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

June 18, 2026

[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 04/22/2026 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**: *03/27/2027*

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**: *126* **Waking Staff**: *95*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *04/22/2026*

Inspection Dates and Department Representative

04/22/2026 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**: *Garden/Daybreak* **Capacity**: *34* **Residents Served**: *32*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *NA*

Are 60 Years of Age or Older: *79*

Diagnosed with Mental Illness: *NA*

Diagnosed with Intellectual Disability: *NA*

Have Mobility Need: *46*

Have Physical Disability: *4*

Inspections / Reviews

04/22/2026 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *05/16/2026*

Inspections / Reviews *(continued)*

06/04/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/14/2026*

06/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2026*

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

51 - Criminal Background Check

1. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted], The staff's criminal background check was completed on [redacted]

Repeat Violation-[redacted]

Plan of Correction ***Accept [redacted] 06/04/2026)***

Immediate Corrective Actions: The Business Office Manager received training by the Executive Director on the regulatory requirements for Criminal History checks and hiring policies on 5/7/2026.

Additional Corrective Actions: The Business Office Manager will audit all current employee records to ensure compliance starting the week of 5/10/2026.

Ongoing Quality Assurance Actions: The Business Office Manager will review 5% sample of employees records each month, and review at the quarterly QA meeting, beginning with a review of Q2 2026 (April, May, June) in July 2026.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented [redacted] 06/18/2026)

65i - Training Record

2. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include the location, title of course or length of course, for all trainings completed by Staff person B.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Immediate Corrective Actions: The Executive Director added on a late entry to the record of training form with all required information on 5/10/2026.

Additional Corrective Actions: The Executive Director will review training records weekly to ensure compliance by 5/10/2026. All Department Directors will be trained by the Executive Director on the required elements for the training attendance sheet, based on the sample form provided on the BHSL website. This form will be utilized for all training beginning 5/22/2026. All 2026 training records will be reviewed by the Executive Director by 5/22/2026 to ensure they include all required information.

Ongoing Quality Assurance Actions: The Business Office Director will review 5 % sample of training records each

65i Training Record (continued)

month for compliance with and review findings at the quarterly QA meeting, beginning with a review of Q2 2026 (January, February, and March) in July 2026.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented [redacted] - 06/18/2026)

82c - Locking Poisonous Materials

3. 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

Crest toothpaste, with a manufacture's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact poison control right away", was unlocked, unattended, and accessible to Residents [redacted] and Resident [redacted] Not all the residents of the home, including Resident [redacted] and Resident [redacted] have been assessed capable of recognizing and using poisons safely.

Equate optimal care toothpaste, with a manufacture's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact poison control right away", was unlocked, unattended, and accessible to Residents [redacted] Not all the residents of the home, including Resident [redacted], have been assessed capable of recognizing and using poisons safely.

Repeat Violation [redacted]

Plan of Correction

Accept [redacted] - 06/04/2026)

Immediate Corrective Actions: The Memory Care Director removed all poisonous materials on 4/22/2026. The Memory Care Director completed audit of all Memory Care rooms for poisonous materials on 4/22/2026.

Additional Corrective Actions: The Memory Care Director received training from the Executive Director on Locking Poisonous Materials and the requirements of 82c. on 5/10/2026. The Memory Care staff received training by the Executive Director of Locking Poisonous Materials and the requirements of 82c on 5/11/2026. The Executive Director will initiate room audits for the management team three times a week to ensure compliance starting the week of 5/10/2026.

Ongoing Quality Assurance Actions: The Executive Director will audit five rooms weekly to ensure continued compliance and report findings to quarterly QA meeting, beginning with a review of Q2 2026 (January, February, and March) in July 2026.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented [redacted] - 06/18/2026)

183b - Meds and Syringes Locked

4. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted] at 10:38a, [redacted] soothing dry eye relief, [redacted], [redacted] and [redacted] was unlocked, unattended, and accessible in room [redacted] for Resident C.

Repeat Violation-[redacted]

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Immediate Corrective Actions: Memory Care Director removed all medications noted at the time of inspection on 4/22/2026.

Additional Corrective Actions: Inservice completed by the Executive Director for all staff related to Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked by 5/22/2026.

Ongoing Quality Assurance Actions: The Executive Director will initiate room audits for the management team three times a week to ensure compliance starting the week of 5/22/2026. The Executive Director will audit five rooms weekly to ensure continued compliance and report findings to quarterly QA meeting, beginning with a review of Q2 2026 (April, May, June) in July 2026.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented [redacted] - 06/18/2026)

183e - Storing Medications

5. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] for Resident [redacted], was opened on the medication cart without an open date or expiration date. According to the manufacturer's instructions medication should be disposed of after 6 weeks after opening.

On [redacted], [redacted] tab for Resident [redacted] was punctured in slot 13 of the blister pack and the pill remained in place.

Repeat Violation-[redacted]

Plan of Correction ***Accept [redacted] 06/04/2026)***

Immediate Corrective Actions: The med tech removed and reordered medications from Resident [redacted] on 4/22/2026 The medication removed resident [redacted] medication in slot #13 to destroy on 4/22/2026.

183e - Storing Medications (continued)

Additional Corrective Actions: The Memory Care Director will provide in-services for Med Techs related to expired medication, manufacturer instructions, broken pill packaging, labeling medication with open date, by 5/5/2026. All med carts will be audited by Med Techs by 5/11/2026 to ensure all medications are stored appropriately. All med techs will complete shift change responsibilities at the beginning and end of each shift. The Memory Care Director and The Executive Director will complete cart audits on three residents each to ensure compliance by 5/22/2026. All med carts will be audited by Med Techs by 5/11/2026 to ensure all medications are stored appropriately.

Ongoing Quality Assurance Actions: The Executive Director will review 5% sample of the completed weekly audits monthly to ensure completion and accuracy. The Executive Director will report on ongoing compliance and as part of our quarterly QA meeting, beginning with a review of Q2 2026 (April, May, June) in July 2026.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 06/18/2026)

185a - Implement Storage Procedures

6. 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 , the glucometer for Resident was not calibrated with the correct time, the glucometer read 1:45pm when the correct time was 3:42pm.

Repeat Violation

Plan of Correction ***Accept - 06/04/2026)***

Immediate Corrective Actions: The violation was corrected when the glucometer times were changed for Resident # Memory Care Director on 4/22/2026.

Additional Corrective Actions: By 5/22/2026 Med Techs will be trained by the Memory Care Director related to Glucometer display times being updated as outlines in shift change protocol. The Memory Care Director will complete an audit of all glucometers weekly to ensure they are correctly calibrated by 5/22/2026.

Ongoing Quality Assurance Actions: The Memory Care Director and Resident Care Director will audit (a 5% sample) the Glucometer weekly to ensure compliance, beginning 5/11/2026. The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q2 2026 (April, May, June) in July 2026.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented - 06/18/2026)