

Department of Human Services
Bureau of Human Service Licensing

November 16, 2022

[REDACTED]
CARE HSL HARLEYSVILLE OPCO LP
[REDACTED]
[REDACTED]
[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 review on 10/17/2022, 11/04/2022 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

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

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:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: CARE HSL HARLEYSVILLE OPCO LP
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 182 **Total Daily Staff:** 292 **Waking Staff:** 219

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 11/17/2022

Inspection Dates and Department Representative

10/17/2022 - On-Site: [REDACTED]
11/04/2022 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 85 **Residents Served:** 74

Secured Dementia Care Unit

In Home: Yes **Area:** Memory Care **Capacity:** 34 **Residents Served:** 28

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 74
Diagnosed with Mental Illness: 2 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 36 **Have Physical Disability:** 3

Inspections / Reviews

10/17/2022 - Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/14/2022

Inspections / Reviews (*continued*)

11/14/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/16/2022

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 11/19/2022

11/15/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/16/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 11/20/2022

11/16/2022 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/16/2022

Reviewer: [REDACTED]

Follow-Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/22, resident #1 was in a wheelchair and rolled down the parking lot in front of the home and fell from the wheelchair. The resident sustained injuries and 911 was called. The resident was transported to the hospital [redacted] [redacted] subsequently was admitted from [redacted] 22 through [redacted] 22. The home did not report this incident to the Department.

Repeat Violation: 1/12/22 et al.

Plan of Correction

Accept ([redacted] - 11/15/2022)

10-17-22

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in 2600.15 (relating to abuse reporting covered by law).

What: "On 9/1/22, resident #1 was in a wheelchair and rolled down the parking lot in front of the home and fell from the wheelchair. The resident sustained injuries and 911 was called. The resident was transported to the hospital [redacted] subsequently was admitted from [redacted] /22 through [redacted] 22. The home did not report this incident to the Department".

Who: The home followed up with the hospital and it was determined that the resident did not sustain a serious injury and was admitted [redacted] for observation [redacted]. This information was shared with the residents responsible party and PCP, but it was determined by the home at that time, since there was no serious injury as outlined in 2600.16.(a)(3) that there was no reporting need.

When: Upon inspection on [redacted]-22, Representative Eberhart made the homes Executive Director aware of the need to report the incident based on the information on reporting in Appendix B from the RCG.

How: The home immediately reported this via Reportable Incidents as outlined in 2600.16(c) (see Attachment A). The homes Executive Director provided training the following day on the information shared at time of inspection with the homes Resident Care Director and Daybreak Director. The training came directly from the departments Regulatory Compliance Guide (see Attachment B).

Ongoing: The homes Resident Care Director and Daybreak Director will continue to monitor when residents are sent out to the hospital on an ongoing basis to ensure that ongoing compliance is maintained and repeat issues of this nature do not occur. Only the homes Resident Care Director, Daybreak Director and Executive Director submit reportable incidents at this time, but 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 on the homes procedures. Any concerns or issues will be reviewed, rectified immediately, and any patterns or trends will be reviewed at the Quarterly Quality Assurance Meeting to ensure ongoing compliance at all times.

16c - Written Incident Report (continued)

Update: 11/15/2022

Please indicate the date and title of the person who reported this incident to the Department following the inspection.

The homes Resident Care Director made the written report to the department on 10/17/22 following the inspection, and can be seen in (Attachment A).

Please provide the date that training was provided.

The homes Executive Director completed the training on 10/18/22 (Attachment B).

Please indicate the specific actionable steps, start date, frequency, and duration that the Resident Care Director and Daybreak Director will monitor residents sent out to the hospital.

The homes Resident Care Director and/or Memory Care Director get notified by community staff whenever there is an incident where a resident has to go out to the hospital. After this inspection on 10/17/22 and the additional training on 10/18/22, each discipline continues to track when and if a resident goes out to the hospital and when they are admitted. This information is shared with the department head team daily each week during morning stand up, and any questions from either discipline on call for the weekend are directed to the homes Executive Director for review. This policy will continue on an ongoing daily basis in order for the home to remain compliant with reporting as outlined in the RCG.

Please indicate the title of the person responsible for reviewing concerns at the QA meetings, the start date, frequency, and duration of this task.

The homes Executive Director is the person responsible for reviewing concerns at the QA meetings. The homes last QA meeting was held in October 2022 and the homes next QA meeting is scheduled for January of 2023. The homes meetings are held on a quarterly ongoing basis each year.

Licensee's Proposed Overall Completion Date: 11/15/2022

Implemented [REDACTED] - 11/16/2022)