

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

December 18, 2025

[REDACTED]
CARE HSL HARLEYSVILLE OPCO LP

[REDACTED]
HERITAGE SENIOR LIVING
[REDACTED]

RE: THE BIRCHES AT HARLEYSVILLE
691 MAIN STREET
HARLEYSVILLE, PA, 19438
LICENSE/COC#: 14266

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/23/2025 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: 03/27/2026
 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

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

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 116 Waking Staff: 87

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Incident Exit Conference Date: 10/23/2025

Inspection Dates and Department Representative

10/23/2025 On 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: Daybreak Capacity: 34 Residents Served: 31
 Hospice
 Current Residents: 7
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 73
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 42 Have Physical Disability: 4

Inspections / Reviews

10/23/2025 - Partial
 Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 11/29/2025

Inspections / Reviews *(continued)*

12/05/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/11/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/12/2025

12/18/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/11/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan dated [REDACTED] for resident [REDACTED] indicates the resident requires assistance with ambulation and transferring in/out of a bed or chair.

On [REDACTED] resident [REDACTED] did not receive this assistance as required. Per staff person A, resident [REDACTED] was being pushed in their wheelchair from the dining area to the common area by another resident without supervision. The support plan dated [REDACTED] states that resident [REDACTED] needs supervision and assistance with mobility for optimal safety. According to staff person A, resident [REDACTED] cannot self-propel.

Plan of Correction

Accept ([REDACTED] - 12/05/2025)

10/23/2025

2600. 23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

"The assessment and support plan dated 05/14/25 for resident [REDACTED] indicates the resident requires assistance with ambulation and transferring in/out of a bed or chair. On 08/29/25, resident [REDACTED] did not receive this assistance as required. Per staff person A, resident [REDACTED] was being pushed in their wheelchair from the dining area to the common area by another resident without supervision. The support plan dated 5/14/25 states that resident [REDACTED] needs supervision and assistance with mobility for optimal safety. According to staff person A, resident [REDACTED] cannot self-propel."

Immediate Corrective Actions: Upon learning about this violation, the homes Executive Director scheduled a date and time to meet with staff person A and completed training related to regulation 23.a. as it relates to residents' assessments and support plans and ensures that all residents are provided with the supervision and assistance needed for optimal safety. This training was completed on 11/23/2025.

Additional Corrective Actions: Every employee of the home will continue to have in-person training on "Meeting Resident Needs as Described in State Required Forms" upon hire and then annually through the homes Relias educational platform.

Ongoing Quality Assurance Actions: The homes Resident Care Director, Memory Care Director and/or Executive Director, will ensure that all residents admitted to the home continue to have a support plan completed within the proper timelines as outlined for the home and that it is shared with all staff that care for the home's residents. The homes Business Office Director and/or Executive Director will continue to oversee training of all new employees, training and all annual training for the home employees through the homes Relias platform. This will be reviewed during each of the homes' ongoing quarterly quality assurance meetings to ensure continued compliance, beginning again at the end of January 2026.

Licensee's Proposed Overall Completion Date: 01/30/2026

Implemented ([REDACTED] 12/18/2025)

42b - Abuse

2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted], at approximately 9:42 am, staff person A heard a resident scream. Staff person A turned to see resident [redacted] biting resident [redacted] hand. Staff person A intervened after hearing the scream. Resident [redacted] was biting resident [redacted] finger. The residents were separated by staff person A. Resident [redacted]s doctor was notified, and per doctor instructions, resident [redacted] was sent to the hospital. Per the resident's hospital discharge record, resident [redacted] was diagnosed with a human bite on the finger. Resident [redacted] was prescribed 5 days of antibiotics and received a tetanus vaccine.

Resident [redacted] moved into the secured memory care unit on [redacted]. The home has documented resident [redacted]s aggressive behaviors. Resident [redacted] has attacked and attempted to bite staff when they are providing care services to the resident.

Plan of Correction

Accept [redacted] 12/05/2025)

10/23/2025

2600.42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately 9:42 am, staff person A heard a resident scream. Staff person A turned to see resident [redacted] biting resident [redacted]s hand. Staff person A intervened after hearing the scream. Resident [redacted] was biting resident [redacted]s finger. The residents were separated by staff person A. Resident [redacted]s doctor was notified, and per doctor instructions, resident [redacted] was sent to the hospital. Per the resident's hospital discharge record, resident [redacted] was diagnosed with a human bite on the finger. Resident [redacted] was prescribed 5 days of antibiotics and received a tetanus vaccine. Resident [redacted] moved into the secured memory care unit on [redacted]. The home has documented resident [redacted]s aggressive behaviors. Resident [redacted] has attacked and attempted to bite staff when they are providing care services to the resident.

Immediate Corrective Actions: Upon learning of the resident-to-resident incident on [redacted] between resident [redacted] and resident [redacted] staff immediately separated the residents and reported it to the homes Memory Care Director. The homes Memory Care Director and Resident Care Director were able to facilitate transfer of resident [redacted] to a Behavioral Health Unit for evaluation and treatment the same day, where the resident remained until 9/19/25 when [redacted] was cleared to return to the community. The home reported the incident per department guidance via reportable incident and via ACT-13.

Additional Corrective Actions: Resident [redacted] had a decline in overall health and passed away on Hospice services in the home on 11/05/2025. Resident [redacted] family relocated the resident due to their family moving out of the area and was discharged from the home on [redacted]. The homes visiting Psychiatrist did continue to follow resident [redacted] upon [redacted] readmission to the home and make medication adjustments as needed. The homes staff were given training in the homes staff meeting on [redacted] on review of the HSL Abuse Policy. Any resident concerns will continue to be reviewed and reported immediately to the homes Executive Director, Resident Care Director or Memory Care

42b Abuse (continued)

Director.

Ongoing Quality Assurance Actions: The homes Resident Care Director, Memory Care Director and/or Executive Director will continue to monitor residents in the home's memory care neighborhood for any behaviors that may be of concern, and they will be addressed immediately and documented in the resident's support plan. This will be reviewed during each of the homes' ongoing quarterly quality assurance meetings to ensure continued compliance, beginning again at the end of January 2026.

Licensee's Proposed Overall Completion Date: 01/30/2026

Implemented [REDACTED] - 12/18/2025)