pennsylvania
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HAMPDEN OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT WEST SHORE**
NAME OF FACILITY OR AGENCY

Located at **1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **115**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 35**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

**55 Pa.Code Chapter 2600: Personal Care Homes**
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 5,** **2021** until **May 5,** **2022**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333811**

ISSUING OFFICER

Jamie L. Buchenauer
DEPUTY SECRETARY

**NOTE:** This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 01/21

pennsylvania
DEPARTMENT OF HUMAN SERVICES

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**
**MAILING DATE: November 5, 2021**

[redacted]
Hampden Operations LLC
4423 Pheasant Ridge Road, Suite 301
Roanoke, Virginia 24014

RE: Harmony at West Shore
1910 Technology Parkway
Mechanicsburg, Pennsylvania 17050
License #: 333810

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on March 9, 2021, April 27, 2021, April 28, 2021 April 29, 2021, July 29, 2021 and July 30, 2021 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (333810) dated May 3, 2021 to May 3, 2022 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated May 3, 2021 to May 3, 2022 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4); (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from November 5, 2021 to May 5, 2022.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie L. Buchenauer

Jamie L. Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Inspection Summary

cc: [redacted]

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

## Facility Information

**Name:** *HARMONY AT WEST SHORE* **License #:** *33381* **License Expiration Date:** *05/03/2021*
**Address:** *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*
**County:** *CUMBERLAND* **Region:** *CENTRAL*

## Administrator

**Name:** [redacted] **Phone:** *7174021200* **Email:** [redacted]

## Legal Entity

**Name:** *HAMPDEN OPERATIONS LLC*
**Address:** *4423 PHEASANT RIDGE RD,STE 301, ROANOKE, VA, 24014*
**Phone:** *7174021200* **Email:** [redacted]

## Certificate(s) of Occupancy

**Type:** *I-2* **Date:** *05/01/2016* **Issued By:** *Hampden Township*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *91* **Waking Staff:** *68*

## Inspection

**Type:** *Full* **Notice:** *Unannounced* **BHA Docket #:**
**Reason:** *Renewal,Com t* **Exit Conference Date:** *04/29/2021*

## Inspection Dates and

*04/27/2021 - On-Site:* [redacted]
*04/28/2021 - On-Site:*
*04/29/2021 - On-Site:*
*03/09/2021 - On-Site:*

## Resident Demograph

### General Informatio

**License Capacity:** *115* **Residents Served:** *66*

### Secured Dementia Care Unit

**In Home:** *Yes* **Area:** *Harmony Square* **Capacity:** *35* **Residents Served:** *23*

### Hospice

**Current Residents:** *10*

**Resident Demographic Data as of Inspection Dates *(continued)***

Number of Residents Who:

**Receive Supplemental Security Income**: *0*
**Are 60 Years of Age or Older**: *66*
**Diagnosed with Mental Illness**: *0*
**Diagnosed with Intellectual Disability**: *0*
**Have Mobility Need**: *25*
**Have Physical Disability**: *1*

## Inspections / Reviews

**04/27/2021 - Full**

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/13/2021*

**6/24/2021 - POC Submission**

**Lead Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/01/2021*

**6/29/2021 - POC Submission**

**Lead Reviewer**: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/30/2021*

**10/7/2021 - Document Submission**

**Lead Reviewer**: [redacted] **Follow-Up Type**: *Exception*

## 16c - Written Incident Report

**1. Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

**Description of Violation**

*On 4/18/2021 and 4/26/2021, several residents did not receive their prescribed morning medications. These medication errors were not reported to the Department:*

*Resident #2 did not receive prescribed Carbidopa-Levo, Duloxetine HCL, Mag-Tab SR, Metformin, Metoprolol Tartrate, Novolog and Pantoprazole Sod DR at 8:00 AM on 4/18/21.*

*Resident #3 did not receive prescribed Carbidopa-Levodopa, Buspirone HCL, Furosemide, Metoprolol Tartrate at 8 AM on 4/18/21.*

*Resident #3 did not receive prescribed Potassium CL at 8:00 AM on 4/20/21 and Digoxin at 8:00 AM on 4/26/21.*

*Resident #4 did not receive prescribed Topiramate at 8:00 AM on 4/18/21.*

*Resident #5 did not receive prescribed Hydrocortisone, Levetiracetam, Sodium Chloride at 8:00 AM and Levothyroxine at 7:30 AM on 4/18/21.*

*Resident #6 did not receive prescribed Acetaminophen 500 mg, Breo Ellipta, Bupropion HCL, Divalproex Sod DR, Duloxetine HCL DR, Eliquis, Escitalopram, Famotidine, Fluticasone Prop, Lidocaine Patch, Magnesium Oxide, Risperidone and Topiramate at 8:00 AM on 4/18/21.*

*Resident #7 did not receive prescribed Carvedilol, Lorazepam and Pantoprazole Sod DR at 8:00 AM on 4/18/21.*

*Resident #8 did not receive prescribed Carvedilol at 8:00 AM on 4/18/21.*

*Medication errors that occurred when medications were not available in the facility were not reported to the Department as a reportable incident as required.*

**Plan of Correction** **Accept**

*All medication errors will be reported to the department as a reportable incident and the Healthcare Director and Executive Director will ensure proper reporting.*

*Healthcare Director will monitor for any medication errors through the MAR on a weekly basis per company policy and evaluate the reporting of medication errors during the Quality Management Reviews on a monthly basis.*

*Staff will be re-educated on the process of reporting Reportable Incidents that are required to be reported as outlined in regulation 2600.16(a) and 2600.188(a). The re-education of staff shall be completed by August 1, 2021*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented** *GE 10/7/21*

## 25b - Contract Signatures

**1. Requirements**

2600.

25.b. 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.

## 25b - Contract Signatures *(continued)*

**Description of Violation**

*The resident-home contract, dated 11/11/2020, for Resident #1 was not signed by the resident.*

**Plan of Correction** **Accept**

*The contract was signed by Resident #1 and placed in the resident file.*
*The Executive Director or Designee will ensure all contracts with residents are signed by the residents, any designated person and the Executive Director or designee.*
*All new contracts will be audited monthly by Executive Director or Designee to ensure all signatures are completed over the next 6 months.*
*The Administrator will complete an audit of all resident records to ensure that each resident has a current signed contract in place . Any contact without the required signatures will be corrected. The audit and correction of all contracts will be done by August 31, 2021.*

**Completion Date:** *08/31/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented** *GE* **10/7/21**

## 63a - First Aid/CPR Training

1. **Requirements**

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

**Description of Violation**

*On 4/14/2021 from 11:00 PM to 7:00 AM on 4/15/2021, 65 residents were present in the home. During this time there was one staff person present who is currently trained and certified in first aid and CPR.*

*On 4/16/21 From 11:00 PM to 7:00 AM on 4/17/21, 65 residents were present in the home. During this time there was one staff person present who is trained in First Aid and CPR and one staff person who is trained in CPR only.*

**Plan of Correction** **Accept**

*The Healthcare Director or designee will ensure at least one staff person to every 50 residents is trained in CPR and First Aid on the daily schedules per each shift.*
*The daily schedules will be monitored to ensure compliance on each shift by the Healthcare Director or Designee.*
*The Healthcare Director had more staff trained in CPR and First Aid to ensure compliance.*

**Completion Date:** *05/30/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 65a - FS Orientation 1st Day

1. **Requirements**

2600.
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.

## 65a - FS Orientation 1st Day *(continued)*

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 Persons A, B, C, D and G have not received orientation in 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.*

**Plan of Correction** **Accept**

*Staff A- hire date [redacted]/20-completed Training Sign off sheet 5/3/21*
*Staff B-hire date [redacted]/20-completed Training Sign off sheet 5/3/21*
*Staff C-hire date [redacted]/20-resigned employment*
*Staff D-hire date [redacted]/20-completed Training Sign off sheet 6/9/21*
*Staff G- hire date [redacted]/20- completed Training Sign off sheet 5/3/21*

*Administrator or Designee will ensure all new staff receive required First Day Trainings on the day of Orientation and will monitor compliance on a monthly basis with Coworker file audits over the next 6 months.*
*Staff person training will also be included in the home Quality Management Review every month.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented** *GE* **7/29/21**

## 65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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.

## 65b - Rights/Abuse 40 Hours *(continued)*

**Description of Violation**

*Staff Persons A, B, C, D, F and G have not received orientation training in the following:*
*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.*

**Plan of Correction** **Accept**

*Staff persons A, B, C, D, F, and G completed required trainings on 5/3/21 and 6/9/21.*

*Administrator or Designee will ensure staff receive the required trainings with in 40 scheduled working hours and will monitor monthly through Co-Worker File audits over the next 6 months.*

*Staff A, B, C, D, F. G had required training completed on 5/3/2021 and 6/9/2021 to be in compliance.*

*Administrator or Designee will ensure all staff receive required trainings with in the 40 scheduled working hours and will be monitored monthly by Co-Worker file audits for all new Co-Workers over the next 6 months*
*Staff person training will also be included in the home's Quality Management review every month.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented** *GE* **7/29/21**

## 65c - Ancillary Staff Orientation

1. **Requirements**

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

**Description of Violation**

*Staff Persons A, B, C, D, F and G who all perform ancillary duties in addition to direct care duties did not have a general orientation to* [redacted] *specific ancillary job functions.*

**Plan of Correction** **Accept**

*Staff persons A, B, C, D, F,, and G whom perform ancillary duties received the required trainings on 5/3/2021 and 6/9/2021.*

*The Administrator or Designee will monitor to ensure all staff persons receive general orientation to the ancillary duties with their job functions and will complete monthly audits of new staff files over the next 6 months.*
*Staff person training will also be included in the home's Quality Management Reviews every month.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE* ***9/30/21*** **Implemented**

*Steps are completed*

## 65d - Initial Direct Care Training

1. **Requirements**

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

**Description of Violation**

*Direct Care Staff Persons A and B provide unsupervised ADL services. However, the staff persons did not complete and pass the Department-approved direct care training course and pass the competency test.*

**Plan of Correction** **Accept**

*Staff persons A and B completed the Direct Care Training Course on 4/30/2021.*
*Direct Care Staff persons will complete and pass the Department approved direct care training course prior to providing unsupervised ADL services and the Administrator or Designee will will ensure all newly hired direct care staff will complete and pass the Department required direct care training course and the new direct care staff files will be audited monthly to ensure completion of the training over the 3 months.*
*Staff person training will also be included in the home's Quality Management Review every month.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 105g - Lint Removal and Duct Cleaning

1. **Requirements**

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

**Description of Violation**

*On 4/27/21, two Speed Queen dryers in the 2nd floor laundry room and one Speed Queen dryer in the third floor laundry had an accumulation of lint in the lint traps. There were no clothes in the dryers at the time.*

**Plan of Correction** **Accept**

*The lint was removed upon discovery on 4/27/2021 from the lint trap of the dryer on the third floor.*
*Signage placed in laundry rooms to remind staff to clean dryer lint traps after each use.*
*Sign off sheet placed in laundry rooms for staff to sign that they cleaned the lint trap in the dryer after each use.*
*Maintenance Director or Designee will monitor and check the Sign of sheet weekly to ensure staff are indicating they cleaned the dryer lint trap after each use*
*Maintenance Director or Designee will complete spot checks weekly to ensure the dryer lint traps are free of any lint over the next 3 months.*

**Completion Date:** *06/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 141a 1-10 Medical Evaluation Information

1. **Requirements**

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

**Description of Violation**

*The medical evaluation for Resident #9, with exam date 3/25/21, does not include information in the fields for blood pressure, temperature, height, pulse rate, body positioning and the date that the form was completed.*

**Plan of Correction** **Accept**

*The medical evaluation for Resident #9 dated 3/25/21 was forwarded to the Physician to complete the fields for blood pressure, temperature, height, pulse rate, body positioning, and date the form was completed.*

*The Healthcare Director or Designee will monitor all medical evaluations for residents to ensure all fields on the medical evaluation are completed by the physician.*

*The Healthcare Director or Designee will conduct monthly resident chart audits to ensure Medical Evaluations are completed in their entirety by the physicians over the next 6 months.*

**Completion Date:** *05/06/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented** GE **7/29/21**

## 183b - Meds and Syringes Locked

1. **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**

*A bottle of fish oil capsules and a vial of Amoxicillin prescribed to a non-resident of the home were on a counter top and table in the room of Resident #10. Resident #10 is unable to self administer medications however, these medications were accessible to this resident.*

## 183b - Meds and Syringes Locked *(continued)*

**Plan of Correction** **Accept**

*The bottle of fish oil capsules and the vial of Amoxicillin were removed and secured from Residents apartment upon discovery by the Healthcare Director. The Executive Director and Healthcare Director notified the POA in regards to regulatory procedures for any medications for residents whom can not self administer medications.*
*Resident #10 Physician was notified to get a current prescription of the 2 medications for Resident #10.*
*Healthcare Director or Designee will monitor resident apartments for any unsecured medications on a daily basis and remove and secure the medications over the next 6 months.*

**Completion Date:** *04/29/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 7/29/21**

## 185a - Implement Storage Procedures

1. **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 Repeat Violation**

*The following blood glucose levels were recorded in the MAR (medication administration record) for Resident #11; however, none of these readings were recorded in the resident's glucometer:*

| *Date & Time* | *blood glucose level* |
|---|---|
| *4/21/21 2:00 PM* | *102* |
| *4/26/21 8:00 AM* | *116* |
| *4/27/21 2:00 PM* | *264* |
| *4/27/21 8:00 PM* | *125* |

*Repeated Violation - 2/10/20*

**Plan of Correction** **Accept**

*Blood glucose levels recorded on the MAR will match the recordings on the residents glucometer.*

*The Healthcare Director or Designee will audit the residents glucometer readings to ensure they match the recorded blood glucose levels recorded on the MAR on a weekly basis and address any areas of concern over the next 3 months.*

*Medication Technicians were trained on the proper procedures for glucometers and recording blood glucose readings on the MAR by the Healthcare Director.*

*The results of the medication audits will be discussed at the home's periodic quality management review every 3 months.*

**Completion Date:** *07/25/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 7/29/21**

## 186b - Medication Used by Resident

**1. Requirements**

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

**Description of Violation**

*A vial of prescribed Amoxicillin was on a table top in the room of Resident #10. The prescription for the Amoxicillin was for a person who is not a resident of the home.*

**Plan of Correction** **Accept**

*The vial of Amoxicillin was removed from Resident #10 apartment and secured by the Healthcare Director. POA was notified that Resident #10 has a vial of Amoxicillin in [redacted] apartment that was prescribed to another individual and not Resident #10 and that the medication was removed from the apartment.*
*Physician for Resident #10 was notified of the medication and requested a prescription for the Amoxicillin in Resident #10 name.*
*Healthcare Director or Designee will monitor residents apartments daily to ensure proper policies are followed for all medications for residents over the next 3 months*

**Completion Date:** *04/29/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*steps are completed*

## 187d - Follow Prescriber's Orders

**1. Requirements**

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

## 187d - Follow Prescriber's Orders *(continued)*

**Description of Repeat Violation**

*Resident #11 is prescribed Carvedilol 6.25 mg at 8 AM and 8 PM, with directions to take the pulse and hold if pulse is under 60. The MAR (medication administration record) for Resident #11 has recorded pulse as "N/A" on 3/1 and 3/7/21.*

*Resident #2 is prescribed Novolog administered on a sliding scale with blood glucose levels checked at 8 AM, 12 PM and 5 PM. On 4/18/21, a blood glucose level was not obtained.*

*Resident #3 is prescribed Digoxin. However, this medication was not administered to Resident #3 on 4/26/21 because the medication was not available in the home.*
*Resident #3 is prescribed Potassium CL ER. This medication was not administered to Resident #3 on 4/20/21 because the medication was not available in the home.*
*Resident #13 is prescribed a Lidocaine pain patch daily. This was not administered to Resident #13 on 4/17/21 as it was not available in the home.*

*Resident #4 is prescribed Nitroglycerine, Acetaminophen, Benefiber, Diclofenac Sodium Gel, Polyethylene Glycol as needed. None of these medications were available in the home.*

*Repeated Violation - 10/13/20, 2/10/20*

**Plan of Correction** **Accept**

*Healthcare Director contacted the communities Pharmacy to have the medications for Resident # 3, #13, and #4 sent to the community so medications were available to administer as prescribed by the residents Physician.*

*Medication Technicians were educated by the Healthcare Director on proper medication administration and following prescribed parameters for specific medications for the Residents.*
*Healthcare Director educated Medication Technicians on proper documenting of blood glucose levels for residents*
*Healthcare Director or Designee will complete weekly audits of the MAR to ensure all medications are available as prescribed by the physicians and all documentation is entered on the MAR over the next 6 months.*

*The results of the medication audits will be discussed at the home's periodic quality management reviews every 3 months.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented** *GE* **7/29/21**

## 188b - Medication Error Reporting

1. **Requirements**

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

## 188b - Medication Error Reporting *(continued)*

**Description of Violation**

*The following medication errors were not reported to each resident's physician:*

*Resident #2 did not receive prescribed Carbidopa-Levo, Duloxetine HCL, Mag-Tab SR, Metformin, Metoprolol Tartrate, Novolog and Pantoprazole Sod DR at 8:00 AM on 4/18/21.*

*Resident #3 did not receive prescribed Carbidopa-Levodopa, Buspirone HCL, Furosemide, Metoprolol Tartrate at 8 AM on 4/18/21.*

*Resident #4 did not receive prescribed Topiramate at 8:00 AM on 4/18/21.*

*Resident #5 did not receive prescribed Hydrocortisone, Levetiracetam, Sodium Chloride at 8:00 AM and Levothyroxine at 7:30 AM on 4/18/21.*

*Resident #6 did not receive prescribed Acetaminophen 500 mg, Breo Ellipta, Bupropion HCL, Divalproex Sod DR, Duloxetine HCL DR, Eliquis, Escitalopram, Famotidine, Fluticasone Prop, Lidocaine Patch, Magnesium Oxide, Risperidone and Topiramate at 8:00 AM on 4/18/21.*

*Resident #7 did not receive prescribed Carvedilol, Lorazepam and Pantoprazole Sod DR at 8:00 AM on 4/18/21.*

*Resident #8 did not receive prescribed Carvedilol at 8:00 AM on 4/18/21.*

*Resident #3 did not receive prescribed Potassium CL at 8:00 AM on 4/20/21 and Digoxin at 8:00 AM on 4/26/21.*

**Plan of Correction** **Accept**

*Medication errors will be reported to the residents prescribing physicians for follow and directives on the medications.*
*Resident #2, #3, #4, #5, #6, #7, #8, physicians were notified of the medication errors and follow up was received for missed medications.*
*Healthcare Director of Designee will ensure all medication errors are reported to the prescribing physicians upon discovery of the error.*

*The results of the medication audits will be discussed at the hoe's periodic quality management reviews every 3 months.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*

## 188b - Medication Error Reporting *(continued)*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 225a - Assessment 15 Days

1. **Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

**Description of Violation**

*Resident #15 was admitted to the home on [redacted]/2020, but did not have an assessment completed until [redacted]/2020.*

*Resident #6's assessment does not include the need for the 2 one-half bedrails which are attached to the resident's bed.*

**Plan of Correction** **Accept**

*Resident #6 physician was contacted for an order for the use of a bed assist rail and the need for a bed assist rail was added to the residents assessment.*

*New admitting residents will have an assessment completed with in 15 days of admission to the community.*

*Healthcare Director or Designee will ensure assessments are completed on al new residents with in 15 days of moving into the community and will monitor though residents chart audits on a monthly basis over the next 6 months.*

*The chart audits will ensure that all diagnoses and medical needs have been identified and addressed in the residents RASP*
*The administrator will develop and implement a tracking system to identify the initial and annual due dates of each resident assessment and support plan (RASP).*

**Completion Date:** *08/31/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 225c - Additional Assessment

1. **Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

**Description of Violation**

*The home completed an assessment for Resident #2 on 10/23/2020. The previous assessment was completed on 6/6/19.*

## 225c - Additional Assessment *(continued)*

**Plan of Correction** **Accept**

*Annual assessments will be completed for all residents by the Healthcare Director or Designee on an annual basis and monitored through resident chart audits on a monthly basis over the next 6 months*

*The administrator will develop and implement a tracking system to identify the initial and annual due dates of each resident assessment and support plan (RASP) to ensure that all RASP's are done correctly, completely, and within the time frames required by this Chapter.*

**Completion Date:** *08/31/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 227a - Support Plan 30 Days

1. **Requirements**

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

**Description of Violation**

*Resident #15 was admitted on [redacted]2020; however, the resident's initial support plan was not completed until [redacted]2020.*

**Plan of Correction** **Accept**

*Initial support plans will be competed with in 30 days of a resident admitting into the community by the Healthcare Director or Designee and monitored through resident chart audits on a monthly basis over the next 6 months*
*The administrator will develop and implement a tracking system to identify the initial and annual due dates of each resident assessment and support plan RASP to ensure that all RASP's are done correctly, completely, and within the time frames required by this chapter.*

**Completion Date:** *08/31/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 227d - Support Plan Medical/Dental

1. **Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

**Description of Violation**

*The RASP for Resident #6 does not include a plan to protect the resident from the potential dangers of the 2 one-half bedrails that are in place on the resident's bed.*

## 227d - Support Plan Medical/Dental *(continued)*

**Plan of Correction** **Accept**

*Resident #6 RASP was updated on 4/30/2021 to include a plan to protect the resident from any potential harm with the utilization of the one bed enabler placed on [redacted] bed to assist [redacted] when getting into and out of bed as well as positioning while in the bed. A Physicians order was obtained for the utilization of the bed enabler.*

*An audit of RASP's will be conducted for all current residents to ensure that all medical needs have been identified and addressed. This audit will be completed by August 31, 2021.*

**Completion Date:** *08/31/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 231b - Medical Evaluation

1. **Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

**Description of Violation**

*Resident #12 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/20; however, the resident's medical evaluation does not indicate a diagnosis of Alzheimer's disease or other dementia.*

**Plan of Correction** **Accept**

*Resident #12 Physician was contacted in regards to a documented dementia diagnosis.*
*Residents being admitted into the secured dementia unit will have a documented diagnosis of dementia or Alzheimer's Disease by the physician.*
*Healthcare Director or Designee will monitor all secured dementia unit resident admissions medical evaluations to ensure it indicates a diagnosis of dementia or Alzheimer's Disease on an on going basis.*

**Completion Date:** *06/10/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 231c - Preadmission Screening

1. **Requirements**

2600.

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

**Description of Violation**

*Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/2020. A written cognitive preadmission screening was not completed for this resident.*

## 231c - Preadmission Screening *(continued)*

**Plan of Correction** **Accept**

*Resident #1 cognitive preadmission screening was completed on [redacted]/2020*
*The Healthcare Director or Designee will ensure all new residents admitting into the secured dementia unit will have a preadmission screening competed with in 72 hours prior to admission to the secured dementia unit.*
*Healthcare Director or Designee will ensure compliance with the preadmission screening by completing resident chart audits monthly over the next 6 months.*

*If the home determines that the resident's needs cannot be met by the home based on the preadmission screening, the home will refer the resident to the appropriate local assessment agency.*

**Completion Date:** *06/25/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented** GE 7/29/21

## 231e - No Objection Statement

1. **Requirements**

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

**Description of Violation**

*Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/2020. The home has no documentation that the resident has not objected to the admission.*

**Plan of Correction** **Accept**

*Resident #1 designated person signed the approval for placement in dementia care unit on [redacted]/20 ad Resident #1 signed approval for placement in dementia care unit on [redacted]/21.*
*Administrator or Designee will ensure all admitting residents to the secured dementia unit will sign the approval for placement into dementia care unit on day of admission.*
*Administrator or Designee will monitor to ensure approvals are signed by residents residing in the secured dementia care unit on a monthly basis through resident file audits over the next 6 months.*

**Completion Date:** *06/10/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** GE 9/30/21 **Implemented**

*Steps are completed*

## 233c - Key-Locking Devices

1. **Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**Description of Repeat Violation**

*The directions for operating the home's locking mechanism are not conspicuously posted near the main door to the Secure Dementia Care Unit (SDCU), the door to the stairway, the door to the parking area or the gate from the courtyard.*

*Repeated Violation - 10/13/20*

## 233c - Key-Locking Devices *(continued)*

**Plan of Correction** **Accept**

*All doors in the SDCU that are utilized as an entrance and exit have been marked with the access code near the key pads. on 4/29/21.*

*All doors in the SDCU will be monitored on a daily basis by the SDCU Manager or designee to ensure the code is located near the key pads at all exiting and entering doors to the SDCU.*

**Completion Date:** *04/29/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

## 254a - Records Discharge/Active

1. **Requirements**

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

**Description of Violation**

*On 4/27/21, a binder containing resident care sheets, medication count sheets and internal incident reports for residents was on top of the medication cart in the Harmony Square, the home's secured dementia care unit. These documents were not secured and were accessible.*

**Plan of Correction** **Accept**

*The binder is secured in the medication cart when not in use so it is not accessible due to the resident information in the binder. Staff have been educated on the importance to secure the binder in the medication cart when not in use.by the Healthcare Director.*
*Harmony Square Director or designee will monitor on a daily basis to ensure the binder is secured in the medication cart when not in use to ensure no confidential information is accessible over the next 3 months.*

**Completion Date:** *04/30/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/30/21* **Implemented**

*Steps are completed*

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

## Facility Information

**Name:** *HARMONY AT WEST SHORE* **License #:** *33381* **License Expiration Date:** *05/03/2022*
**Address:** *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*
**County:** *CUMBERLAND* **Region:** *CENTRAL*

## Administrator

**Name:** [redacted] **Phone:** *7174021200* **Email:** [redacted]

## Legal Entity

**Name:** *HAMPDEN OPERATIONS LLC*
**Address:** *4423 PHEASANT RIDGE RD,STE 301, ROANOKE, VA, 24014*
**Phone:** *7174021200* **Email:** [redacted]

## Certificate(s) of Occupancy

**Type:** *I-2* **Date:** *05/01/2016* **Issued By:** *Hampden Township*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *87* **Waking Staff:** *65*

## Inspection

**Type:** *Partial* **Notice:** *Unannounced* **BHA Docket #:**
**Reason:** *Interim, POC Verification* **Exit Conference Date:** *07/30/2021*

## Inspection Dates and Department Representative

*07/29/2021 - On-Site:* [redacted]
*07/30/2021 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *115* **Residents Served:** *63*

### Secured Dementia Care Unit

**In Home:** *Yes* **Area:** *Harmony Square* **Capacity:** *35* **Residents Served:** *22*

### Hospice

**Current Residents:** *8*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0* **Are 60 Years of Age or Older:** *63*
**Diagnosed with Mental Illness:** *0* **Diagnosed with Intellectual Disability:** *0*
**Have Mobility Need:** *24* **Have Physical Disability:** *1*

## Inspections / Reviews

**07/29/2021 - Partial**

**Lead Inspector:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/19/2021*

**9/8/2021 - POC Submission**

**Lead Reviewer:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/10/2021*

**9/14/2021 - POC Submission**

**Lead Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/21/2021*

**10/13/2021 - Document Submission**

**Lead Reviewer:** [redacted] **Follow-Up Type:** *Exception*

## 16c - Written Incident Report

1. **Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

**Description of Violation**

*Medication errors occurred 7/1 through 7/5/21 when Resident 10's medications were not available to be given. These errors were not reported to the Department:*

*-Vitamin D3 1000 unit tablet given once per day*
*-Folic Acid 0.4 mg tablet given once per day*
*-Cinacalcet HCL 60 mg 1 1/2 tablets given once per day*

**Plan of Correction** **Accept**

*All medication errors will be reported to the department within 24hours.*
*Medications were placed on hold by MD until further notice dated 5/3/21.*
*Health Care Director will monitor for any medication errors through the MAR on a weekly basis per company policy and evaluate the reporting of medication errors during the Quality Management Reviews on a monthly basis. Staff will be re-educated on the process of reportable incidents that are required to be reported as outlined in regulation 2600.16.c The re education of staff will be completed by 9/30/21.*

***Completion Date:*** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 10/14/21**

## 25b - Contract Signatures

1. **Requirements**

2600.

25.b. 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.

## 25b - Contract Signatures *(continued)*

**Description of Violation**

*The resident-home contract, dated 3/5/21 for Resident 2, was not signed by the resident.*

**Plan of Correction** **Accept**

*All contracts will be signed by the administer and the payor.*
*Contract was signed by resident on 7/29/21 while inspector was on site and placed in her file. The Executive Director or Designee will ensure all contracts with residents are signed by the residents, and designated person and the Executive Director or designee.*
*All Contracts will be audited monthly by the Executive Director or Designee to ensure all signatures are completed over the next 3 months.*
*The administrator will complete an audit of all resident records to ensure that each resident has a current signed contract in place. Any contract without required signatures will be corrected. The audit of all contracts will be done by November 8, 21.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 10/14/21**

## 65a - FS Orientation 1st Day

1. **Requirements**

2600.
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.

**Description of Violation**

*Staff Person B, hired [redacted]/21, did not receive orientation on evacuation procedures, staff duties and responsibilities during fire drills, location and use of fire extinguishers, smoke detectors and fire alarms, or telephone use and notification of emergency services.*

## 65a - FS Orientation 1st Day *(continued)*

**Plan of Correction** **Accept**

*Orientation for all staff will be provided to all staff members prior to their first day of work. Staff person B hire date [redacted]21 completed training on 8/3/21.*

*Administrator or designee will ensure all new staff receive required first day trainings on the day of orientation and will monitor compliance on a monthly basis and will monitor compliance on a monthly basis with co-worker file audits over the next 3 months. Staff training will also be included in the home Quality Management Review every month.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented GE 10/14/21**

## 65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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.

**Description of Violation**

*The following staff did not receive training on mandatory reporting of abuse and neglect or reporting of reportable incidents and conditions:*

*- Direct Care Staff A, hired [redacted]/21*
*- Direct Care Staff B, hired [redacted]/21*
*- Direct Care Staff C, hired [redacted]/21*
*- Direct Care Staff D, hired [redacted]/21*
*- Direct Care Staff E, hired [redacted]/21*
*- Ancillary Staff F, hired [redacted]/21*

**Plan of Correction** **Accept**

*All staff will receive training on mandatory reporting of abuse and neglect. Staff will receive training on reporting of reportable incidents*

*Staff members A,B,C,D,E,F have all received training on mandatory reporting of abuse and neglect [on 8/3/21]. Staff members A,B,C,D,E,F have received training of reportable incidents and conditions to be incompliance [on 8/3/21].*

*Administrator or Designee will ensure al staff receive required trainings within the 40 scheduled working hours and will be monitored monthly by CO-worker file audits of all new Coworkers over the next 6 months. Staff person training will also be included in the home's Quality Management review every month.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented GE 10/14/21**

## 82a - Poisonous Materials

1. **Requirements**

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

## 82a - Poisonous Materials *(continued)*

**Description of Violation**

*A generic spray bottle, labeled "CLR," was stored on the cleaning cart in the Harmony Square secured dementia care unit (SDCU). According to staff, CLR is a calcium-, lime-, and rust-removing cleaning product.*

**Plan of Correction** **Accept**

*Educated staff to proper labeling and storage of poisonous materials [on 8/5/21].*
*Staff training included. Maintenance Director or designee will do daily audits of poisonous materials over the next 3 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/21/21* **Implemented**

*Steps have been completed*

## 82c - Locking Poisonous Materials

1. **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**

*A generic spray bottle, labeled "CLR," was stored on the unlocked cleaning cart in an unsecured and accessible bedroom in the Harmony Square SDCU. The material safety data sheet (MSDS) for this product states if ingested, "DO NOT induce vomiting. CALL A PHYSICIAN OR POISON CONTROL CENTER IMMEDIATELY." Residents of the SDCU are not assessed to be able to safely use or identify poisonous materials.*

**Plan of Correction** **Accept**

*Educated staff [on 8/5/21] that poisonous materials should be locked and stored properly and not accessible to residents. The CLR spray bottle was removed immediately by the maintenance director and replaced with a proper labeled CLR bottle. Maintenance Director will do daily checks for to make sure the cleaning carts are labeled properly and locked when doing morning walk- throughs. Housekeeping Staff will be doing daily checks of their cleaning carts and making sure everything is labeled properly. If something is not labeled appropriately staff will report to Maintenance Director.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/21/21* **Implemented**

*Steps have been completed*

## 141a - Medical Evaluation

1. **Requirements**

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

## 141a - Medical Evaluation *(continued)*

**Description of Violation**

*The medical evaluation for Resident 3, dated 6/16/21, does not include the medical professional's name or license number.*

**Plan of Correction** **Accept**

*Executive Director/ Healthcare Director will make sure that when DME is returned that the DME is properly filled out by the medical professional.*
*Medical professional updated DME form with name and license number. New document provided. The Healthcare Director or Designee will monitor all medical evaluations for residents to ensure all fields on the medical evaluation are completed by the physician.*
*The Healthcare or designee will conduct monthly resident chart audits to ensure Medical evaluations are completed in their entirely by the physicians over the next 6 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 10/14/21**

## 183b - Meds and Syringes Locked

1. **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 7/28/21 at about 9:40 am, a 4-ounce tube of CVS Lidocaine pain relief roll-on was unlocked and accessible on the kitchen counter of Resident 4's bedroom. Resident 4 is not assessed to be able to self-administer medications.*

*On 7/28/21 at about 9:40 am, a small, round, pink tablet marked "Lupin 20" was lying on the floor outside of Bedroom 322.*

**Plan of Correction** **Accept**

*Executive Director/ Healthcare Director will advise all residents and residents family that all medications need to be provide to the home and that the home will obtain an order for resident to have. All medications will be stored in the medication cart unless order to have at bedside by a physician. [Home received physician's order for identified resident on 8/2/21.] Executive Director and HealthCare Director will be doing daily audits of rooms to ensure residents do not have any medications in their rooms over the next 6 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 10/14/21**

## 183e - Storing Medications

1. **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.

## 183e - Storing Medications *(continued)*

**Description of Violation**

*The blister card for Resident 5's Oxycodone was torn and a tablet was protruding through the foil backing.*

**Plan of Correction** **Accept**

*When doing narcotic count staff will check each blister pack to make sure medications are sealed in accordance with manufactures instructions. On 8/3/21 staff received training regarding medication storage.*
*Resident 5 blister pack was corrected on site. Staff will do daily audits of narcotic blister packs.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/21/21* **Implemented**

*Steps have been completed*

## 185a - Implement Storage Procedures

1. **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 Repeat Violation**

*Resident 5's glucometer was programmed with the wrong date; on 7/30, 7/16 was recorded.*

*Resident 6's glucometer was programmed with the wrong time; at 9:37 am, 6:25 was displayed.*

*Repeated Violation - 2/10/20*

**Plan of Correction** **Accept**

*Staff will check glucometers date and time are correct with each when the battery needs changed will correct date and time.*
*Residents 5&6 glucometer was programmed correctly on site. Staff education on glucometers. Harmony Square Director will do daily audits of glucometers to ensure date and time are correct with each use.*
*Medication Technicians were trained on the proper procedures of glucometers date and time [on 8/3/21 - see attached]. Harmony Square Director will monitor on the daily basis.*
*The results will be discussed at our monthly Quality management review every 3 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** **Not Implemented GE 10/14/21**

## 187a - Medication Record

1. **Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
5. Dosage form.
10. Duration of therapy, if applicable.
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

## 187a - Medication Record *(continued)*

**Description of Violation**

*Residents 5, 7, and 8 are prescribed sliding scale insulin that varies in dose depending on the resident's blood sugar reading at the time of administration. During July, 2021, the home's medication administration records for these residents did not include the dose of insulin that was administered.*

*Resident 5 was prescribed Lotemax SM 0.38% ophth gel, one drop in both eyes twice a day for five days. The duration of this therapy is not listed on the medication administration record.*

*Resident 8 is prescribed Freestyle Libre 14 day sensor, inject 1 kit under the skin every 14 days. Staff Person G stated that the injection was given on 7/10/21. There was no record of the injection having been given from 7/1/21 through7/24/21.*

**Plan of Correction** **Accept**

*Executive Director/ Healthcare Director will ensure any sliding scale insulin units are recorded in the MAR for documentation.*
*Executive Director/ Healthcare Director will ensure duration of therapy is listed on the MAR. Staff training on injections that is given is properly documented was held on 8/3/21.*
*Healthcare or designee will do weekly audits for next 3 months of MARS to ensure accuracy.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*
**Document Submission** **Not Implemented GE 10/14/21**

## 187d - Follow Prescriber's Orders

1. **Requirements**

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

**Description of Repeat Violation**

*The following medications for Resident 10 were not given from 7/1/21 through 7/5/21 because they were not available:*

*-Vitamin D3 1000 unit tablet to be given once per day*
*-Folic Acid 0.4 mg tablet to be given once per day*
*-Cinacalcet HCL 60 mg 1 1/2 tablets to be given once per day*

*Repeated Violation - 10/13/20,*

## 187d - Follow Prescriber's Orders *(continued)*

**Plan of Correction** **Accept**

*The home will follow the directions of the provider. Staff training when medication is not available to contact pharmacy, contact family if provides and MD. If prescribed medication is unavailable contact PCP to make aware medications are not available and get an order to place on hold.*
*Enclosed is the document to hold these meds until further notice dated 5/3/21.*
*Executive Director and Healthcare Director will ensure staff is following the order by the doctor by doing weekly audits and monthly staff education on new orders and following procedures.*
*Medication Technicians were educated by the HealthCare Director on proper medication administration and following the prescribed orders for the residents.*
*Healthcare or designee will monitor over the next 3 months*

**Completion Date:** *09/08/2021*
**Document Submission** **Not Implemented GE 10/14/21**

## 224a - Preadmission Screen Form

1. **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 3's preadmission screening form, dated [redacted]21, does not include a determination that the needs of the resident can be met by the services provided by the home.*

**Plan of Correction** **Accept**

*All pre admission screenings will be checked by the Executive Director and Healthcare Director that the appropriate boxes are filled out correctly. Executive Director and Health Care Director will do weekly audits to all pre admission screenings in the SCDU for the next 3 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/21/21* **Implemented**

*Steps in process*

## 227h - Support Plan Refuse Sign

1. **Requirements**

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

**Description of Violation**

*The support plan for Resident 9, completed 11/16/20, was not signed by the resident nor is there any mark of [redacted] refusal or inability to sign.*

## 227h - Support Plan Refuse Sign *(continued)*

**Plan of Correction** **Accept**

*All support plans will be checked and if residents are unable to sign it will be documented.*
*Resident 9 signed support plan on 8/3/21. document enclosed.*
*Executive Director and HealthCare Director will do monthly audits of all support plans to ensure all signatures are obtained in the next 3 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/21/21* **Implemented**

*Steps in process*

## 231c - Preadmission Screening

1. **Requirements**

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

**Description of Violation**

*Resident 3 was admitted to the home on [redacted]21, however the resident's preadmission screening was not completed until [redacted]/21.*

**Plan of Correction** **Accept**

*All cognitive screenings will be completed 72 hours prior to admission to the secured memory care unit. Executive Director will check all documents and do weekly audits to admissions to SDCU over the next 3 months.*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

***Document Submission*** ***Not Implemented GE 10/14/21***

## 234a - Admission Support Plan

1. **Requirements**

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

**Description of Violation**

*Resident 3 was admitted to the Harmony Square SDCU on [redacted]/21, however, the resident's initial support plan was completed on [redacted]/21.*

**Plan of Correction** **Accept**

*All Support plans will be developed, implemented and documented 72 hours prior or within 72 hours in the secured dementia unit. Executive Director and HealthCare Director will do audits to SDCU after any admission to the SCDU to ensure support plans are done within 72 hours before or after admission. HealthCare Director or designee will monitor over the next 3 months*

**Completion Date:** *09/08/2021* *Licensee's Proposed Date for POC Implementation.*

**Document Submission** *GE 9/21/21* **Implemented**

*Steps in process*