Department of Human Services
Bureau of Human Service Licensing

May 23, 2022

[redacted]
CARE HSL HARLEYSVILLE OPCO LP
[redacted]

RE: THE BIRCHES AT HARLEYSVILLE
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 licensing inspections on 04/06/2022 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations 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: *THE BIRCHES AT HARLEYSVILLE* **License #**: *14266* **License Expiration**: *03/27/2023*

Address: *691 MAIN STREET, HARLEYSVILLE, PA 19438*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *215-541-3701* **Email**: [redacted]

Legal Entity

Name: *CARE HSL HARLEYSVILLE OPCO LP*

Address: *660 SENTRY PARKWAY, SUITE 220, HERITAGE SENIOR LIVING, BLUEBELL, PA, 19422*

Phone: *2155413700* **Email**: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *04/06/2022*

Inspection Dates and Department Representative

04/06/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *64*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *25* **Residents Served**: *20*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

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

Have Mobility Need: *32* **Have Physical Disability**: *1*

Inspections / Reviews

04/06/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/22/2022*

05/23/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/25/2022*

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 is prescribed Levothyroxine 137 mcg 1 tablet 1 time daily. However, Resident #1 was not administered Levothyroxine from 3/1/22 through 3/29/22.

Plan of Correction ***Accept***

4-6-22

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

What: "Resident #1 is prescribed Levothyroxine 137 mcg 1 tablet 1 time daily. However, Resident #1 was not administered Levothyroxine from 3/1/22 through 3/29/22."

Who: The omission of this medication was noted upon a medication review that the homes Resident Care Director completed with the hospital when the resident went out for an unrelated issue.

When: Upon the resident being sent out to the hospital and being admitted for an unrelated health issue on [redacted]

How: The home immediately notified the residents Physician and Daughter/POA of the discovery to make them aware of this finding. The home also reported this omission via Reportable Incidents as outlined in 2600.16 general requirements. After an investigation was launched into the matter, the Resident Care Director was able to note that this error happened due to human error at the pharmacy level. The pharmacy had duplicate orders on the resident's profile, one in Brand Name and one in Generic Name. When this was noted by the homes Resident Care Director, the physician wrote an order to keep the Generic on profile and discontinue the Brand. After getting that order, the pharmacy sent the discontinue in the system to remove the Brand and once approved by the homes Resident Care Director, both orders fell off of the resident's medication profile since they were linked. All current medication approvers received training on 187.d from the departments Regulatory Compliance Guide on 5/16/22 (see Attachment A).

Ongoing: The homes Resident Care Director and/or Designee will continue to monitor the system on an ongoing basis to ensure that ongoing compliance is maintained and repeat issues of this nature do not occur. At present time, only the homes Nursing Management and Nurses are the disciplines approved to review any orders, and in order to prevent an error such as this happening again, a second check after approval will be conducted. Any concerns or issues will be reviewed, rectified immediately, and any patterns or trends will be reviewed at the Quarterly Quality Assurance Meeting and communicated with the pharmacy. As any future members of the community team are trained or added to the Designee role they will receive the same oral training from the homes Administrator from the Regulatory Compliance Guide and the same oral training on the homes medication approval procedures, to ensure ongoing compliance at all times.

Completion Date: *05/18/2022*