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

January 16, 2025

DRI/HEARTIS BUCKS COUNTY LLC

RE: HEARTIS BUCKS COUNTY
945 YORK ROAD
WARMINSTER, PA, 18974
LICENSE/COC#: 14855

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/26/2024, 09/27/2024, 10/04/2024, 10/15/2024, 10/18/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HEARTIS BUCKS COUNTY* **License #**: *14855* **License Expiration**: *03/13/2025*

Address: *945 YORK ROAD, WARMINSTER, PA 18974*

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

Administrator

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

Legal Entity

Name: *DRI/HEARTIS BUCKS COUNTY LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *10/18/2024*

Inspection Dates and Department Representative

09/26/2024 - On-Site:
09/27/2024 - Off-Site:
10/04/2024 - Off-Site:
10/15/2024 - Off-Site:
10/18/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *47*

Special Care Unit

In Home: *Yes* **Area**: *Generations* **Capacity**: *30* **Residents Served**: *12*

Hospice

Current Residents: *xx*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *25* **Have Physical Disability**: *0*

Inspections / Reviews

09/26/2024 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/07/2024*

Inspections / Reviews *(continued)*

11/07/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow Up Type: *POC Submission* **Follow Up Date:** *11/12/2024*

11/15/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date:** *12/06/2024*

01/16/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

5a1 DHS access

1. Requirements

2800.

5.a. The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:

1. Agents of the Department.

Description of Violation

While reviewing a resident's progress notes onsite on [redacted] an agent of the Department came upon an entry entered by direct care staff A, which needed some clarification. Multiple calls and voicemail messages were made to/left for staff A on [redacted] and [redacted]. The residence's administrator was asked on [redacted] to instruct the staff to return the call as well; however, staff A never responded.

Plan of Correction ***Accept [redacted] - 11/15/2024)***

Upon request of the agent of the department, the administrator did in fact contact the staff person A via text message notifying them of the request to speak with the BHSL representative on [redacted] regarding a bureau investigation. Again on [redacted] the administrator contacted staff person A after receiving notification via phone from the bureau representative that staff person A had not contacted the representative as requested. Based on this fact violation 5a was given.

To prevent delayed, late, or non-compliance with 2800.5a the administrator will ensure all requests for information, records, and communication will be immediately presented or accessed by the residence. Beginning 11/8/24 to ensure compliance the administrator or designee will follow up with staff persons via phone and email and require the employee to report to the home to comply with an interview request. Documentation of communication will be kept. Employee policy updated on 11/8/24 by VP of Clinical Services to reflect the employee requirement to communicate with the department when not present in the home. The administrator or designee will educate staff persons of the residence on regulation 2800.5a and the policy update by November 30, 2024.

At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 01/16/2025)

65a Fire Safety-1st day

2. 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.

65a Fire Safety-1st day *(continued)*

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics:
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.

Repeat violation: 04/15/2024

Plan of Correction ***Accept [redacted] 11/15/2024)***

Staff person B was hired on [redacted] and did go through the new hire orientation program to include training on regulation 2800.65a on 7/23/24. However, this documentation was not present in the associate file. Due to a subsequent personnel issue the associate is no longer employed by the residence.
The administrator or designee will re-educate the Building Services Director to document the 1st day orientation training relating to regulation 2800.65a by 11/15/24. The administrator or designee will audit associate files to ensure all 1st day-Fire Safety training are documented and placed in the associate's file by 11/30/24. Any files found not incompliance will be brought to compliance by re-training associates by 11/30/24 and documentation noted the correction is due to auditing for plan of correction and dated appropriately. Beginning 11/15/24 the Administrator or designee will audit new employee files weekly for 4 weeks for continued compliance.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 01/16/2025)

65e Rights/Abuse 40 Hours

3. 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:

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.

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

Description of Violation

Staff person B, who completed 40th scheduled work hour sometime in late July did not complete training in the following topics:
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.

Plan of Correction ***Accept - 11/15/2024)***

Staff person B was hired on and did go through the new hire orientation program to include training on regulation 2800.65e beginning on 7/23/24. However, this documentation was not present in the associate file upon inspection. Due to a subsequent personnel issue the associate is no longer employed by the residence.
The administrator or designee will re educate the Business Office Manager, Scheduling Coordinator, and administrative staff to document the Rights/Abuse 40 hours training relating to regulation 2800.65e by 11/15/24. The administrator or designee will audit associate files to ensure training of Rights/Abuse 40 hours are documented and placed in the associate's file by 11/30/24. Any files found not incompliance will be brought to compliance and noted the correction is due to auditing for plan of correction and dated appropriately. Staff training regarding this regulation will be conducted by 11/30/24 by the administrator or designee to ensure compliance of records.
Beginning 11/15/24 the Administrator or designee will audit new employee files weekly for 4 weeks for continued compliance.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented - 01/16/2025)

65g Initial direct care training

4. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person C has been providing unsupervised assisted living services since August 2023; however, the staff did not complete the Department approved direct care training course and pass the competency test.

Plan of Correction ***Accept - 11/07/2024)***

Staff member C is no longer employed by the residence.

65g Initial direct care training (continued)

The administrator or designee will re-educate the Business Office Manager, Scheduling Coordinator, Health Care Director, or designee, and administrative staff to obtain the Initial Direct Care Training competency test/certificate prior to hire or on the 1st day of new hire orientation by 11/30/24. Upon receipt the document will be placed on file. If staff person cannot produce the document. The staff person will not be allowed to provide unsupervised assisted living services until completion of the department approved direct care training course is passed and the competency test is completed and the residence is in receipt of the certification.
The administrator or designee will audit associate files to ensure direct care staff have the department-approved initial direct care training certification on file by 11/30/24. Any files found not incompliance will be brought to compliance and noted the correction is due to auditing for plan of correction and dated appropriately by 11/30/24.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/16/2025)

162c Menus - posted

5. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The residence's menu posted was for the months of June, July, and August, not for the month of September.

Repeat Violation: 10/27/2023

Plan of Correction ***Accept - 11/07/2024)***

The September menus were immediately framed/posted by the Administrator to the memory care dining room on the wall and on the sideboard cabinet for resident view on . Menus will continue to be placed/posted by the Culinary Services Director or designee in the dining areas per this regulation. The Culinary Services Director or designee will complete weekly checks for 4 weeks beginning 11/4/24.
By 11/30/24 the administrator or designee will educate the Culinary Services Director on regulation 2800.162c.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented - 01/16/2025)

231c1 Preadmit screening

6. Requirements

2800.

231c1 Preadmit screening *(continued)*

231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident was admitted to the special care unit on . However, the resident's written cognitive preadmission screening was not dated, making it impossible to determine if it was completed timely.

Repeat Violation: 05/09/2024

Plan of Correction ***Accept (- 11/15/2024)***

Preadmission screening for resident has been updated and signed and dated by the Administrator as part of the plan of correction on The Memory Care Director or designee will conduct an audit of all special care unit charts for compliance with 2800.231c1 by 11/30/24. Charts found out of compliance will be updated per the plan of correction. The residence will utilize a 3 person checklist (Health Care Director or designee, Memory Care Director or designee, and Administrator or designee) beginning 11/11/24 for accuracy and compliance with preadmission screening. This document will be place on file for auditing purposes.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented 01/16/2025)

234a Admission – support plan

7. Requirements

2800.
234.a.1. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident was admitted to the special care unit on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept (11/07/2024)***

The support plan for resident was initiated within the 72 hours timeframe by the Resident Care Director. However, the RCD failed to lock the assessment appropriately upon its completion on . Upon a file review, the RCD discovered the mistake and subsequently locked the assessment on 8/8/24 causing it to be documented late.
The administrator or designee will reeducate the RCD and clinical team on the process of completing the initial support plan within the appropriate timeframe of 72 hours of admission or within 72 hours prior to the resident's admission to the special care unit by 11/30/24.
The RCD or designee will conduct an audit of resident charts by 11/30/24 to ensure compliance with this regulation. Support plans found out of compliance will be updated and dated accordingly noted per the plan of correction.
Beginning 11/15/24 the RCD or designee shall audit the completed support plans prior to filling in resident record.
Support Plans to be audited weekly x 4 weeks beginning 11/15/24.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

234a Admission – support plan (continued)

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/16/2025)

234d Support plan - review

8. Requirements

2800.
234.d.1. The support plan for a resident of a special care unit for residents with Alzheimer's disease or dementia shall be reviewed, and if necessary, revised at least quarterly and as the resident's condition changes.

Description of Violation

A support plan for resident was developed on The resident was observed block the door to the resident's room from the inside with a couch, a chair, or a laundry hamper to keep people including staff from entering the room; however, the resident's support plan was not updated to address this behavior.

Repeat Violation: 05/09/2024

Plan of Correction ***Accept (11/07/2024)***

An updated Support Plan was created on by the Generations Program Director to reflect the new behavior of resident barricading the apartment door with furniture. The Assessment and Support Plan includes description of service needs and the plan to meet the service need of the resident.
The administrator or designee will reeducate the clinical team on the process for updating Assessment and Support Plans as needed for changes in condition or behaviors that occur to meet regulatory compliance and this regulation 2800.234d by 11/30/24. Going forward the clinical team will review Assessment and Support Plan per regulation and document any notable changes to the Assessment and Support Plan. Resident Assessment and Support Plan will be reviewed quarterly, changes found during this review will be updated as required by the Resident Care Director or designee.
Beginning 11/15/24 the administrator or designee will audit 5 random resident Assessment and Support Plan weekly x4 weeks to ensure revisions are accurate.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented - 01/16/2025)

236a Staff training

9. Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

236a Staff training *(continued)*

Description of Violation

Direct care staff person B, date of hire , works in the special care unit but did not complete any training related to dementia care within the first 30 days of the date of hire.

Plan of Correction ***Accept - 11/07/2024)***

Staff person B was hired on and did go through the new hire orientation program to include training on regulation 2800.236a beginning on However, this documentation was not present in the associate file upon inspection. Due to a subsequent personnel issue the associate is no longer employed by the residence.
The administrator or designee will re educate the Business Office Manager, Scheduling Coordinator, and administrative staff to document the Alzheimer's disease/Dementia training within the first 30 days of hire relating to regulation 2800.236a by 11/30/24. The administrator or designee will audit associate files to ensure the required 8 hours of initial Alzheimer's disease/Dementia training was conducted, documented, and placed in the associate's file by 11/30/24. Any files found not incompliance will be brought to compliance and noted the correction is due to auditing for plan of correction and dated appropriately.
Beginning 11/15/24 the administrator or designee shall audit new hire files weekly x4 weeks for required education and trainings.
At the next QM meeting by 12/30/24, the plan will be reviewed by the committee for continued compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented 01/16/2025)