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

April 5, 2024

[redacted], MANAGER
DRI HEARTIS YARDLEY LLC
[redacted]

RE: HEARTIS YARDLEY
255 OXFORD VALLEY ROAD
YARDLEY, PA, 19067
LICENSE/COC#: 14772

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/05/2024, 02/06/2024 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: *HEARTIS YARDLEY* **License #**: *14772* **License Expiration**: *09/14/2024*

Address: *255 OXFORD VALLEY ROAD, YARDLEY, PA 19067*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *DRI HEARTIS YARDLEY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/01/2020* **Issued By**: *Lower Makefield township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *139* **Waking Staff**: *104*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/06/2024*

Inspection Dates and Department Representative

02/05/2024 - On-Site: [redacted]

02/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *100*

Special Care Unit

In Home: *Yes* **Area**: *Generations* **Capacity**: *21* **Residents Served**: *20*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *100*

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

Have Mobility Need: *39* **Have Physical Disability**: *0*

Inspections / Reviews

02/05/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/01/2024*

03/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/04/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/12/2024*

Inspections / Reviews *(continued)*

03/18/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/04/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/04/2024*

04/05/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/04/2024*

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

65a Fire Safety-1st day

1. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted], did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

Plan of Correction ***Accept ([redacted] - 03/18/2024)***

The Fire Safety-1st day training form for Staff Member A was not found in the employee file. Staff Member A will be re-trained by 3/8/24 on Fire Safety-1st day by the Building Services Director or designee.
Business Office Director or designee will conduct an audit of employee files to determine if any Fire Safety- 1st day trainings are out of compliance by 3/31/24.
Any staff member found out of compliance will be mandated to attend the next scheduled new hire orientation where the Fire Safety-1st day training is conducted by the Building Services Director or designee. New Hire Orientations are held 2 times a month.
To prevent non-compliance issues going forward.
The ED or designee will review and sign off on all Fire Safety-1st Day, 1st 40 hours Rights/Abuse, and Annual training record form indicating all trainings have been presented, completed, and acknowledged by the employee and the trainer as an ongoing process and to ensure all training documents are on file and present in the employee file.

Proposed Overall Completion Date: 03/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 04/05/2024)

65e Rights/Abuse 40 Hours

2. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

65e Rights/Abuse 40 Hours *(continued)*

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

Staff person A completed his/her 40th scheduled work hour on [redacted]. However, this staff person did not complete training in the following topics: resident rights, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Plan of Correction ***Accept [redacted] - 03/18/2024)***

The Rights/Abuse 40 hours training form for Staff Member A was not found in the employee file. Staff Member A will be re-trained by 3/8/24 on Rights/Abuse by the Business Office Director or designee.
Business Office Director or designee will conduct an audit of employee files to determine if any Rights/Abuse trainings are out of compliance by 3/31/24.
Any staff member found out of compliance will be mandated to attend the next scheduled new hire orientation where Rights/Abuse 40 hours training are conducted by the Executive Director. New Hire Orientations are held 2 times a month.
To prevent non-compliance issues going forward.
The ED or designee will review and sign off on all Fire Safety-1st Day, 1st 40 hours Rights/Abuse, and Annual training record form indicating all trainings have been presented, completed, and acknowledged by the employee and the trainer as an ongoing process and to ensure all training documents are on file and present in the employee file.
Proposed Overall Completion Date: 03/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] 04/05/2024)

65j Annual training content

3. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
3. Resident rights.

Description of Violation

Staff person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert., resident rights during training year January 2023 to December 2023.

65j Annual training content (continued)

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert., emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708), Falls and accident prevention during training year January 2023 to December 2023.

Plan of Correction ***Accept ([redacted] - 03/18/2024)***

Staff member A and B did not attend the Annual 2023 training in Fire Safety, Emergency Preparedness Procedures, Resident Rights, OAPSA, and Falls and Accident Prevention training to maintain compliance for 2023.
Staff members A and B will be mandated to attend a New Hire Orientation completed by 3/31/24 conducted by the Building Services Director, Resident Care Director, and the Executive Director or designee.
Business Office Director or designee will conduct an employee file audit for year 2023 for 2800.65j compliance.
Any staff member missing annual training for 2023 will be mandated to attend a new hire orientation schedule for the month. New Hire Orientations are held 2 times a month.
To prevent non-compliance issues going forward.
The ED or designee will review and sign off on all Fire Safety-1st Day, 1st 40 hours Rights/Abuse, and Annual training record form indicating all trainings have been presented, completed, and acknowledged by the employee and the trainer as an ongoing process and to ensure all training documents are on file and present in the employee file.
Proposed Overall Completion Date: 03/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 04/05/2024)

81b Resident equip – good repair

4. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 2/6/2024, a bedside mobility device was present on resident 1's bed, with openings measuring 16" inches by 12" inches between the top and the middle of the enabler. The enabler was not securely attached to the frame of the bed.

On 2/6/2024, a bedside mobility device was present on resident 2's bed, with openings measuring 13" inches by 9" inches between the top and the middle of the enabler. The enabler was not securely attached to the frame of the bed.

On 2/6/2024, a bedside mobility device was present on resident 3's bed, with openings measuring 16" inches by 12" inches between the top and the middle of the enabler. The enabler was not securely attached to the frame of the bed.

Plan of Correction ***Accept ([redacted] - 03/07/2024)***

The bedside mobility device for residents #1, #2, and #3 were rechecked and are secured through straps that are

81b Resident equip – good repair (continued)

attached to the frame of the bed.
The residence will search for alternative devices/measures that will provide support to resident and their bed mobility needs. Residents #1, #2, and #3 will be re assessed by Fox Therapy for resident need for the device, continual intended use and risks associated with the use of the device, along with the resident's ability to use the device safely for the intended purposes. Any bed mobility device used will be made secure to the bedframe of the bed.
Going forward, Therapy services will identify the specific device to be used and whether a cover of the device is required to meet FDA guidelines. If appropriate the device will be installed and maintained according to the manufacturer's instructions.
If utilized the Resident Care Director, Resident Care Coordinator, Generations Program Director, or designee will ensure the device is clean, in good repair and free from hazards.
The RCD, RCC, GPD, or designee will add the use of the device to the resident's support plan and conduct periodic assessments on proper installation and maintenance to ensure the device remains appropriate for resident use.
Any device found unsafe or out of compliance will be removed from use and the resident will be re assessed for the need for a replacement and fitted for the most appropriate device.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 04/05/2024)

91 Telephone Numbers

5. Requirements

2800.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire Department on or by the telephone in Resident 2's bedroom.

There are no emergency telephone numbers to include the nearest hospital and fire Department on or by the telephone in Resident 4's bedroom.

Plan of Correction ***Accept ([redacted] - 03/07/2024)***

Emergency telephone numbers were placed in the living units of residents #2 and #4 the same day of the inspection completed on 2/6/24.
The Building Services Director or designee will conduct an audit of resident living units to ensure all occupied units have emergency telephone numbers available in plain sight for emergency purposes. The Audit will be concluded by 3/15/24. Any units missing emergency numbers will be corrected upon discovery.
The Director of Sales and Marketing or designee will issue all new residents moving into new units an emergency telephone numbers plaque or card for emergencies as an on going practice.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Implemented ([redacted] - 04/05/2024)

101j7 Lighting/operable lamp

6. Requirements

101j7 Lighting/operable lamp *(continued)*

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 2 does not have access to a source of light that can be turned on/off at bedside.

Resident 5 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 03/07/2024)***

Upon discovery on date of inspection, lamps were added into resident #2 and #5 rooms that can be turned on at bedside.
Additionally, Housekeeping is assigned to go into every apartment to provide a weekly service, these staff members were re-trained by the Building Services Director on 2/29/2024 on ensuring there is lighting/operable lamp at the bedside in each resident unit.
The housekeeping staff will report directly to the Building Services Director as soon as possible if an apartment does not have an operable light source at the bedside so one can be added immediately to the resident living unit.
On 2/29/2024, the weekly Housekeeping Cleaning Checklist has been updated to include this task.
Building Services Director will monitor this directly for the next 30 days.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented ([redacted] - 04/05/2024)

103g Storing food

7. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The Ice Cream in the ice cream freezer was opened and unsealed.

Plan of Correction ***Accept ([redacted] - 03/07/2024)***

The POC includes a weekly food storage audit, to be completed by the Culinary Services Director, beginning the week of 2/25/2024, and continuing through the week of 3/24/2024. In addition, staff training on food storage standards will be completed by culinary staff in the above-mentioned time frame.
Staff training on the subject will ensure all staff is aware of the regulations and the steps needed to meet them. On 2/28/2024 Culinary Services Director conducted a Re-Education of Dining Staff on proper storage of food regarding covering, labels, dates, correct storage of food products in the kitchen and storage areas.
The responsibility to fully cover and properly store food is shared by the entire culinary staff, and in this particular case, is to be maintained and monitored by the Front of House Supervisor and Waitstaff. This process will be monitored by the FOH Supervisor and CSD to ensure compliance is met at all times.

Proposed Overall Completion Date: 03/24/2024

Licensee's Proposed Overall Completion Date: *03/24/2024*

Implemented ([redacted] - 04/05/2024)

105g Dryer lint removal

8. Requirements

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 2/6/2024, there was an approximate 1/4-inch accumulation of lint in the lint trap of the dryer located in the laundry room on the 1st floor. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] - 03/07/2024)***

Upon discovery of lint in the 1st FL dryer lint trap, the lint was removed immediately at the time of inspection on 2/6/2024. Additionally, all other dryers were checked for lint at the time of inspection with no additional findings of accumulation.
A re-training will be completed by 3/18/2024 by the Building Services Director with all care staff, that it is their responsibility to clean the lint trap after every use.
Additionally, Building Services has and will continue to check all dryers and complete an in-house cleaning as outlined in assigned weekly TELS task checklist,
All dryer vents are serviced by a 3rd party provider on a semi-annual basis and the Building Services Director will maintain that schedule and document as necessary.
Building Services Director will monitor this process directly for the next 30 days ending 4/18/2024.

Proposed Overall Completion Date: 04/18/2024

Licensee's Proposed Overall Completion Date: *04/18/2024*

Implemented [redacted] - 04/05/2024)

183d Current medications

9. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On [redacted] prescribed for resident 1, was in the medication cart; however, the medication was discontinued on [redacted].

Plan of Correction ***Accept [redacted] - 03/18/2024)***

Discontinued medication for Resident 1 was removed from the cart and returned to the pharmacy in accordance with pharmacy medication return practices. Beginning week of 3/4/2024 Resident Care Director will conduct weekly cart audits for 1 month to ensure discontinued medications are removed from the med carts.
Any discontinued medications found will be destroyed/returned to pharmacy as per appropriate methods in accordance with 2800.183d.
RCD or designee will review the Med Tech audit tool and follow up on any findings. RCD or designee will complete one med cart audit on a weekly rotation of four med carts for four weeks.
The Med Cart Audit tool has been revised to indicate that all medications are currently available, expired medications are/have been removed and refills requested, and that discontinued medications are/have been

183d Current medications (continued)

removed from the cart.

Licensee's Proposed Overall Completion Date: *04/16/2024*

Implemented [redacted] - 04/05/2024)

187d Follow prescriber's orders

10. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 1 is prescribed [redacted] However, this medication was not administered to resident 1 because the medication was not available in the residence.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

Resident #1 is currently out at the hospital upon return to facility the medication will be ordered and administered as prescribed by the physician. Resident Care Director, Resident Care Coordinator, Generations Program Director, or designee will perform a mart to cart audit 1 time weekly for 1 month beginning 3/4/24 to ensure all medications are present and available for administration to resident as prescribed by the physician.
Any medication not available for administration the RCD, RCC, GPD, or designee will be immediately contact the physician and request an order for the medication. All med techs will be re trained on the proper notification to the RCD, RCC, GPD, or designee when a medication is not available for administration to a resident. Training to be concluded by 4/4/24.
RCD or designee will review the Med Tech audit tool and follow up on any findings. RCD or designee will complete one med cart audit on a weekly rotation of four med carts for four weeks.
The Med Cart Audit tool has been revised to indicate that all medications are currently available, expired medications are/have been removed and refills requested, and that discontinued medications are/have been removed from the cart.

Licensee's Proposed Overall Completion Date: *04/16/2024*

Implemented [redacted] - 04/05/2024)

227c Final support plan - revision

11. Requirements

2800.
227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident 6 support plan has not been reviewed on a quarterly basis; the last review was completed on [redacted]

Plan of Correction ***Accept [redacted] - 03/07/2024)***

Quarterly reviews had been conducted for the appropriate periods and not present in the chart at the time of the inspection. Updated quarterly reviews for resident #6 for July and October of 2023 and January 2024 are current and place in resident chart.
Resident Care Director, Resident Care Coordinator, Generations Program Director, or designee will review support

227c Final support plan revision (continued)

plans on a quarterly basis as per the Eldermark (Electronic Health Record) system populates their due periods. Support plan will be identified in writing as the quarterly review period and signed by the assessor as appropriate. The RCD, RCC, GPD, or designee will conduct an audit of support plans to ensure compliance with 2800.227c by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] 04/05/2024)