



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **FOX CHAPEL OPERATIONS LLC**

LEGAL ENTITY

To operate **HARMONY AT HARTS RUN**

NAME OF FACILITY OR AGENCY

Located at **3450 HARTS RUN ROAD, GLENSHAW, PA 15116**

(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 **114**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

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 **July 24, 2023** until **January 24, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **453222**

[Signature]
ISSUING OFFICER

[Signature]
ACTING 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 – 04/23



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: July 24, 2023

[REDACTED]
Fox Chapel Operations LLC
[REDACTED]
[REDACTED]

RE: Harmony at Harts Run
3450 Harts Run Road
Glenshaw, Pennsylvania 15116
License/COC #: 453222

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 29, 2022, November 30, 2022, January 23, 2023, January 26, 2023, January 30, 2023, and April 13, 2023, 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), mistreatment or abuse of residents being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from July 24, 2023 to January 24, 2024.

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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
42(b)	II	61	\$5	\$305	5 calendar days from mailing date of this letter
187(d)	II	61	\$5	\$305	5 calendar days from mailing date of this letter
231(b)	II	61	\$5	\$305	5 calendar days from mailing date of this letter
231(c)	II	61	\$5	\$305	5 calendar days from mailing date of this letter
234(a)	II	61	\$5	\$305	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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:


 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,

A handwritten signature in dark ink, reading "Juliet Marsala". The signature is written in a cursive style with a large, stylized "J" and "M".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

A series of four horizontal black bars of varying lengths, redacting the names of the recipients in the carbon copy list.

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

Facility Information

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *04/14/2023*
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *05/08/2021* Issued By: *Township of Indiana*
Type: *I-2* Date: *08/23/2021* Issued By: *Township of Indiana*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *72* Waking Staff: *54*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident* Exit Conference Date: *11/30/2022*

Inspection Dates and Department Representative

11/29/2022 - On-Site: [REDACTED]
11/30/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* Residents Served: *54*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *40* Residents Served: *14*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *53*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *18* Have Physical Disability: *1*

Inspections / Reviews

11/29/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/23/2022*

01/03/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/27/2023*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/13/2023*

01/19/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/27/2023*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/29/2023*

06/07/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: *01/27/2023*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

42b - Abuse

1. Requirements

2600.

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

Description of Violation

On 11/13/22 at approximately 4:00 p.m., resident #1 bit resident #2 on the left arm "leaving bleeding bite mark on it." Resident #1 had a previous incident of biting another resident on 10/4/22. On approximately 11/11/22, the home identified the need for 24 hour supervision for the resident. However, the home did not provide the needed supervision.

Repeat violation 6/21/22 et al

Plan of Correction

Directed [REDACTED] - 01/19/2023)

Resident #1 was not properly supervised to prevent any further biting episodes.

Staff did not supervise resident closely enough due to lack of education of the importance of this.

Resident #1 was sent to the hospital for a psychiatric evaluation and was not permitted to return to the community due to continued aggressive behaviors.

All new residents will be evaluated for aggressive behaviors prior to admission by the Healthcare Director and if any current residents have aggressive behaviors, they will be addressed with their physician promptly to determine what is needed to manage the behaviors. No other aggressive behaviors noted upon evaluation of current residents.

Support plans will reflect accurate current needs of each resident.

Staff will be educated by the Health Care Director or designee within 24 hours of change of support plan needs.

Staff were re-educated by Area Agency on Aging on Abuse 11/15/22 and will be re-educated annually.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall privately interview three residents a week for three month and three residents a month thereafter to ensure residents are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Documentation of interviews shall be kept. 1/19/23 [REDACTED]

Directed Completion Date: 01/20/2023

Not Implemented [REDACTED] - 06/07/2023)

42s - Privacy

2. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 9/13/22, resident #1's family moved the resident's belongings into the unit she was to occupy. On 9/15/22 at approximately 9:00 a.m., the family informed the home that several items including a small table, bed linens, a pillow, towels, rags and an 8'X10' rug totalling \$448 were missing from the resident's apartment.

Plan of Correction

Directed [REDACTED] - 01/19/2023)

The community failed to protect a resident's belongings from being stolen.

Police were notified at the time we were informed items were missing.

After police investigation it has been unproven as to who removed the belongings and when.

42s - Privacy (continued)

The total amount of \$448 will be refunded to the resident within 30 days of room being vacated of belongings, which was 11/22/22.

Cameras have been purchased and will be installed on exterior main exits by March 13, 2023.

Staff were re educated on resident rights by Area Agency on Aging on 11/15/22 and will be repeated in 6 months (May 2023) and annually thereafter by the Executive Director.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall offer all residents the option of completing a resident inventory form at the time of admission. 1/19/23

Directed Completion Date: 01/20/2023

Not Implemented - 06/07/2023

187d - Follow Prescriber's Orders**3. Requirements**

2600.

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

Description of Violation

Resident #2 is ordered Acetaminophen 500mg caplet take 2 tablets (=1000mg) by mouth every 8 hours for pain. However, according to the times on the resident's December 2022 medication administration record (MAR), this medication is administered at 7:00 a.m., 1:00 p.m. and 7:00 p.m.

Repeat violation 6/21/22 et al

Plan of Correction

Accepted - 01/03/2023

The medication times listed in the MAR were not entered to match how they were ordered.

The nurse/medication aide who entered the times did not read the order correctly and inadvertently entered the wrong times for the medication.

The physician was notified of the error and changed the order directions to 7am, 1pm and 7pm.

All medication aides were re educated by the Health Care Director on 11/29 & 11/30/22 on the importance of reading orders thoroughly and transcribing them correctly onto the MAR.

The Healthcare Director will check all new orders daily and ensure they have been added to the MAR correctly for the next 3 months, then will randomly check orders weekly for accuracy.

Licensee's Proposed Overall Completion Date: 12/23/2022

Not Implemented - 06/07/2023

231b - Medical Evaluation**4. Requirements**

2600.

231b - Medical Evaluation (continued)

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 #1 was admitted to the Secure Dementia Care Unit on [REDACTED] However, the resident's medical evaluation was completed 6/27/22 which exceeds 60 days prior to admission.

Repeat violation 6/21/22 et al

Plan of Correction

Accept [REDACTED] - 01/03/2023)

The resident's medical evaluation was not completed in the required time frame of admission.

The Healthcare director did not check to make sure dates were in compliance.

All new admission paperwork will be checked by the Healthcare Director and then checked by the Executive Director 3 days prior to move in to ensure compliance with dates is met. The HealthCare Director will audit all files of current residents and to be completed by 12/31/2022 to ensure compliance.

Licensee's Proposed Overall Completion Date: 12/23/2022

Not Implemented [REDACTED] 06/07/2023)

231c - Preadmission Screening**5. 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

Prior to discharge, resident #1 resided in the home's Secure Dementia Care Unit. Resident #1's preadmission screening completed 9/8/22 for resident #1 does not indicate the name or signature of the person completing the cognitive screening. The screening also does not indicate that the resident requires a secured dementia care unit. This section was blank.

Resident #3 was admitted to the Secure Dementia Care Unit on [REDACTED] However, the resident's preadmission screening, including the cognitive screening, was completed on 7/14/22.

Repeat violation 5/11/22 et al, 6/21/22 et al

Plan of Correction

Directed ([REDACTED] - 01/19/2023)

The residents prescreen was not completed correctly or signed within 72hrs prior to admission.

All new admission paperwork will be checked by the Healthcare Director and then signed by the Executive Director 3 days prior to move in to ensure compliance with dates is met. The HealthCare Director will audit pre-admission screenings to ensure compliance and to be completed on 12/31/2022. Newly hired Healthcare Director was educated on POC items on 1/12/23 and will follow up with all POC items noted. Audits will be ongoing-no end date.

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

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure compliance with Regulation 2600.231(c). 1/19/23

Directed Completion Date: 01/20/2023

Not Implemented - 06/07/2023)

234a - Admission Support Plan**6. 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 Secure Dementia Care Unit (SDCU) on However, the resident's initial support plan was completed on 8/16/22.

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on However, the resident's initial support plan was completed on 10/4/22.

Repeat violation 5/11/22 et al, 6/21/22 et al

Plan of Correction

Directed - 01/19/2023)

The residents support plan was not completed within the required time frame on 2 residents.

The Healthcare Director did not complete and did not report to anyone that they needed completed.

The newly hired Healthcare Director has been educated on this POC and requirements of it.

The Health Care Director and/or designee will check all new residents' files within 3 days of admission to ensure support plans are completed timely. Audits will be ongoing with no end date.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure compliance with Regulation 2600.234(a). 1/19/23

Directed Completion Date: 01/20/2023

Not Implemented - 06/07/2023)

234c - Support Plan Responsible Person**7. Requirements**

2600.

234.c. The support plan must identify the individual responsible to address the resident's needs.

Description of Violation

The home uses a form created by the home as the resident's assessment and support plan.

The support plan completed on 11/7/22 for resident #4 did not include the individual responsible to address the resident's needs as follows:

Page 3 Orientation assessment indicates resident is frequently disoriented and requires frequent supervision and

234c - Support Plan Responsible Person (continued)

oversight.

Page 3 Vision assessment indicates resident can see with devices. However, the support plan does not indicate what assistance is needed to maintain/clean devices.

Page 4 Communication Enabling Devices & Methods indicates resident has speech problems and an enabling device for communication. However, resident does not have an enabling device for communication.

Page 4 Wandering assessment indicates resident "... Has history of leaving immediate area, getting lost or being combative about returning." However, the support plan does not include plan/tactics that work to redirect resident.

Page 4 Judgement assessment indicates "Resident resists care. Cannot make appropriate decisions for self or makes unsafe decisions and needs supervision. Judgment is poor." However, the resident's support plan does not indicate who will provide supervision or the frequency of supervision needed.

Page 5 Anxiety assessment indicates that resident has "current history of frequent anxiety." However, the support plan does not indicate who is responsible to address this need.

Page 9 Bathing Level of Assistance indicates "Extensive: Resident requires hands on assistance with participation by the resident to complete task. However, the support plan does not indicate what assistance resident needs and who is responsible to provide the service.

Page 11 Additional Nursing Services/Outside Services the resident's assessment indicates additional nursing services to include physical therapy and occupational therapy. However, the support plan does not include the name of the provider of these services.

Plan of Correction**Directed** [REDACTED] 01/19/2023)

The support plan did not indicate the individual responsible for addressing the resident's needs.

A corrected support plan was completed on 1/12/23. [REDACTED] involved in completing support plan and signatures obtained.

The Healthcare Director or designee will audit 3 new admission support plans every month for the next 6 months, and then randomly, to ensure they are completed correctly.

The newly hired Healthcare Director was educated on items on this POC on 1/12/23. Audits will be ongoing.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure compliance with Regulation 2600.234(c). 1/19/23 [REDACTED]

Directed Completion Date: 01/20/2023

Not Implemented [REDACTED] - 06/07/2023)**234e - Involvement/Participation****8. Requirements**

2600.

234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

The support plan developed 11/7/22 for resident #2 did not include documentation that the resident or the designated person was involved in the development of the support plan.

234e - Involvement/Participation (*continued*)**Plan of Correction****Directed** ■ - 01/19/2023)

The support plan was developed without documentation that the resident or designated person was involved in the development of the plan.

The Healthcare Director and/or designee will audit 3 new admission support plans every month for the next 6 months, and then randomly, to ensure they are completed correctly.

The newly hired Healthcare Director was educated on 1/12/23 on the items in this POC. The Healthcare Director and or designee will meet with designated person of all new admissions in developing the support plan. This plan will be ongoing with no end date.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure compliance with Regulation 2600.234(e). 1/19/23 ■

Directed Completion Date: 01/20/2023

Not Implemented ■ - 06/07/2023)

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

Facility Information

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *04/14/2023*
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *08/23/2021* Issued By: *Township of Indiana*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *78* Waking Staff: *59*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Provisional* Exit Conference Date: *01/30/2023*

Inspection Dates and Department Representative

01/23/2023 - On-Site: [REDACTED]
01/26/2023 - On-Site: [REDACTED]
01/30/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* Residents Served: *54*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *40* Residents Served: *15*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *53*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *24* Have Physical Disability: *2*

Inspections / Reviews

01/23/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/20/2023*

02/28/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: *05/17/2023*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/07/2023*

03/09/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: *05/17/2023*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *03/16/2023*

06/08/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: *05/17/2023*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 1/26/23 at 1:31 p.m., there were two orange binders labeled Monarch Hospice setting on the accessible and unattended nurse's station desk outside of the medication room of the home's secure dementia care unit. The binders contained protected information including POLSTs and care notes for residents #1 and #2.

On 1/30/23 at 10:22 a.m., there were medical evaluations for resident #3 and resident #4 and a white binder setting open with pages titled "End of Shift Report" dating from 1/30/23 as far back as 7/17/22 that included resident care information for residents #5, #6, #7, #8, et al., setting on the desk in the accessible and unattended third floor nurse's station.

REPEAT VIOLATION 5/11/22 et al., 6/21/22 et al.

Plan of Correction

Accept () 03/09/2023

The two orange hospice binders observed unattended at the nurse station on 1/26/23 were removed immediately on 1/26/23 and stored in the locked medication room. The medical evaluations for residents #3 and #4 and the End of Shift Report binder observed unattended at the nurse station on 1/30/23 were removed immediately and stored in the locked medication room. All nursing and care staff were re-educated on 2-20-2023 and 2-22-2023 on resident confidentiality and all resident records and documentation shall not be left unattended and are to be stored and maintained in the locked medication room when not in use. Executive Director, nurse, or medication staff on duty will perform a daily audit that all resident records and documentation of care are not unattended and stored and maintained in the locked medication room. Daily audits will be documented on a tracker/log. (see attached)

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented () 06/08/2023

42s - Privacy

2. Requirements

2600.

- 42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 1/26/23 at 9:05 a.m., a voice-controlled electronic device was observed in the common lounge area at the main entrance to the personal care home. On 1/26/23 at 1:30 p.m., the device was observed setting at the nurse's station in the home's secure dementia care unit. The home also has a device in the dining room area near the independent living entrance.

The home does not have any policies and procedures related to the use of the devices to address:

- Identification of staff who have access to administrative rights for the device.*
- Written notification of the use of the device is posted and includes notification that the device is in operation and may be recording conversations, including conversations not intended to be recorded. While the facility may have access*

42s - Privacy (continued)

to these recorded conversations, the facility will delete the conversation history from any device used by the facility on a regular basis as determined by the facility.

- The facility will maintain policies and procedures that prevent recorded conversations from being shared or disclosed in any way, unless required by law.
- Knowing or intentional recording without the person's consent or the consent of their legal representative, is prohibited.
- Use of the device within the facility should be addressed at a minimum, in the resident-home contract.

Plan of Correction**Accept (██████) 02/28/2023)**

The "voice-controlled electronic device" observed in the main entrance common lounge area, the secured memory care unit, and the dining room was an Amazon Alexa/Echo and has only been used to play music for the residents and is activated by a voice command. At the surveyor's recommendation, due to concerns the device may be recording without consent, the devices have been removed and are no longer being used in the community.

Complete: 1-26-2023

Licensee's Proposed Overall Completion Date: 02/24/2023

Not Implemented (██████) - 06/08/2023)**63a - First Aid/CPR Training****3. 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 1/13/23, the home served 54 residents. However, there were no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 3:00 p.m. – 11:00 p.m. and only one staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. – 2:00 a.m. on 1/14/23.

On 1/15/23, the home served 54 residents. However, there were no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 3:00 p.m. – 11:00 p.m. and only one staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. – 7:00 a.m. on 1/16/23.

On 1/21/23, the home served 52 residents. However, there were no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 3:00 p.m. – 11:00 p.m. and only one staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. – 7:00 a.m. on 1/22/23.

Plan of Correction**Accept (██████) - 02/28/2023)**

CPR and First Aid certification was obtained for staff on 1-31-2023. Copies of the certification were stored in the employee files. Executive Director, HCD, and or designee will monitor the schedule each week to ensure that there is at least 1 person for every 50 residents will be scheduled each shift. Additional training for current and new staff will be ongoing.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented (██████) 06/08/2023)

64a - Admin Training

4. Requirements

2600.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

1. An orientation program approved and administered by the Department.
3. A Department-approved competency-based training test with a passing score.

Description of Violation

Staff person A, the home's administrator, did not have documentation of completing an orientation program approved and administered by the Department nor documentation of successfully completing a Department-approved competency-based training test with a passing score.

Plan of Correction

Accept [REDACTED] - 02/28/2023)

Staff person A's required certifications were placed in their employee file on 2-3-2023. Any new administrator will have copies of all required certifications placed in their employee file on hire before the start date.

Licensee's Proposed Overall Completion Date: 02/24/2023

Not Implemented [REDACTED] - 06/08/2023)

66a - Staff Training Plan

5. Requirements

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

On 1/26/23 at 9:15 a.m., the home did not have a staff training plan for the 2023 training year.

Plan of Correction

Accept [REDACTED] - 02/28/2023)

The 2023 Annual staff training plan was updated 1-26-2023. The Business Office Manager will audit and update the annual training binder for employee files monthly to ensure training plan for employees are updated, and in December each year the upcoming new year's training plan and tracker will be updated and placed in each employee's file.

Licensee's Proposed Overall Completion Date: 02/24/2023

Not Implemented [REDACTED] - 06/08/2023)

82a - Poisonous Materials

6. Requirements

2600.

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

Description of Violation

On 1/26/23 at 12:43 p.m., there was a half-full unlabeled bottle with yellow liquid identified as All-Purpose Cleaner on an unlocked, unattended housekeeping cart in the hallway outside of the first-floor staff break room.

Plan of Correction

Accept [REDACTED] 03/09/2023)

The unlabeled bottle of All-Purpose cleaner was labeled and secured in a locked area not accessible to residents immediately on 1-26-2023. All staff have been reeducated on 2-20-,2-23-2-22-2023 by Corporate clinical

82a - Poisonous Materials (continued)

Specialist on all products being required to have a label, not leaving poisonous materials unlocked, unattended, and accessible to residents, all poisonous materials must be stored in a locked and secured area that is not accessible to residents when not in use, and housekeeping carts are to be stored in the locked housekeeping closet when not in use. The home and secured unit will be monitored daily by the Executive Director/designee to ensure no poisonous materials are in unlocked areas or areas accessible to residents and housekeeping carts are stored in housekeeping closets and not left unattended when not in use. Daily audits will be documented on a tracker/log. See attached. Complete: re education on 2-22-2023.

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented [REDACTED] - 06/08/2023)

82c - Locking Poisonous Materials**7. 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

On 1/26/23 at 12:43 p.m., the following poisons were in the unlocked roll up compartment of the unattended housekeeping cart in the first-floor hallway outside of the staff break room:

** Two full bottles and one ¼ full bottle of yellow All-Purpose Cleaner with warning label that indicates "call a poison control center or doctor . . ."*

** Two partially full bottles of Bio-Enzymatic Odor Eliminator with a warning label that indicates "get medical advice/attention if you feel unwell."*

Resident #9 has not been assessed as able to safely use and avoid hazardous material.

Plan of Correction

Accept [REDACTED] 02/28/2023)

The 3 unlabeled bottles of All-Purpose cleaner observed in the unlocked roll-up compartment of the housekeeping cart, along with the 2 bottles of Bio-Enzymatic odor eliminator were labeled and secured in a locked area not accessible to residents immediately on 1-26-2023. All staff have been reeducated on 2-22-2023 by Corporate Clinical Specialist on not leaving poisonous materials unlocked, unattended, and accessible to residents, all poisonous materials must be stored in a locked and secured area that is not accessible to residents when not in use, and housekeeping carts are to be stored in the locked housekeeping closet when not in use. The home and secured unit will be monitored daily by the Executive Director, Maintenance Technician, HCD and all staff to ensure no poisonous materials are in unlocked areas or areas accessible to residents and housekeeping carts are stored in housekeeping closets and not left unattended when not in use. Complete: 2-22-2023

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented [REDACTED] - 06/08/2023)

85a - Sanitary Conditions**8. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

85a - Sanitary Conditions (continued)**Description of Violation**

On 1/23/23 at 12:19 p.m., there was a large black trash bag with smaller filled trash bags inside setting open on the floor in front of the third-floor nurse's station.

Plan of Correction

Accept [REDACTED] 02/28/2023)

The large black trash bag in front of the nurse station on 3rd floor was removed immediately on 1-26-2023 All staff were re-educated on 1/23/23 and 1/24/23 by Maintenance Technical on proper handling and disposal of trash and trash bags. Executive Director, Maintenance Technician, all staff and or designee will monitor daily that no trash or trash bags are left unattended and are placed in appropriate locked areas or receptacles.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented [REDACTED] - 06/08/2023)

85e - Trash Outside Home**9. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/23/23 at 12:00 p.m., there was an approximately 10" X 10" X 2' high brown and pebble trash can with approximately 6" round openings on two of the four sides setting outside of the main entrance to the personal care home.

REPEAT VIOLATION 5/11/22 et al.

Plan of Correction

Accept [REDACTED] 03/09/2023)

2 of the outdoor trash receptacles were removed immediately on 1-23-2023 and were replaced with cans that have a lid. Staff were educated on 2/20/23 and 2/22/23 on proper storage of garbage and the requirement of all garbage cans to have a lid. ED/Maintenance Director will check common area garbage cans daily to ensure the lid is in place and audits will be documented on tracker/log. See attached.

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented [REDACTED] 06/08/2023)

91 - Telephone Numbers**10. Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 1/30/23 at 11: 20 a.m., there were no telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline posted on or near the telephone in resident room [REDACTED]

91 - Telephone Numbers (continued)

Plan of Correction

Accept () 02/28/2023

A list of telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline was replaced in Resident room #328 immediately on 2-20-2023. All resident rooms, nurse stations, reception desks and any other phone areas have been audited for the appropriate telephone number list. The list of telephone numbers will be replaced, if missing from any required location. Complete: 2-22-2023. A monthly audit will be conducted by ED, HCD, MT and or designee to ensure telephone lists are intact. Complete: reeducation on 2-20-2023-2-22-2023 for current employees on this importancergency telephone numbers were immediately placed in room #328 on 1/30/23. Going forward housekeeping will do weekly audits of emergency telephone numbers and will immediately place for all new resident's moving into Harmony. The Executive Director will monitor weekly audits to ensure compliance.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented () 06/08/2023

103e - Left Overs

11. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 1/23/23 at approximately 2:30 p.m., there was an unlabeled, undated bowl with two scoops of chocolate ice cream setting in the ice cream freezer in the home's kitchen.

Plan of Correction

Accept () 02/28/2023

The unlabeled undated bowl of ice cream was removed immediately from the freezer on 1-23-2023 Kitchen staff were reeducated on proper storage, labeling, and dating of food on 2/13/23, 2/14/23, and 2/15/23. ED, Dining Director, Cook and or kitchen staff will audit refrigerators and freezers daily to ensure all food and containers are properly stored, labeled, and dated. Complete reeducation was completed by 2-20-2023.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented () 06/08/2023

103f - Refrigerator/Freezer Temps

12. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 1/23/23 at approximately 2:30 p.m., the temperature of the ice cream freezer in the home's kitchen measured 10 degrees Fahrenheit.

REPEAT VIOLATION 5/11/22 et al.

Plan of Correction

Accept () 02/28/2023

The freezer temperature was reset to 0 degrees F on 2-23-2023. Kitchen staff were reeducated on proper temperatures for refrigerators and freezers on 2/13/23, 2/14/23, and 2/2-/23. Dining Director will monitor

103f - Refrigerator/Freezer Temps (continued)

refrigerator and freezer temperatures daily to ensure proper temperatures are maintained. Complete re education by 2-20-2023

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented [REDACTED] 06/08/2023)

103g - Storing Food**13. Requirements**

2600.

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

Description of Violation

On 1/23/23 at approximately 2:25 p.m., there was a partially uncovered large rectangular "hotel" pan with 18 hotdogs setting in water in the walk-in refrigerator in the home's kitchen.

On 1/23/23 at approximately 2:30 p.m., there was an uncovered bowl with two scoops of chocolate ice cream setting in the ice cream freezer.

REPEAT VIOLATION 5/11/22 et al.

Plan of Correction

Accept [REDACTED] 02/28/2023)

The pan of hotdogs was immediately covered and bowl of ice cream was removed 2-23-2023. Kitchen staff were reeducated on proper storage, labeling, and dating of food on 2/13/23, 2/14/23, and 2/20/23. Dining Director, cook and or kitchen staff will audit refrigerators and freezers daily to ensure all food and containers are properly stored, labeled, and dated. Complete reeducation on 2-20-2023.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented [REDACTED] 06/08/2023)

107c - Food/Water 3 Day Supply**14. Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1/23/23, at 2:45 p.m., the home served 54 residents requiring 162 gallons of emergency water to be on site. However, the home had 120 gallons of emergency water on site. The home does not have a contract regarding water being supplied in the event of an emergency.

Plan of Correction

Accept [REDACTED] 02/28/2023)

42 Gallons of water were ordered from Sysco on 1/24 and received on 1/26. Dining Director and kitchen staff were reeducated on need for at least a 3 day supply of food and drinking water to be maintained at all times on 2-20-2023. Dining Director, cook, and or ED will audit the 3 day emergency supply of food and water monthly to ensure adequate amounts. Completed reeducation was completed 2-20-2023 to assure new emergency supply is monitored each week for new residents moving in and additional supplies are ordered timely.

107c - Food/Water 3 Day Supply (continued)**Licensee's Proposed Overall Completion Date:** 02/24/2023**Implemented** [REDACTED] - 06/08/2023)**126a - Furnace Inspection****15. Requirements**

2600.

126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home's personal care and memory care areas consist of 73 resident rooms/suites each with an individual heat pump/furnace in addition to five additional heat pump/furnaces that serve the common areas. However, on 1/30/23, the home had documentation that only 13 resident rooms and the five common area furnaces had been inspected in the past year by a trained maintenance staff person. There is no documentation when the previous inspections had occurred.

Plan of Correction**Accept** [REDACTED] 02/28/2023)

All 73 resident heat pump/furnaces and 5 common area heat pumps/furnaces will have been inspected and documented by [REDACTED] HVAC by March 31st 2023. Executive Director will monitor heat pump/furnace inspection records annually to ensure all units have been inspected and contain proper documentation each year.

Licensee's Proposed Overall Completion Date: 03/31/2023**Implemented** [REDACTED] - 06/08/2023)**132a - Monthly Fire Drill****16. Requirements**

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Unannounced fire drills were not held in October 2022 and November 2022.

Plan of Correction**Accept** [REDACTED] 02/28/2023)

A fire drill was conducted and documented with all required information (date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative for the home 1-31-2023 Monthly fire drills with corresponding required information and documentation will be conducted and reviewed by the Executive Director and or Maintenance Technical each month or each drill.

Licensee's Proposed Overall Completion Date: 02/24/2023**Implemented** [REDACTED] 06/08/2023)**132c - Fire Drill Records****17. Requirements**

2600.

132c - Fire Drill Records (continued)

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record for the fire drill conducted on 12/28/22 at 3:00 p.m. does not include the number of residents evacuated.

REPEAT VIOLATION 5/11/22 et al.

Plan of Correction

Accept (██████) 03/09/2023)

A fire drill was conducted and documented with all required information (date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative for the home 1-31-2023. Monthly fire drills with all required information and documentation will be conducted monthly and reviewed for accuracy by the Executive Director, Maintenance and or designee. ED will review the fire drill documentation monthly for 3 months then quarterly and will be documented on the tracker/log. See attached.

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented (██████) 06/08/2023)

132d - Evacuation**18. Requirements**

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill conducted on 6/13/22 at 9:30 a.m., only 49 of 52 residents were evacuated.

During the fire drill conducted on 7/22/22 at 6:30 p.m., only 51 of 56 residents were evacuated.

During the fire drill conducted on 8/9/22 at 5:00 a.m., only 55 of 65 residents were evacuated.

During the fire drill conducted on 9/18/22 at 1:30 p.m., only 56 of 65 residents were evacuated.

Plan of Correction

Accept (██████) 03/09/2023)

A full evacuation of all residents was performed on 1-31-2023 by the Maintenance Technician and fire safety expert and properly documented. Staff were trained on the importance of evacuating all residents to a fire safe area during a fire emergency. Executive Director, Maintenance Technician scheduled a Fire Safety inspection on 2-6-2023 with the fire safety expert. It was recommended to add numbers to fire safe areas in order to better describe fire safe area used during evacuation. That was completed on 2-21-2023. ED will review the fire drill documentation monthly for 3 months then quarterly and will be documented on the tracker/log. See attached.

132d - Evacuation (*continued*)

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented [REDACTED] 06/08/2023)

132f - Alternate Exit Routes

19. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home did not alternate the exit routes used for fire drills from June 2022 through December 2022. The fire drills conducted by the home on 6/13/22 at 9:30 a.m., 7/22/22 at 6:30 p.m., 8/9/22 at 5:00 a.m., 9/18/22 at 1:30 p.m. and 12/28/22 at 3:00 p.m. all indicate that the exit route used was the "Elevator Safe Zone."

Plan of Correction

Accept [REDACTED] - 03/09/2023)

A fire drill using an alternate route from the previous fire drill was conducted and documented with all required information (date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative for the home 1-23-2023. Monthly fire drills using alternate evacuation routes with corresponding required information and documentation will be conducted and reviewed by the Executive Director, Maintenance Technician and or designee. ED will review the fire drill documentation monthly for 3 months then quarterly and will be documented on the tracker/log. See attached.

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented [REDACTED] - 06/08/2023)

141a 1-10 Medical Evaluation Information

20. 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 initial medical evaluation (DME) completed 10/19/22 for resident #10 does not include a list of the resident's medication. The addendum indicates "see attached." However, nothing was attached.

The initial DME completed 10/11/22 for resident #11 does not include the resident's pulse rate, temperature and list

141a 1-10 Medical Evaluation Information (continued)

of medications. These sections were blank.

The initial DME completed 12/22/22 for resident #12 was updated in Section (8) Body Positioning/Movement with "W/C" written in blue ink. However, this update does not include the initials and credentials of the staff person making the update nor the date and time when the staff person spoke with the medical professional who completed the evaluation to update the document.

REPEAT VIOLATION 5/11/22 et al.

Plan of Correction**Accept** [REDACTED] 02/28/2023

Resident # 10 medication list was corrected and attached with signature from Move in, on 2-21-2023. SEE attached. Resident # 11 Vital signs were completed and added to the DME with the PCP being made aware of this addition on 2-21-2023. See Attached

Resident #12 body positioning update made was made aware of the PCP on 2-21-2023. See attached.

The Sales staff and HCD were re-educated on the importance of completed sections by the physician prior to move in, the need for correct late entries to the DME, and the need for notice of the physician being made aware of any changed entries 2-20-2023.

A complete audit of current DME's was completed by February 28th 2023 to identify any incomplete entries, additional late entries, and or missing signed medication lists. Any items found will be corrected as per this regulation.

Licensee's Proposed Overall Completion Date: 02/28/2023

Implemented [REDACTED] 06/08/2023**141b1 - Annual Medical Evaluation****21. Requirements**

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The annual medical evaluation completed 1/13/23 for resident #1, admitted [REDACTED] does not include the resident's weight. This section is blank.

Plan of Correction**Accept** ([REDACTED] 02/28/2023)

Resident #1 weight will be completed upon his return to the community with [REDACTED] new DME for Significant change in condition from rehabilitation setting.

The HCD, and nursing staff were re-educated on 2-20-2023 on the importance of all entries being completed on the DME. HCD and nursing staff may add the weights and VS prior to the physician reviewing, completing, and signing the document for new, annual, and or significant changes.

The complete audit was completed by 2-24-2023 for any other corrections needed on the existing DME's. The ED, HCD and Nursing staff will assure all entries are added to the document prior to filing in the medical record. See Attached

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented ([REDACTED] 06/08/2023)

183d - Prescription Current

22. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 1/26/23 at 1:35 p.m., there was a blister pack with 10 remaining tablets of potassium CL ER 20meq tablets with pharmacy label for resident #1 in the secure dementia care unit (SDCU) medication cart. However, this medication was discontinued on 1/23/23.

On 1/26/23 at 1:50 p.m., there were 2 blister packs with a total of 21 tablets of Mirtazapine 15mg tablets with pharmacy labels for resident #10 in the SDCU medication cart. However, this medication was discontinued on 1/16/23.

REPEAT VIOLATION 5/11/22 et al, 9/13/22 et al.

Plan of Correction

Accepted [REDACTED] 03/09/2023)

Resident # 1 and resident # 10 discontinued medication was removed from med cart immediately. A complete cart to E-MAR audit will be completed by an Express Care pharmacy nurse on February 27 and 28 2023.

All current orders that are being discontinued are being removed immediately from the cart. The HCD will assure this has occurred each day.

All current medication technicians were re-educated on all medication state regulations on 1/17/2023. A partial audit was completed by the pharmacy representative on 1/12/2023. A full cart audit performed by Express Care Pharmacy was completed on 2/27 and 2/28/23 to ensure that no discontinued medications were in the cart and that the meds in the cart matched the MAR.

Going forward the HCD/nurse and or designee will conduct weekly medication cart audits to ensure only current medications are in the cart. This will be documented on weekly cart audit forms. See attached.

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented [REDACTED] 06/08/2023)

185a - Implement Storage Procedures

23. 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 1/26/23 at approximately 1:00 p.m., the following medications ordered for resident #13 were not available in the home for administration:

* Benzonatate 200mg [Tessalon Perles] – take one capsule by mouth every 8 hours as needed for cough

* Melatonin 5mg – take 1 tablet by mouth at bedtime as needed for insomnia

* Ondansetron HCl 4mg – take 1 tablet by mouth every eight hours as needed

REPEAT VIOLATION 9/13/22 et al.

Plan of Correction

Directed [REDACTED] 03/09/2023)

Resident # 1 and resident # 10 discontinued medication was removed immediately. A complete cart to E-MAR audit was completed by an Express Care pharmacy nurse on February 27 and 28 2023.

185a - Implement Storage Procedures (continued)

All current orders that are being discontinued are being removed immediately from the cart. The HCD will assure this has occurred each day.

All current medication technicians were re-educated on all medication state regulations on January 17th 2023. Going forward the HCD/nurse and or designee will assure all medications will be removed from the cart when a new discontinued order is received.

They will conduct weekly medication cart audits to ensure only current medications are in the cart. This will be documented on weekly cart audit forms. See attached.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all medications prescribed for resident #13 and obtain all medications and have the medications available in the home for administration. 3/9/23 [REDACTED]

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident's medications to ensure all prescribed medications are available in the home for administration. 3/9/23 [REDACTED]

Within 15 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the home's policy and procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons to specifically address the replacement and ordering of medications when needed. Documentation of education shall be kept. 3/9/23 [REDACTED]

Within one calendar day of receipt of the accepted plan of correction: The administrator shall conduct a monthly audit of all resident prescribed medications to ensure all medications are available in the home for administration. Documentation of audits shall be kept. 3/9/23 [REDACTED]

Directed Completion Date: 03/24/2023

Implemented ([REDACTED] - 06/08/2023)

187b - Date/Time of Medication Admin.**24. Requirements**

2600.

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

Description of Violation

Resident #9 is ordered mupirocin 2% ointment – apply to left heel [REDACTED] and distal left hallux topically two times a day. On 1/26/23 at 12:40 p.m., staff person B, a medication technician, indicated that resident #9 self-administers this medication. However, the resident's January 2023 medication administration record (MAR) was signed off by medication staff as having administered the medication at 9:00 a.m. and 9:00 p.m. from 1/1/23 through 1/25/23 except for the 9:00 a.m. administrations on 1/4/23 and 1/14/23 which indicate in notes that the resident self-administers the medication.

Plan of Correction

Directed ([REDACTED] - 03/09/2023)

The medication Benzonatate for #13 was expired and removed from the cart on 1-23-2023 and was not delivered until 1-26-2023 after 11pm.

The Melatonin and ondansetron were delivered on 2-21-2023.

All Medication technician were re-educated on the importance of medication being always available to the

187b - Date/Time of Medication Admin. (continued)

residents as prescribed. The HCD/nurse, and Certified MT's are re educated and aware to re order in a timely manner to assure the availability is present on 2 20 2023 and 2 23 2023.

Going forward the HCD/nurse and or designee will conduct weekly medication cart audits to ensure only current medications are in the cart. This will be documented on weekly cart audit forms.

DIRECTED

Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the requirements of Regulation 2600.187(b). Documentation of education shall be kept. 3/9/23 ■

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident medication administration records for accuracy and completeness including the requirements of Regulation 2600.187(b). 3/9/23 ■

Directed Completion Date: 03/14/2023

Implemented ■ 06/08/2023)

187d - Follow Prescriber's Orders**25. Requirements**

2600.

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

Description of Violation

Resident #9 was ordered Buprenorphine 5mcg/hr patch Place 1 patch onto the skin every 7 days. According to the resident's January 2023 medication administration record (MAR), this medication was not available and not administered on 1/6/23 and 1/13/23. The medication was not discontinued until 1/18/23.

Resident #10 is ordered Marinol 5mg one capsule by mouth two times a day. However, according to resident #10's January 2023 MAR, this medication was not available and not administered from 1/17/23 at 7:00 a.m. through 7/26/23 at 7:00 a.m. Repeat violation 6/21/22 et al.

Plan of Correction

Accept ■ - 02/28/2023)

Resident #9 order was received to discontinue the Buprenorphine patch and the physician and family was made aware at that time and there was no ill effect of those 2 missed doses. The medication patch was safely disposed.

#10 resident medication Marinol was discontinued on 1 13 2023, and again on 1 26 2023. Please see the attached e mar for dates noted. The pharmacy enters these dates.

The current HCD/Nurse and certified MT's will be re educated on February 20 and 22rd on the importance of reordering medication in a timely manner. This is also a critical timeline to reorder narcotics 7 days prior to being due. Some physicians may have access to a e scribe function through the pharmacy to order quickly. Cart audits will occur periodically by the HCD, nurse, and or designee from Weekly x 4 weeks, to monthly thereafter and ongoing to identify any additional documentation/medication availability needs for additional re education needs of the nurse and certified MT's

Licensee's Proposed Overall Completion Date: 02/24/2023

Not Implemented ■ - 06/08/2023)

224a - Preadmission Screen Form

26. 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 #10 was admitted to the home's secure dementia care until (SDCU) on [REDACTED]. However, the resident's preadmission screening was not completed until 11/2/22.

Resident #11 was admitted to the home's SDCU on [REDACTED]. However, the preadmission screening for this resident was not completed until 1/20/23.

REPEAT VIOLATION 9/13/22 et al.

Plan of Correction**Directed [REDACTED] - 03/09/2023)**

Resident #10 and resident #11 screens were not completed timely and when identified as missing they were completed late. This form is to identify the ability to care for the needs of any resident admitted to the community PRIOR to admission. This form is to be completed upon the same assessment date of care level. There will be re education to the Sales team, HCD, on 2 23 2023. The ED and or designee is the responsible party to assure all necessary forms/documents are fully completed dated and signed prior to admission for all residents. ED will check each residents file using a resident file checklist to ensure each file is complete before admission. See attached.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure each resident has a preadmission screening form completed, the home can meet the needs of the resident, and the form is in each resident record. 3/9/23 [REDACTED]

Directed Completion Date: 03/10/2023

Implemented [REDACTED] - 06/08/2023)

225a - Assessment 15 Days

27. 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 #9 was admitted to the home on [REDACTED]. However, the resident's initial assessment is dated 11/8/22.

REPEAT VIOLATION 5/11/22 et al.

Plan of Correction**Directed [REDACTED] - 03/09/2023)**

Resident #9 prescreen was not completed timely and when identified as missing they were completed late. This form is to identify the ability to care for the needs of any resident admitted to the community PRIOR to admission. This form is to be completed upon the same assessment date of care level. There will be re education to the Sales team, HCD, on 2 20 2023. The ED and or designee is the responsible party to assure all necessary forms/documents are fully completed dated and signed prior to admission for all residents. ED will review each new residents paperwork

225a - Assessment 15 Days (continued)

prior to move in to ensure all required documents are in place. This will be documented on tracker/log. See attached.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure each resident has a current and completed assessment in their record. 9/3/23 ■

Within one calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a policy and procedures to ensure each new resident has an initial assessment within 15 days of admission. All staff responsible for resident admissions shall be educated on the policy and procedures. Documentation of education shall be kept. 3/9/23 ■

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all new resident admissions to ensure each new resident has a written initial assessment that is documented on the Department's assessment form within 15 days of admission. 3/9/23 ■

Directed Completion Date: 03/10/2023

Implemented ■ - 06/08/2023)

225c - Additional Assessment**28. Requirements**

2600.

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

1. Annually.

Description of Violation

The most recent assessment for resident #13, admitted ■ is dated 10/31/21.

Plan of Correction

Directed ■ - 03/09/2023)

Resident #9 admitted on ■ cannot be corrected at this time, it was completed late. This was under prior administration. The HCD/nurse has been re educated that the assessment will be completed within 15 days of move in on 2 20 2023. The ED, HCD, and or designee will assure this is checked and or correct upon the first 2 weeks of admission. This can be discussed each day in stand up morning meeting to assure no new resident is missed. An Audit has been completed to assure there are not any missing assessments. late or otherwise. ED/designee will review each new move in with the HCD each week to ensure no RASP has been missed and that it meets the regulatory requirements regarding timeliness and this will be documented on tracker/log. See attached.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall complete an assessment for resident #13. 3/9/23 ■

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure each resident has a current and completed assessment in their record. 9/3/23 ■

225c - Additional Assessment (continued)

Within one calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a policy and procedures to ensure each resident has an assessment completed at least annually. 3/9/23

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure each new resident has a completed assessment within the last year documented on the Department's assessment form and is in the resident's record. 3/9/23

Directed Completion Date: 03/07/2023

Implemented - 06/08/2023)

227g -Support Plan Signatures**29. Requirements**

2600.

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

Description of Violation

Resident #5's support plan, dated 10/7/22, was not signed by the assessor or the resident. There is no documentation that the resident was unable or chose not to sign the support plan.

Resident #9's support plan, dated 11/8/22, was not signed by the assessor or the resident. There is no documentation that the resident was unable or chose not to sign the support plan.

Resident #10's support plan, dated 11/4/22, was not signed by the assessor or the resident. There is no documentation that the resident was unable or chose not to sign the support plan.

Resident #12's support plan dated 1/19/23, was not signed by the assessor.

Plan of Correction

Directed - 03/09/2023)

Resident # 5, #9, #10 were completed by prior administration and cannot be signed by assessor. Resident #12 assessment was signed by the assessor on 1 23 2023. See attached. The ED, HCD/Nurse were re educated on the support plan being signed by the assessor completing the document on 2 20 2023. Going forward all resident's assessment will be reviewed by the HCD/Nurse, ED, resident, and or family before placing it in the medical record. An audit will be completed by 2 24 2023 on current resident records to assure the current support plans have been signed. When able, any support plans not signed by current administration will be corrected. This will be included in our new move in checklist and the ED/HCD will document with each new move in once completed.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall complete a new support plan for residents #5, #9, #10, and #12. 3/9/23

Within one calendar day of receipt of the accepted plan of correction: The administrator shall Audit all current resident support plans to ensure all applicable signatures have been obtained in accordance with Regulation 2600.227(g). 3/9/23

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all newly

227g -Support Plan Signatures (continued)

completed support plans to ensure all applicable signatures have been obtained in accordance with Regulation 2600.227(g). 3/9/23 ■

Directed Completion Date: 03/10/2023

Implemented ■ - 06/08/2023)

231c - Preadmission Screening**30. 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

The cognitive screening for resident #10, admitted to the home's secure dementia care unit (SDCU) on ■ was not completed until 11/2/22.

The cognitive screening for resident #12, admitted to the home's SDCU on ■ was not completed until 1/14/23.

REPEAT VIOLATION 5/11/22 et al

Plan of Correction

Accepted ■ - 02/28/2023)

Resident #10 late cognitive screen portion cannot be corrected as this was prior to this administration.

Resident # 12 is a late cognitive screen. Going forward, the re education to the current administration, HCD/Nurse on the importance of the tie to complete the cognitive screen portion, 72 hours PRIOR to admission/transfer to the Memory Care neighborhood. The ED, HCD and or designee will be responsible to monitor any new admissions, or current resident transitioning to the memory care neighborhood to assure the cognitive screens are completed correctly and timely. The audit of all current resident screens will be completed by 2 28 2023.

Licensee's Proposed Overall Completion Date: 02/28/2023

Not Implemented ■ -
06/08/2023)

233b - Lock Manufacturer Statement**31. Requirements**

2600.

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock releasing device.

Description of Violation

The statement from ■ e + Interiors dated 7/7/21 does not indicate that the magnetically locked egress doors in the home's secure dementia care unit will release in the event of a power outage.

Plan of Correction

Accepted ■ - 02/28/2023)

The home retrieved an updated statement from the Architect group responsible for development of the home to

233b - Lock Manufacturer Statement (continued)

reflect that our egress doors in the secured unit do automatically release in the event of a power outage. See Attached.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented (█ - 06/08/2023)

251b - Record Entries Legible**32. Requirements**

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The date entry for the preadmission screening for resident #12, admitted █ was partially scribbled over changing the date from what appears to have been "12/2/22" to "1/2/22."

Correction fluid was used and written over on page one of resident #14's assessment and service [support] plan dated 12/14/22 for the entries for "Assessment Date" and "Resident Status."

Plan of Correction

Accept █ 03/09/2023)

Resident #12 had a date corrected incorrectly. A single line through the date and initial of the person correcting the document should have been used. At this time the individual that used the correction fluid has not been identified. Correction fluid has been removed from the community.

Resident #14 found with correction fluid used. The ED, HCD, Nurses were educated on the proper way to correct a document when needed on 2-20-2023 Correction fluid is never to be used on any medical/legal documents. A monthly audit of 10 resident files on resident record documentation will be completed by the HCD to ensure documents are legible and no white out is used. This will be documented on our tracker/log.

Licensee's Proposed Overall Completion Date: 03/07/2023

Implemented (█ - 06/08/2023)

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

Facility Information

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *04/14/2023*
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *08/23/2021* Issued By: *Township of Indiana*

Staffing Hours

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

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *04/13/2023*

Inspection Dates and Department Representative

04/13/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* Residents Served: *61*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *40* Residents Served: *17*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *59*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30* Have Physical Disability: *1*

Inspections / Reviews

04/13/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/22/2023*

Inspections / Reviews (*continued*)

05/16/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/25/2023
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/23/2023

05/19/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/25/2023
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 05/26/2023

06/08/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: 05/25/2023
Reviewer: [REDACTED] Follow-Up Type: Enforcement

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:

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.

Description of Violation

Staff person A, LPN, began working for the home on [REDACTED] and had worked in excess of 40 hours by 1/25/23. However, the home does not have acknowledgement that staff person A received training in Resident rights, Emergency medical plan, Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and Reportable incidents and conditions.

Plan of Correction

Accept [REDACTED] 05/16/2023)

New staff person A was hired [REDACTED] and the correct orientation was provided to the staff person however the documentation did not get completed to show this.

This staff person no longer works for this company.

An audit of all employee files was completed on 5/1/23 to ensure all had completed/signed orientation forms.

All new hires will receive the required orientation and paperwork will be completed by the ED/HCD/BOM or designee within the first 40 hours of employment and will be documented on the orientation form.

The ED/BOM will be responsible to ensure all training is completed and documented for all new hires. ED will review orientation form before it gets filed in employee file.

Licensee's Proposed Overall Completion Date: 05/15/2023

Implemented [REDACTED] - 06/08/2023)

187d - Follow Prescriber's Orders

2. Requirements

2600.

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

Description of Violation

On 2/13/23, staff person A, LPN, was reportedly unable to access the home's electronic medication administration record (MAR) to administer residents' P.M. medications. Another staff person provided paper MARs to staff person A. However, staff person A opted not to administer the evening medications to 11 residents in the memory care unit to include:

* Residents #1's Olanzapine

* Resident #2's carvedilol 3.125mg, Eliquis 2.5mg, Entresto 24mg-26mg, escitalopram 10mg, latanoprost 0.0005% eye drops, memantine Hcl 5mg, and mirtazapine 30mg.

Resident #2 is ordered the following medications that were not administered on 4/10/23 at 7:00 p.m. due to not being available in the home according to the resident's April 2023 MAR:

* Carvedilol 3.125mg oral tablet – take 1 tablet by mouth 2 times a day

* Eliquis 2.5mg tablet – 1 tablet oral two times daily

* Escitalopram 10mg tablet – 1.5 tablet oral one time daily

187d - Follow Prescriber's Orders (continued)

- * Memantine 5mg tablet 1 tablet oral two times daily
- * Mirtazapine 30mg tablet 1 tablet oral at hour of sleep

Repeat violation 6/21/22 et al.

Plan of Correction

Accepted [REDACTED] 05/19/2023)

Staff person A did not administer medications as prescribed.

This staff person no longer works for the company.

Resident's physicians and families were notified of medications not being given. No ill effects occurred due to missed dose of medication.

The administrator educated all staff persons qualified to administer medications on the requirements of 2600.187 on 3/13/23 and 3/14/23.

MAR audits will be done weekly on 10 random residents' MAR's by the HCD and will be documented on a MAR audit form and kept in the HCD's office for the next 3 months, then quarterly.

Licensee's Proposed Overall Completion Date: 05/18/2023

Not Implemented [REDACTED] 06/08/2023)