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

August 24, 2023

[redacted], REGIONAL VICE PRESIDENT OF OPERATIONS
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 02/13/2023, 02/14/2023 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* **Licen e #**: *14772* **Licen e Expiration**: *02/10/2023*

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]

Phone [redacted] **Email** [redacted]

Certificate(s) of Occupancy

Type: *I 2* **Date**: *12/01/2020* **I ued By**: *Lower Makefield TWSP*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/14/2023*

Inspection Dates and Department Representative

02/13/2023 On Site [redacted]

02/14/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *97*

Special Care Unit

In Home: *Yes* **Area**: *Generations* **Capacity**: *21* **Residents Served**: *19*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *97*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *19* **Have Physical Disability**: *0*

Inspections / Reviews

02/13/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/17/2023*

03/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/02/2023*

Inspections / Reviews *(continued)*

04/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/01/2023*

08/24/2023 - Document Submission

Submitted By [redacted] **Date Submitted:** *05/01/2023*

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

22a1 Medical Eval - time frames

1. Requirements

2800.
22.a. Documentation. The following admission documents shall be completed for each resident:
1. Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies

Description of Violation

Resident #1 was admitted on [redacted]. The resident's medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 04/05/2023)***

New medical evaluation obtained by nurse designee that was signed and dated on 12/22/2022 to reflect current status. Residence has implemented on 12/23/22 the use of a new move in "check list" that requires ED review and signature for accuracy. Residence created and implemented a "transfer" check list that requires ED sign off for transfers within the community effective 12/23/22 and ongoing.

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented ([redacted] - 05/17/2023)

25b Contract signatures and renewal

2. Requirements

2800.
25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

The contract for resident #2 dated [redacted] was not signed by the resident.

Plan of Correction ***Accept [redacted] - 04/05/2023)***

One time audit of all resident files to be completed by 4/30/2023 by ED or designee to ensure compliance of regulation 2800.25b. Effective 4/3/2023 and on-going, ED or designee will meet with each resident by physical move-in date to obtain all signatures on all contractual documents.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] 05/17/2023)

42b Abuse/Neglect

3. Requirements

2800.
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]/2023 around [redacted], resident #3 reported $40 missing from his/her wallet kept in the bedside table drawer. The last time the resident checked the wallet was the previous evening and there was $60 (3 $20 bills). In the morning around [redacted] AM, on [redacted]/2023, staff A came in to make the resident's bed and left saying that the resident's pillow case was dirty and needed to be replaced. Staff A came back, tagged along by staff B who made the bed. The resident asked them to empty the trash can, which staff A did and told the resident that the staff would

42b Abuse/Neglect (continued)

come back with a trash bag, which never happened. Resident #3 checked the wallet, found the money missing and reported it to the administration around [redacted] PM. According to the resident, staff A and B were the only ones who came to his/her room since the previous evening.

Repeated Violation: 12/13/21 et al, 4/27/22 et al

Plan of Correction ***Accept [redacted] 04/05/2023)***

Facility offered resident a lock box for valuables, which resident declined. Staff persons were removed from the facility at time of incident. Staff person A/agency caregiver removed permanently. Resident abuse training was provided at General Staff meeting on 1/31/2023 by ED. By 4/30/2023, ED to hire third party trainer to perform Abuse/Neglect re-training to do general staff inservice.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] - 05/17/2023)

51 Criminal background checks

4. Requirements

2800.

51.a. 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's date of hire was [redacted] The criminal background check on file did not include a PA PATCH clearance.

Repeated Violation: 2/16/22,

Plan of Correction ***Accept ([redacted] 04/05/2023)***

Staff person A was part of Temporary Staffing Agency. Agency was utilizing a third party system to complete their criminal background checks. Staff person A no longer works at facility. ED notified agency on 2/14/2023 that moving forward, PA PATCH is to be utilized for Criminal Background checks for employees that will be sent to our facility. All current staff records were audited for compliance on 2/6/2023. ED or designee will meet with agency director by 4/30/2023 to obtain a list of staff that service Heartis Yardley to ensure proper background checks have been obtained. By 4/7/23, ED or designee will establish a weekly call with Agency Director, for the remainder of agency use, to discuss any potential new employee to ensure proper background checks have been obtained.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] - 05/17/2023)

65a Fire Safety-1st day

5. 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:

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

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]2, 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

Repeated Violation: 2/16/22 et al, 4/27/22 et al

Plan of Correction ***Accept [redacted] 04/05/2023)***

ED/BOD to developed a Fire Safety training packet for substitute personnel.
ED/BOD to meet with Agency Director by week of 4/7/2023 on the need to have all substitute personnel oriented in general fire safety and emergency procedures on their first day of work at the residence.
RCD,RCC,GPD, Designee to meet with substitute personnel on first day of work to review and document fire safety procedures.
Record of training maintained by BOD and audited monthly for 2 months to ensure compliance with audit completed by 5/31//2023.
Process ongoing per utilization of substitute personnel.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ([redacted] - 05/17/2023)

65e Rights/Abuse 40 Hours

6. 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.

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

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 in November. However, this staff person did not complete training on 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.

Repeated Violation: 4/27/22 et al

Plan of Correction ***Accept ([redacted] - 04/05/2023)***

ED/Designee to speak with Agency Director week of 4/7/2023 on need to have all substitute personnel trained on Resident Rights/Abuse within the 1st 40 working hours.
ED/BOD to develop training packet specific to all required 40 hour training per regulation.
RCD,RCC,GPD, Designee to meet with substitute personnel within the 1st 40 working hours to complete this training.
ED/BOD to maintain record of training for retention and will audit records monthly for 2 months to ensure compliance with audit completed by 5/31/2023.
Process of training ongoing while utilizing substitute personnel.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ([redacted] - 05/17/2023)

69 Dementia training

7. Requirements

2800.
69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

The residence does not have the dementia training record for staff person C, date of hire [redacted] on file.

Repeated Violation: 4/27/22 et al.

Plan of Correction ***Accept ([redacted] - 04/05/2023)***

ED/BOD currently auditing staff training records for compliance with Dementia related training.

69 Dementia training (continued)

GPD/Designee to sign off on Dementia related trainings upon hire and ongoing.
ED/Designee to sign off on initial/annual training forms to confirm trainings were provided and signed by both staff member and trainer.
Process: initial-upon hire, as conducted, and annually.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented [redacted] - 05/17/2023)

85d Trash cans – kitchen/bath

8. Requirements

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 02/13/2022 around 10:30 AM, the trashcan in the Winter Garden activity room had no cover and the trashcan in the 2nd floor common bathroom far right side of the building near the elevator had no cover.

Plan of Correction ***Accept [redacted] - 04/05/2023)***

Trashcan lid had a designed opening to place garbage in receptacle.
ED/BSD purchased new trashcans with appropriate coverings and implemented in those areas while surveyor on site.
On 2/14/2023 BSD replaced trashcans with appropriate cover within the residence.
Non-compliant trashcans were removed by BSD from facility.
Effective 4/3/2023, BSD to initiate documented audit of trashcans in public/shared bathrooms and kitchens weekly for 1 month to ensure continued compliance.
Audit completed by 4/30/2023.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented [redacted] - 05/17/2023)

96a First aid kit

9. Requirements

2800.
96.a. The residence shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. The residence shall have an automatic external defibrillation device located in each building on the premises.

Description of Violation

The first aid kit located in the medication cart in the Secured Dementia Care Unit (SDCU) does not include scissors, tweezers, and thermometer.

Repeated Violation: 2/16/22 et al

Plan of Correction ***Accept [redacted] - 04/05/2023)***

ED purchased supplies on 2/22/2023 for affected first aid kits to bring them into compliance.

96a First aid kit (continued)

ED/AED to hire vendor to stock and monitor inventory monthly of all first aid kits and supplies by 4/30/2023.
n the interim, RCD, RCC or designee to audit first aid kits monthly beginning 4/4/2023 to ensure compliance.
First aid kit to be in full compliance by 4/30/2023

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (- 05/17/2023)

101j7 Lighting/operable lamp

10. Requirements

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 room # 7 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (04/05/2023)***

DSM provided lamp to resident beside table while surveyor was onsite.
BSD to audit all occupied resident apartments by 4/30/2023 to ensure compliance.
RCD, GPD or designee to complete random sample audit of 5 units monthly to ensure continued compliance.
Completion date: 5/31/2023

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented - 05/17/2023)

103g Storing food

11. Requirements

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

Description of Violation

There were two large ice cream containers without lids in the freezer section of the kitchen service refrigerator.

Plan of Correction ***Accept (- 03/28/2023)***

Education to be provided to culinary staff by CSD by 3/31/2023. CSD to complete weekly audit of food storage areas within main kitchen for 2 months to ensure compliance with 103g.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented - 08/24/2023)

107a Emergency preparedness

12. Requirements

2800.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the residence is located.

Description of Violation

Staff person D, , did not have a copy of the emergency preparedness plan for the local municipality.

107a Emergency preparedness *(continued)*

Plan of Correction ***Accept (04/05/2023)***

ED or AED to reach out to Lower Makefield Township, where residence is located, by 4/30/23 to request a copy of the emergency preparedness plan.
ED and Administrator to review plan upon receipt and implement procedures from EPP in the event that emergencies should arise.
ED/Designee will communicate with Lower Makefield Township Emergency Management Division on a quarterly basis to keep abreast of any changes to their emergency response systems.
Process to occur semi-annually/annually

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented - 05/17/2023)

107d Procedure EMA submission

13. Requirements

2800.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The residence's written emergency procedures have not been submitted to the local emergency management agency since 2021.

Repeated Violation: 12/13/21

Plan of Correction ***Accept - 04/05/2023)***

ED/Administrator will update the EMA annually or upon changes to residence or municipalities relating to emergency services and procedures.
ED and Administrator reviewing and updating written emergency procedures to be completed by 4/15/2023.
Upon completion, ED and/or administrator to submit written emergency plan to local management agency for review and approval by 4/30/2023.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented - 05/17/2023)

132e Fire drill sleeping hours

14. Requirements

2800.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The residence's night shift is between 10:00 PM and 06:00 AM next morning. The last fire drill conducted during sleeping hours was on 07/27/2022 at 10:30 PM.

Plan of Correction ***Accept (- 04/05/2023)***

BSD/ED to ensure Fire drills are conducted by local fire safety expert.
ED spoke with vendor on 2/14/2023 to discuss appropriate time for sleeping hour drills, per the recommendation from BHSL surveyor. Prior sleeping hours drill provided on 2/27/23 at 12:30am were not within the suggested timeframe to be considered "sleeping hours"

132e Fire drill - sleeping hours (continued)

BSD/ED/Fire Safety Expert will provide fire-drills after midnight and before 5am every 6 months for compliance with Fire Safety regulations.
Completion date: Every Six months as required by regulations.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (- 05/17/2023)

182c Medication administration

15. Requirements

2800.
182.c. Medication administration includes the following activities, based on the needs of the resident:
3. Remove the medication from the original container.

Description of Violation

Resident #4 is prescribed [redacted] twice a day at 08:00 AM and 04:00 PM. The resident had a separate order of [redacted] every 8 hours as needed (PRN), which was discontinued on 06/10/2022. However, the blister pack remained in the medication cart. Between 06/11/2022 and 02/11/2023, med administration staff failed to follow the proper procedures of medication administration (5 Rights) and signed out the resident's [redacted] mg from the PRN blister pack 20 times, most recently on 01/08/2023 at 07:30 AM and 05:00 PM, on 01/10/2023 at 09:00 AM, on 02/05/2023 at 08:00 AM, on 02/10/2023 at 04:00 PM and on 02/11/2023 at 04:00 PM.

Plan of Correction ***Accept (- 04/05/2023)***

Upon discovery medication was removed and destroyed by nurse on 2/14/23.
Nurse/RCD/RCC or Designee will reeducated Med Techs on the proper procedures of medication administration 5 Rights.
Nurse/RCD/RCC or Designee will perform MAR-TO-CART-Narcotic audit 1 time weekly for 1 month. Audit completed by 4/30/2023.
Nurse/RCD/RCC/Designee to reeducate Med Techs by 4/15/2023.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (- 08/24/2023)

183d Current medications

16. 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 02/14/2023 [redacted] (PRN) prescribed for resident #4 was in the residence's medication cart; however, the medication was discontinued on 06/10/2022.

Plan of Correction ***Accept - 03/28/2023)***

Upon discovery medication was removed and destroyed by nurse on 2/14/23. Facility implemented medication scanners on med carts effective 2/14/23 in effort to reduce possibility of medication administration errors.

183d Current medications (continued)

Beginning the week of 3/20/23, RCD, RCC or designee to complete weekly med cart audits for 1 month to ensure compliance with 2800.183d.

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented (08/24/2023)

185a Storage procedures

17. Requirements

2800.
185.a. The residence 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

Resident #5 is prescribed [redacted] as needed. On 02/14/2023, this medication was not available in the residence.

Plan of Correction ***Accept (- 04/05/2023)***

Nurse/RCD to follow up on 4/3/2023 with doctor to reorder medication to bring medication order into compliance.
Nurse/RCD/RCC or designee to re-educate Med Techs on orders and discontinue procedures within 30 days completed by 4/30/2023.
Nurse/RCD/RCC or designee to complete weekly med cart audits for 1 month to ensure compliance completed by 4/30/2023.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented - 05/17/2023)

187b Date/time of med admin

18. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #6 is prescribed [redacted] as needed. The resident's February medication administration record (MAR) does not include the initials of the staff person who administered this medication on 02/05/2023 at 07:00 PM.

Plan of Correction ***Accept (- 04/05/2023)***

RCD, RCC, GPD or designee to retrain med techs on self auditing techniques to ensure compliance completed by 4/30/2023.
RCD, RCC, GPD or designee to run missed-med report 1 time weekly for 1 month.
Report to run beginning week of 4/3/2023.
Audit completed by 4/30/2023.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (- 08/24/2023)

227g Support plan - signatures

19. Requirements

2800.

227g Support plan - signatures *(continued)*

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #7's initial Assessment/Support Plan (ASP) dated [redacted] was not signed or dated by the assessor or the resident.

Repeated Violation: 12/13/21 et al, 2/16/22 et al

Plan of Correction ***Accept ([redacted] 04/05/2023)***

Former RCC completed ASP on 11/9/2022 without signing. AED (did not post-dated signature, but rather signed name of former RCC along with the signature of the AED to indicate completion.
Signature of resident obtained on date of survey of 2/14/2023.
New ASP completed on 12/15/2022 and signed by all parties.
RCD, RCC and GPD to be educated by ED/Designee on the requirements to obtain signatures and dates of all participants in the development of the resident.
Education completed by 4/30/23.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented [redacted] - 05/17/2023)

231c1 Preadmit screening

20. Requirements

2800.
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 #1 was admitted to the SDCU on [redacted]. However, the resident's cognitive prescreening form was completed on [redacted]
Resident #7 was admitted to the Secured Dementia Unit (SDCU) on [redacted] The resident's cognitive prescreening form is missing the date and diagnosis.

Plan of Correction ***Accept ([redacted] 04/05/2023)***

Audit completed of Memory Care resident charts on 2/8/2023 by nurse. Residence has implemented the use of a new move in "check list" that requires ED/AED review and signature for accuracy effective 1/1/23 - on-going.
Residence has also created and implement a "transfer" check list that will require ED/AED sign-off for transfers within the community effective 1/1/23 and ongoing.

Licensee's Proposed Overall Completion Date: *03/31/2023*

[redacted] - 05/17/2023)