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

April 15, 2024

[redacted], COO
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 review on 02/28/2024, 02/29/2024 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: *THE BIRCHES AT HARLEYSVILLE* **License #**: *14266* **License Expiration**: *03/27/2024*

Address: [redacted]

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

Administrator

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

Legal Entity

Name: *CARE HSL HARLEYSVILLE OPCO LP*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I 1* **Date**: *11/12/2021* **Issued By**: *Lower Salford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/29/2024*

Inspection Dates and Department Representative

02/28/2024 On Site: [redacted]

02/29/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *34* **Residents Served**: *34*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *80*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *48*

Have Physical Disability: *1*

Inspections / Reviews

02/28/2024 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/24/2024*

Inspections / Reviews *(continued)*

03/25/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/05/2024*

04/15/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2024*

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

81b - Resident Personal Equipment

1. Requirements

2600.
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 2/29/2024, Resident 1 had an enabler bar that measured 13" wide and 15" high. The enabler bar was not secured to the bed frame per manufactures instructions.

On 2/29/2024, Resident 2 had an enabler bar that measured 12" wide by 15" high. The enabler bar was not secured to the bed frame per manufactures intructions.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

Immediate Corrective Actions: On the date of inspection, 2/29/2024, the homes Executive Director asked the homes Maintenance Director to secure Resident 1 and Resident 2 enablers bars to each of their beds. The homes Maintenance Director secured each bar to the bed with straps that attached to each of the residents bed frames. This was verbally communicated by the home to the lead inspector on site that day at time of inspection.

Additional Corrective Actions: The home followed up with both Resident 1 and Resident 2 responsible parties and shared the need to further secure each enabler bar to the bed frames with bolts as per manufactures instructions to ensure that the devices were free of hazards. Both Resident 1 and Resident 2 responsible parties agreed and the homes Maintenance Director secured both residents enabler bars securely to the frames of their beds. The homes Executive Director met with the Regional Director for FOX Rehab, the homes rehabilitation partner on 3/12/24, and verbally relayed the expectations regarding enabler bars and installation of them with him. On 3/13/24, the homes Executive Director shared the link for another additional option that the department has been suggesting via email with the Regional Director for FOX Rehab, so that he could review with his team. This link was shared at time of inspection by the lead inspector with the homes Executive Director.

Ongoing Quality Assurance Actions: The Executive Director will ensure that the homes Bedside Mobility Device Policy is implemented and maintained. The homes Executive Director will ensure that all residents that currently have a Bedside Mobility Device have them secured to their bed frames following manufactures instructions. FOX Partners in the home will notify the homes Resident Care Director and Executive Director of any additional residents that they recommend enabler bars for, and moving forward will communicate the link provided by the department as the preferred enabler bar for procurement. This will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/15/2024)

82c - Locking Poisonous Materials

2. 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 Violation

Purell Hand Santizer

82c - Locking Poisonous Materials (continued)

, with a manufacture's label indicating "to contact poison control", was unlocked, unattended, and accessible to residents in memory care. Not all the residents of the home, including memory care residents, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

Immediate Corrective Actions: On the date of inspection, 2/29/2024, the homes Memory Care Director removed the Purell Hand Sanitizer from the kitchen area in the homes memory care neighborhood and placed it into the locked cabinets in the area of the home.

Additional Corrective Actions: The homes Memory Care Director and/or Resident Care Director have checked the homes secured neighborhoods using the daily walk through checklist to ensure that all items used by staff during meal times are then stored safely away after the meal has completed. On days that neither discipline is in the community, the homes Executive Director and/or Manager on Duty have continued to follow this procedure. On March 7, 2024 education on this regulation was provided to the homes care staff that service the residents of the homes secured neighborhoods by the homes Resident Care Director.

Ongoing Quality Assurance Actions: The homes Memory Care Director, Resident Care Director, Executive Director and/or Manager on Duty will use the daily walk through checklist to ensure compliance. Verbal education will be provided to staff when needed. Patterns, trends, and findings will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/15/2024)

125b - Combustible Restrictions

3. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 2/28/2024, a can of butane was unlocked, unattended, and accessible to resident(s) garden house memory care area.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

Immediate Corrective Actions: On the date of inspection, 2/29/2024, the homes Memory Care Director removed the can of butane from the unlocked cabinet in the homes garden level memory care that was left due to human error after a community family event and it was removed from the home.

Additional Corrective Actions: The home will ensure that after any future family events that all materials are removed from resident areas, and stored in areas that are inaccessible to the residents. On March 7, 2024 education on this regulation was provided to the homes care staff that service the residents of the homes secured neighborhoods by the homes Resident Care Director to ensure understanding of regulation and prevent reoccurrence.

125b Combustible Restrictions (continued)

Ongoing Quality Assurance Actions: The homes Management Team will inspect all areas of the home, including the homes secured neighborhoods after family events to ensure compliance, using the daily walk through checklist. Patterns, trends, and findings will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/15/2024)

183d - Prescription Current

4. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] prescribed for Resident 3, was in the home's medication cart; however, the medication expired on [redacted].

On [redacted], Resident 4's [redacted] label reads to use by [redacted]. The medication remained in the cart.

Plan of Correction ***Accept ([redacted] - 03/25/2024)***

Immediate Corrective Actions: On the date of inspection, 2/29/2024, the homes Resident Care Director removed both Resident 3 and Resident 4 medications from the cart and they were destroyed. Both medications were reordered and delivered from the homes pharmacy the same day.

Additional Corrective Actions: On March 7, 2024 education on this regulation was provided to all of the homes Medication Administration staff by the homes Resident Care Director. Education was from the Regulatory Compliance Guide and included removal of medications that are expired.

Ongoing Quality Assurance Actions: The homes Resident Care Director will review the Weekly Medication Audit Forms after they are completed. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/15/2024)

185a - Implement Storage Procedures

5. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [redacted] Staff Person A walked away and left the medication care unlocked in the garden house memory care area.

185a Implement Storage Procedures (continued)

On [redacted], Resident 5's glucometer was not calibrated properly. At [redacted] the glucometer read [redacted]

On [redacted] Resident 6's glucometer was not calibrated properly. At [redacted] the glucometer read [redacted].

Plan of Correction ***Accept ([redacted] - 03/25/2024)***

Immediate Corrective Actions: On the date of inspection, 2/28/2024, the homes Memory Care Director locked the medication cart at time of the safety walk through with the inspector. The Memory Care Director followed up with Staff Person A, who had left it unlocked due to human error, and the need to immediately assist a resident in the homes garden level memory care neighborhood. Staff Person A was provided with additional education by the homes Resident Care Director on the date on inspection. On the date of the inspection, 2/29/2024, the homes Resident Care Director recalibrated Resident 5 and Resident 6 glucometers, which had not had the time changed due to daylight savings time.

Additional Corrective Actions: On March 7, 2024 education on this regulation was provided to all of the homes Medication Administration staff by the homes Resident Care Director. Education was from the Regulatory Compliance Guide. Staff person A was also present for this education.

Ongoing Quality Assurance Actions: The homes Resident Care Director will review the Weekly Medication Audit Forms after they are completed, and ensure Change of Shift Responsibilities are completed. The homes Executive Director will provide second checks each daylight savings time on an ongoing basis to ensure that each resident who uses a glucometer are calibrated with the proper time. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/15/2024)

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident 7 is prescribed [redacted]. However, resident 7 was administered [redacted]. The administration time should be [redacted].

Plan of Correction ***Accept [redacted] - 03/25/2024)***

Immediate Corrective Actions: Upon learning of Resident 7 receiving medication prior to the time it was prescribed on 2/15, 2/16 and 2/17, the homes Resident Care Director provided training the following day on 3/1/2024 to the two Medication Administration staff that were responsible for administration on the dates in question.

Additional Corrective Actions: On March 7, 2024 education on this regulation was provided to all of the homes

187d - Follow Prescriber's Orders (continued)

Medication Administration staff by the homes Resident Care Director. Education was from the Regulatory Compliance Guide. The two above mentioned staff persons were also present for this repeat education.

Ongoing Quality Assurance Actions: The homes Resident Care Director will use the EMAR Dashboard to review medication administration process and documentation and provide oversight to all staff. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/15/2024)

224a - Preadmission Screen Form

7. 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 10 was admitted to the home on [redacted]; however, the resident's preadmission screening form was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 03/25/2024)***

Immediate Corrective Actions: Resident 10 took financial possession on [redacted], but did not physically move into the home until 2/15/24. Although the home did complete a pre-admission screen prior to the resident taking possession of the room, a new form was completed prior to physical move in to ensure that screening was completed within 30 days of move in.

Additional Corrective Actions: On March 1, 2024 education on this regulation was provided by the homes Executive Director to the homes Resident Care Director and Memory Care Director, as they are the only two current disciplines in the home that come pre-admission screenings other than the homes Executive Director. Education was from the Regulatory Compliance Guide. A note was made in Resident 10's chart by the homes Executive Director noting deficiency on this form should this resident be selected in future inspections.

Ongoing Quality Assurance Actions: The homes Executive Director review all pre-admission screenings that are completed to ensure compliance. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings, beginning again in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] 04/15/2024)