Department of Human Services
Bureau of Human Service Licensing

April 26, 2021

[redacted] REGIONAL DIRECTOR
CARE HSL HARLEYSVILLE OPCO LLC
765 SKIPPACK PIKE
HERITAGE SENIOR LIVING
BLUEBELL, PA 19422

RE: BIRCHES AT ARBOUR SQUARE
691 MAIN STREET
HARLEYSVILLE, PA, 19438
LICENSE/COC#: 14266

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/02/2021, 03/03/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *BIRCHES AT ARBOUR SQUARE* **Licen e #**: *14266* **Licen e Expiration Date**: *03/27/2021*
Addre : *691 MAIN STREET, HARLEYSVILLE, PA 19438*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: *2155413700* **Email**:

Legal Entity

Name: *CARE HSL HARLEYSVILLE OPCO LLC*
Address: *765 SKIPPACK PIKE, HERITAGE SENIOR LIVING, BLUEBELL, PA, 19422*
Phone: *2155413700* **Email**:

Certificate(s) of Occupancy

Type: *R-3* **Date**: *03/10/2009* **Issued By**: *Lower Salford Township*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *97* **Waking Staff**: *73*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *03/03/2021*

Inspection Dates and Department Representative

03/02/2021 - On-Site:
03/03/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *63*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *25* **Residents Served**: *23*

Hospice

Current Re ident : *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*
Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *34* **Have Physical Disability**: *1*

Inspections / Reviews

03/02/2021 - Full

Lead In pector: ██████ **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/21/2021*

3/24/2021 POC Submi ion

Lead Reviewer: ██████ **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/26/2021*

4/26/2021 - Document Submission

Lead Reviewer: ██████ **Follow-Up Type:** *Not Required*

17 - Record Confidentiality

1. **Requirements**

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident s designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident s power of attorney for health care or health care pro y or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 03/02/2021 during the initial walk-through of the building, three narcotics sign-out books (two on the 2nd floor med-carts and one on the SDCU med-cart) were unlocked, unattended, and accessible.

Plan of Correction **Accept**

What: On 3/2/21, during the initial walk-through of the building during the annual survey, 3 narcotics sign-out books were unlocked, unattended, and accessible. The violation was corrected immediately during the initial walk-through when the books were removed from the med carts.
Who: The Resident Care Director or designee will train the Management Team and Med Techs on Plan of Correction-Confidential Resident Records (Attachment A) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment C).
When: Training to be completed by 4/23/21
How: Resident Care Director or Designee will assure narcotics sign-out books and any other confidential resident information are not unlocked, unattended, and/or accessible on med carts.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit of med carts to assure there is no confidential resident information unlocked, unattended, and/or accessible. Results will be documented on the Weekly Clinical Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

82a Poisonous Materials

1. **Requirements**

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

There were several spray bottles marked in black ink as air-freshener in the SDCU's closet which is used as laundry space.

82a - Poisonous Materials *(continued)*

Plan of Correction **Accept**

What: On 3/2/21, there were several spray bottles marked in black ink as air-freshener in the SDCU's closet which is used as laundry space. The violation was corrected on 3/2/21 when the improperly labeled bottles were removed from the Daybreak Neighborhood.
Who: The Executive Director or designee will train the Management Team and then Department Directors will train their departments on Plan of Correction-Poisonous Materials in Original Labeled Containers (Attachment D) and Environmental Audit Tool Weekly (Attachment E) and complete Sign-in Sheet (Attachment F).
When: Training to be completed by 4/23/21
How: All Team Members will assure all poisonous materials in spray bottles are in their original, labeled containers.
Ongoing: The Housekeeping Director or Designee will conduct a weekly audit of the Daybreak and Personal Care Neighborhoods to assure all poisonous materials in spray bottles are in their original, labeled containers and document on Weekly Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

82c - Locking Poisonous Materials

1. **Requirements**

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Repeat Violation

There were multiple spray bottles including Febreze air-freshener and anti-bacterial disinfectant and disinfectant wipes in the unlocked closet of the SDCU. Most of the SDCU residents have been assessed incapable of recognizing and using poisons safely.

Repeated Violation: 11/19/2020

82c - Locking Poisonous Materials *(continued)*

Plan of Correction **Accept**

What: On 3/2/21, there were multiple spray bottles including Febreze air-freshener and anti-bacterial disinfectant and disinfectant wipes in the unlocked closet of the SDCU. Most of the SDCU residents have been assessed incapable of recognizing and using poisons safely. The violation was corrected on 3/2/21 when the closet was locked in the Daybreak Neighborhood.
Who: The Executive Director or designee will train the Management Team and then Department Directors will train their departments on Plan of Correction-Poisonous Materials Locked (Attachment G) and Environmental Audit Tool Weekly (Attachment E) and complete Sign-in Sheet (Attachment H).
When: Training to be completed by 4/23/21
How: All Team Members will assure all poisonous materials are locked and not accessible to residents in Daybreak.
Ongoing: The Housekeeping Director or Designee will conduct a weekly audit of the Daybreak Neighborhood to assure poisonous materials are locked and document on Environment Audit Tool Weekly (Attachment E). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

85a - Sanitary Conditions

1. **Requirements**

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

Description of Violation

On 03/03/2021 around 10:00 AM, the toilet bowl in the bathroom of resident room # was ringed with black mold. There was a strong odor of urine in the hallway near resident room and the resident's room itself. Around lunch time, there was a strong odor of urine in the SDCU hallway near resident room #

Plan of Correction **Accept**

What: On 3/3/21 around 10AM, the toilet bowl in the bathroom of resident room # was ringed with black mold. There was a strong odor of urine in the hallway near resident room # and the resident's room itself. Around lunch time, there was a strong odor of urine in the hallway near resident room . This violation was corrected when: The toilet in # was cleaned on 3/3/21. The used depends in were removed from the bathroom trash can on 3/3/21. The carpet was extracted in # on 3/4/21.
Who: The Executive Director or designee will train the Management Team and then Department Directors will train their departments on Plan of Correction-Maintaining Sanitary Conditions (Attachment I) and Environmental Audit Tool Weekly (Attachment E) and complete Sign-in Sheet (Attachment J).
When: Training to be completed by 4/23/21
How: All Team Members will make sure sanitary conditions are maintained.
Ongoing: The Housekeeping Director or Designee will conduct a weekly audit of 5 random resident toilets, trash cans, and carpet in their apartment for sanitary conditions and document on Environment Audit Tool Weekly (Attachment E). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

85a - Sanitary Conditions *(continued)*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

131f - Fire Extinguisher Inspection

1. **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.

Description of Violation

The fire extinguisher in the home's van has not been inspected by a fire safety expert since December 2019.

Plan of Correction **Accept**

What: On 3/3/21 The fire extinguisher in the home's van has not been inspected by a fire safety expert since December 2019. The violation was corrected when the extinguisher was inspected on 3/10/21.
Who: The Maintenance Director or designee will train the Management Team and Van Driver on Plan of Correction-Fire Extinguisher Inspection (Attachment K) and Weekly Vehicle Maintenance Inspection (Attachment L) and complete Sign-in Sheet (Attachment M).
When: Training to be completed by 4/23/21
How: The Maintenance Director will assure the fire extinguisher in the bus is inspected annually.
Ongoing: The Maintenance Director or Designee will conduct a weekly audit of the bus to assure the fire extinguisher inspection is valid and document on Weekly Vehicle Maintenance Inspection (Attachment L). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

141b1 - Annual Medical Evaluation

1. **Requirements**

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Repeat Violation

Resident #1's most recent medical evaluation was completed on 01/28/2021. The resident's previous medical evaluation was completed on 04/26/2019.

Repeat Violation: 11/19/2020

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction **Accept**

What: On 3/2/21 it was found during the survey that a resident's most recent medical evaluation was completed on 1/28/21. The resident's previous medical evaluation was completed on 4/26/19. This violation will be corrected when the next DME is completed annually prior to 1/28/22 or for a significant change before that date.
Who: The Resident Care Director or designee will train the Clinical Leadership Team and Med Techs on Plan of Correction-Annual Medical Evaluation (Attachment N) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment O).
When: Training to be completed by 4/23/21
How: The Clinical Leadership team will assure a new medical evaluation is completed at least annually.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit of all medical evaluations due that week requiring a new annual evaluation and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

182c - Medication Administration

1. **Requirements**

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
3. Remove the medication from the original container.

Description of Violation

Resident #2 is prescribed Vimpat 50 mg in the morning and Vimpat 100 mg in the evening. There are separate cards for each dose. On 01/26/2021 at 06:30 PM, the nurse who administered resident #2's evening Vimpat 100 mg failed to check the label and took 2 tabs from the resident's morning Vimpat 50 mg card.

Plan of Correction **Accept**

What: On 3/3/21, it was identified that a resident was prescribed Vimpat 50 mg in the morning and Vimpat 100 mg in the evening. There are separate cards for each dose. On 1/26/21 at 6:30 AM, the nurse who administered the evening Vimpat 100 mg failed to check the label and took two tablets from the resident's morning Vimpat 50 mg card. It was corrected when the resident received the next administered dose from the correct card.
Who: The Resident Care Director or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medication Administration (Attachment P) and Cart Audit and Med Cart Education Tool (Attachment Q) and complete Sign-in Sheet (Attachment R).
When: Training to be completed by 4/23/21
How: The Med Techs and Clinical Leadership team will assure prescriber's orders match what residents are administered.
Ongoing: The Resident Care Director or Designee will conduct a weekly cart audit to check that orders match what is administered to residents and document on Cart Audit (Attachment Q). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

182c - Medication Administration *(continued)*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

185b - Medication Procedures

1. **Requirements**

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.

Description of Violation

The controlled substance sign-out sheet for resident #3's Oxycodone 5 mg does not show when the med was received (60 counts) and when and why one was destroyed, leaving 59 counts.

Plan of Correction **Accept**

What: On 3/3/21, it was identified that the controlled substance sign-out sheet for a resident's Oxycodone 5mg does not show when the medication was received (60 count) and when and why one was destroyed, leaving 59 counts. This was corrected on 3/8/21 when all med techs involved were counseled on medication procedures for destroying medications properly.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medication Procedures (Attachment S) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment T).
When: Training to be completed by 4/23/21
How: The Clinical Leadership team and Med Techs will assure controlled substance sign-out sheets for residents are completed accurately.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit to check 3 resident controlled substance sign-out sheets for accuracy and completeness and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

187b - Date/Time of Medication Admin.

1. **Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Morphine Sulfate 0.25 mg syringe every 2 hours as needed. The med was signed out at 01:00 PM on 02/25/2021 and at 12:05 AM and 04:00 AM on 02/28/2021. However, resident #4's February 2021 medication administration record (MAR) does not include the initials of the staff person who administered these medications.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction **Accept**

What: On 3/3/21, it was identified that a resident was prescribed Morphine Sulfate 0.25 mg syringe every 2 hours as needed. The med was signed out at 1PM on 2/25/21 and at 12:05 AM and at 4AM on 2/28/21. However, the resident s February 2021 medication administration record (MAR) does not include the initials of the staff person who administered these medications. This was corrected on 3/11/21 when all Med Tech involved were counseled on the rights of medication administration.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction Date/Time of Med Administration (Attachment U) and Clinical Audit Tool Weekly (Attachment B) and complete Sign in Sheet (Attachment V).
When: Training to be completed by 4/23/21
How: The Med Techs and Clinical Leadership team will assure medication administered to residents is accurately reflected in the residents MAR.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit of 3 resident s MAR to check that all medication given has the Med Tech s initials are in the MAR and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

224a - Preadmission Screen Form

1. **Requirements**

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department s preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #5 s preadmission screening form, dated 08/11/2020, does not include a determination that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form *(continued)*

Plan of Correction **Accept**

What: On 3/3/21, it was identified that a resident's preadmission screening form, dated 8/11/20, does not include a determination that the needs of the resident can be met by the services provided by the home. This was corrected on 3/18/21 when the Team Member who completed the prescreen updated the form to reflect that the home can meet the needs of the resident by the home.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Preadmission Screen Form (Attachment W) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment X).
When: Training to be completed by 4/23/21
How: The Med Techs and Clinical Leadership team will assure prescreens include a determination that the home can meet the needs of the resident by the services provided.
Ongoing: The Resident Care Director or Designee will complete a weekly audit of preadmission screen forms for all residents who moved into the community that week and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

225a - Assessment 15 Days

1. **Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Repeat Violation

Resident #5 was admitted on [redacted]; however, the resident's assessment was not completed until 08/31/2020.

Repeat Violation: 11/19/2020

Plan of Correction **Accept**

What: On 3/2/21, it was identified that a resident admitted on [redacted] did not have an assessment completed until 8/31/20. This will be corrected when the annual or significant change assessment is completed.
Who: The Resident Care Director or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Timeframe for Support Plan Completion (Attachment Y) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment Z).
When: Training to be completed by 4/23/21
How: The Clinical Leadership team will assure a new resident assessment is completed timely after admission.
Ongoing: The Resident Care Director or Designee will conduct a random weekly audit of all residents who were admitted in the last week to make sure their assessment has been completed in 15 days for Personal Care and 72 hours for Memory Care residents and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

225a - Assessment 15 Days *(continued)*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

227d - Support Plan Medical/Dental

1. **Requirements**

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment and support plan (RASP) for resident #6, dated 01/14/2021, is blank on section 2 (medical/dental needs). The resident has medical conditions including hypertension, high cholesterol, paroxysmal, and diabetes according to the DME dated 01/14/2021.

Plan of Correction **Accept**

What: On 3/2/21, it was identified that a current resident's assessment and support plan (RASP) dated 1/14/21 is blank on section 2 (medical/dental needs). The resident has medical conditions including hypertension, high cholesterol, paroxysmal, and diabetes according to the DME dated 1/14/21. This will be corrected when the annual or significant change assessment is completed with a new medical evaluation.
Who: The Resident Care Director or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Support Plan No Blanks (Attachment AA) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment BB).
When: Training to be completed by 4/23/21
How: The Clinical Leadership team will assure resident assessments are completed in all sections with no blanks when a resident has a signif cant change or annual assessment.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit of all residents who had a new assessment completed that week for no blanks and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.

231b - Medical Evaluation

1. **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 #7 was admitted to the SDCU on [redacted] however, the resident's medical evaluation was completed on 01/19/2021.

231b - Medical Evaluation *(continued)*

Plan of Correction **Accept**

What: On 3/2/21, it was identified that a resident was admitted to the SDCU on [redacted] However, the medical evaluation was completed on 1/19/21. This will be corrected when the annual or significant change assessment is required and a new medical evaluation is needed to be completed with the assessment.
Who: The Resident Care Director or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medical Evaluation (Attachment CC) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment DD).
When: Training to be completed by 4/23/21
How: The Clinical Leadership team will assure when a resident moves into our Daybreak Neighborhood the DME is completed prior to admission.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit of DME for newly admitted residents who moved in that week to ensure the medical evaluation was completed prior to admission and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *03/19/2021*

Document Submission **Implemented**

All required team members trained by 4/23/21. See attached sign in sheet.