse

1. Requirements

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

Description of Violation

On [redacted], Resident [redacted] was found in Resident [redacted] room by Staff Person A. Resident [redacted] and [redacted] were lying in bed. Resident [redacted] blouse and pants were open, and Resident [redacted] had their right hand in Resident [redacted] pants. Resident [redacted] was fully clothed and was verbally directed out of Resident [redacted] room. Both residents reside in the secured dementia unit and are unable to consent.

Plan of Correction ***Accept [redacted] 08/08/2025)***

Immediate Corrective Actions:
On 06/17/2025, when Resident [redacted] was found in Resident [redacted]s room by Staff Person A, the two residents were redirected to separate areas by staff, with Resident [redacted] leaving the room with Staff Person A. Both residents were assessed, and they had no injuries, nor were they in distress. Neither resident was able to recall the incident, and both denied having any concerns. Responsible parties and physicians were notified on 6/17/25 as well. Private duty for Resident [redacted] started at 5:45 PM, after dinner until bedtime on 6/17/25, and continued daily from 9am to 5pm beginning 6/18/25. Since this incident, there have been no attempts by Resident [redacted] to go into any residents' rooms. This was the first and only incident of this kind for both residents.

Additional Corrective Actions:
All Resident Care Staff were assigned the Relias Training on Resident Abuse on 8/1/25, as a review, to be completed by 8/31/25. The Resident Life Director will continue to coordinate Structured Day programming to provide a variety of activities to keep memory care residents engaged, and direct care staff will assist with encouraging their attendance throughout the day. Reminders to do so will be communicated in the communication log in TabulaPro by 8/8/25.

Ongoing Quality Assurance Actions:
The Executive Director will round the Daybreak neighborhood weekly to audit residents' rooms and common areas, to ensure residents are safe and interacting appropriately. Rounds will be recorded in the communication log in TabulaPro, starting the week of 8/4/25. The Executive Director will address any concerns immediately. Audits, activities, and ongoing compliance will be reviewed as part of the Quarterly QA Meetings, beginning with the Q3 Review in October 2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 08/26/2025)

131f - Fire Extinguisher Inspection

2. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

131f Fire Extinguisher Inspection *(continued)*

Description of Violation

At 9:55 a.m. fire extinguisher #22 in East 2 wing did not have a tag to indicate that it had been inspected by a fire safety expert.

Plan of Correction ***Accept [redacted] 08/05/2025)***

Immediate Corrective Actions:
On 7/10/25 during the survey it was identified that fire extinguisher #22 in East 2 wing did not have a tag to indicate that it had been inspected by a fire safety expert. All fire extinguishers were inspected on 6/1/25 and tags were in place. It is not known when it may have been removed or fallen off the extinguisher. The violation was corrected on 8/1/25 when Cintas inspected all the fire extinguishers in the community and put a new tag on #22.

Additional Corrective Actions:
The Executive Director/Fire Safety Expert will train the management team by 8/15/25 on the requirement that all fire extinguishers shall be inspected and approved annually by a fire safety expert, and must have tags to show the completion date of the inspection. A weekly audit will be completed by the Executive Director, who will audit 3 fire extinguishers each week and ensure there is a tag on each extinguisher. These audits will begin the week of 8/4/25 and will be documented by the Executive Director to track that all extinguishers are checked in the course of doing sample audits.

Ongoing Quality Assurance Actions:
The Executive Director will address any concerns immediately. Audits and ongoing compliance will be reviewed as part of the Quarterly QA Meetings, beginning with the Q3 Review in October 2025.

Licensee's Proposed Overall Completion Date: *08/15/2025*

Implemented [redacted] - 08/22/2025)