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 **September 26, 2023** until **March 26, 2024**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333811**

ISSUING OFFICER

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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: SEPTEMBER 26, 2023

[redacted]
Hampden Operations LLC
[redacted]

RE: Harmony at West Shore
1910 Technology Parkway
Mechanicsburg, Pennsylvania
17050 License #: 33381

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on March 8-9, 2023, April 26, 2023, May 30-31, 2023 and July 20, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (333810) dated June 8, 2023 to June 8, 2024 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. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible

regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

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**: *06/08/2023*

Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **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**: *111* **Waking Staff**: *83*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/09/2023*

Inspection Dates and Department Representative

03/08/2023 - On-Site: [redacted]

03/09/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Harmony Square* **Capacity**: *35* **Residents Served**: *32*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *105*

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

Have Mobility Need: *38* **Have Physical Disability**: *0*

Inspections / Reviews

03/08/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/26/2023*

03/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/06/2023*

04/11/2023 - POC Submission

Submitted By: [redacted] [redacted] **Submitted:** *04/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/18/2023*

08/25/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

51 - Criminal Background Check

1. Requirements

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

Description of Violation

Staff Member A, who was hired [redacted]/23, did not have a criminal background check completed until 3/9/23.

Plan of Correction ***Directed ([redacted] - 04/06/2023)***

As of 4/3/23 Criminal backgrounds will be completed on all new staff members prior to orientation. The Business Office Manager will be responsible for obtaining these documents. The executive director will complete quarterly audits of employee files through 4/3/24 to ensure compliance. A complete audit of employee files was completed 3/31/23 by the Executive Director, at which time backgrounds were requested and will be completed by 05/01/2023.

Directed Plan:

- *Criminal Background Check was completed for Staff Member A on 01/24/23*
- *Starting 4/3/23 Criminal backgrounds will be completed on all new staff members prior to orientation. Business Office Manager will be responsible for obtaining these documents.*
- *The executive director will complete quarterly audits of employee files through 4/3/24 to ensure compliance.*
- *A complete audit of employee files was completed 3/31/23 by the Executive Director, at which time backgrounds were requested and will be completed by 05/01/2023.*

Directed Completion Date: *05/01/2023*

Implemented [redacted] 04/18/2023)

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

The home has 108 residents and requires 3 Staff Members, certified in CPR and First Aid, per shift. However, only 2 staff members certified in CPR and First Aid were were present and working in the home during the following dates and times:
On 02/25/23 from 07:00am to 3:00pm
On 02/26/23 from 11:00pm to 7:00am
On 02/27/23 from 11:00pm to 7:00am

Plan of Correction ***Accept [redacted] - 04/06/2023)***

CPR classes have been scheduled for 4/10/23, 4/11/23, 4/13/23 and 4/14/23. A complete audit of Employee files was completed 3/31/23 by the Executive Director. Each Direct care staff member in need of CPR was assigned to a class. Executive Director and/or Healthcare Director will ensure at least one staff person to 50 residents is trained in CPR or First aid on the daily schedules per each shift, to begin 4/15/23. The daily schedules will be monitored to ensure

63a - First Aid/CPR Training (continued)

compliance on each shift by the Executive Director and/or Healthcare Director through 4/15/24 to ensure compliance. Staff will be trained in CPR and First Aid by 4/20/23.

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

Not Implemented [redacted] - 07/26/2023)

65d - Initial Direct Care Training

4. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

Description of Violation

Direct Care Staff Member C, was hired on [redacted]/23, and began providing unsupervised ADL services on this date. Staff Member C has not completed the initial direct care staff training.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

The Executive Director administered the training for Staff Member C 4/3/23. To begin 4/3/23 all New Direct Care staff will complete the Direct Care training prior to being unsupervised on the floor. The Healthcare Director and/or the Memory Care Director will complete this training. A complete Audit of employee files was completed 3/31/23 by the Executive Director. Each Direct Care staff member who has not completed this training was notified 4/3/23 and all trainings will be completed by 4/10/23.

Licensee's Proposed Overall Completion Date: *04/10/2023*

Implemented [redacted] - 04/18/2023)

81b - Resident Personal Equipment

5. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Uncovered enabler bars were observed on Resident 1's and Resident 2's beds. The maximum opening on both bars measured wider than 4 ¾ inches potentially posing a hazard to the residents.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

Resident 1 has since moved out of the building. The Enabler bar was removed on 03/10/2023, by the Maintenance Director. The Executive Director placed a covering on Resident 2 enabler bar on 3/21/23. To begin 4/3/23 the maintenance Director will measure enabler bars and report measurements to Executive Director and/or Healthcare Director. The Executive Director and/or Healthcare Director will review measurements for compliance and provide covering if needed. Beginning 4/3/23 The Maintenance Director will maintain, and update as needed a list of all Personal Care residents possessing enabler bars by 04/10/23.

Licensee's Proposed Overall Completion Date: *04/10/2023*

Implemented [redacted] - 04/24/2023)

85d - Trash Receptacles

6. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 3/9/23, there were two trash cans located in the kitchen near the preparation table which were not actively being used, were filled with trash, and had lids which were broken exposing the trash.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

On 3/9/23 the Dining Services Director ordered lids for the Kitchen Trash cans. The lids were received 3/17/23 and placed on the trash cans. Beginning 3/17/23 the Dining Services Director or lead cook will audit the Kitchen trash cans daily.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented [redacted] 04/18/2023)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

Fire damage was observed on the dining room patio to a portion of the wall, resulting in nails protruding from the wall, presenting a potential hazard to residents and staff.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

Immediately on 3/09/2023 the Maintenance Director removed the nails protruding from the fire damaged wall. Maintenance Director will repair remaining wall no later than 5/1/23. Beginning 4/3/23 Maintenance Director or Maintenance Assistant will complete weekly walk throughs and report any issues or concerns to Executive Director.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Not Implemented [redacted] - 04/24/2023)

105g - Lint Removal and Duct Cleaning

8. 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

The Lint Traps for the Dryers in the home were last cleaned 6/10/21.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

The Maintenance Director contacted Duct wizard 03/09/2023. Duct Wizard completed service 3/21/23. The Maintenance Director or Maintenance Assistant will complete weekly inspections of all dryer vents beginning 4/3/23. Beginning 3/21/23 the Maintenance Director will ensure dryer vent ducts are cleaned quarterly.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented [redacted] - 04/24/2023)

109b - Rabies Vaccination

9. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 3/9/23, Resident 3's and Resident 4's pets were present at the home. The home does not have a current certificate of rabies vaccination for the pets which expired 12/9/2020.

Plan of Correction ***Accept (- 04/06/2023)***

Resident 4's received vaccinations on 3/13/23. Resident 3's received vaccinations on 3/15/23. Vaccine Certificates are now on file. Beginning 4/3/23 The Executive Director or Health Care Director will obtain vaccination records for any animals prior to moving into the building. Beginning 4/3/23 the Life Enrichment Director will maintain and update vaccination records on current pets as required.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented (- 04/18/2023)

[redacted]

WITHDRAWN - NSC, 9/22/23

[redacted]

183b - Meds and Syringes Locked

11. 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 3/9/23 at 3:15pm a small cup containing a round white tablet and a round light brown tablet were unlocked and accessible on a table next to Resident 5.

Resident 6 is prescribed Cerave Hydrating Cleanser use as directed to Wash Affected Areas every day for Dry Skin. On 3/9/23 at 11:35am the medication was observed unlocked, unattended, and accessible in the Residents bathroom.

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

Plan of Correction ***Accept [redacted]/06/2023)***

Resident 5 medications were immediately removed on 3/9/2023, by the Executive Director. Resident 6 cleanser was immediately removed on 3/9/2023, by the Executive Director. The Executive Director provided re-education to Med Techs on 3/23/23 to ensure all prescription medications, OTC medications CAM and syringes are to be kept in a secured/locked area.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Not Implemented [redacted] - 04/18/2023)

183e - Storing Medications

12. Requirements

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

Description of Violation

Resident 7 is prescribed Lantus Solostar 100 Unit/ML check BS and Inject Subcutaneously per SSI at Bedtime for DM, SSI: <120=6U, Skipped Snack =6U, >/=120=12U. On 3/9/23, the Lantus Solostar injection pin was not labeled with the date the pin was opened in accordance with the manufacturer's instructions.

Resident 8 is prescribed Lantus Solostar 100 Unit/ML Inject 12U into the skin every day for diabetes if her BG IS <110 Take Half the scheduled does which is 6U. On 3/9/23, the Lantus Solostar injection pin was not labeled with the date the pin was opened in accordance with the manufacturer's instructions.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

Immediately on 3/9/2023 all unlabeled insulin pens were removed from the cart by Healthcare Director and replaced with new insulin pens with date open stickers. The Healthcare Director provided re-education to med techs on proper labeling of insulin pens with date open stickers on 3/23/2023. Healthcare Director or Harmony Square Director will complete weekly cart audits starting on 3/24/2023

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented [redacted] - 04/18/2023)

185a - Implement Storage Procedures

13. 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

Resident 8 is prescribed Nystop 100,000 U/GM-Powder Mycostatin 100,000 Units/GM PW Apply one application topically to affected area (s) every 12 hours for rash. On 3/9/23 at approximately 1:00pm, the medication was not found in the home.

Resident 8 is prescribed nitroglycerin 0.4 MG Tablet Nitrostat 0.4 MG Sub Ea dissolve every 5 minutes. Max 3 tablets within 15 minutes as needed for Chest Pain if no relieve after 1st dose call 911. On 3/9/23 at approximately 1:00pm, the medication was not found in the home.

185a - Implement Storage Procedures (continued)

Resident 9 is prescribed Biscolax 10 MG Suppository unwrap and insert 1 suppository rectally everyday as needed for constipation. On 3/9/23 at approximately 3:30pm, the medication was not found in the home.

Resident 10 is prescribed Anti-Diarrheal 2MG Caplet Imodium A-D 2MG Caplet tablet by mouth every 4 hours as needed for diarrhea "Max 8 tablets in 24 hours." On 3/9/23 at approximately 1:15pm, the medication was not found in the home.

Resident 11 is prescribed Tramadol HCL 50 MG Tablet, take one tablet by mouth every 6 hours as needed for pain (Scale 7-10). On 3/9/23 at approximately 1:30pm, the medication was not found in the home.

Plan of Correction ***Accept (- 04/06/2023)***

The Healthcare Director received Resident 8 medications from the pharmacy on 3/10/2023 and placed them in the medication cart. The Healthcare Director discontinued medications on 3/10/23 for Resident 9 and Resident 10. The Healthcare Director re-ordered, received and placed medications for Resident 11 in the Med Cart. Re-education was provided to the Med Techs by the Healthcare Director on 3/23/23 reviewing the medication policy. The Health Care Director to complete weekly med cart audits beginning 3/10/23 through 3/10/24.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented - 07/26/2023)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident 8 is prescribed Lantus Solostar 100 Unit/ML Inject 12U into the skin every day for diabetes if BG IS <110 Take Half the scheduled dose which is 6U. However, resident 8 was not administered the medication 3/1/23, 3/3/23, 3/5/23, 3/7/23 and 3/8/23.

Plan of Correction ***Accept - 04/06/2023)***

Resident 8 was refusing to take the prescribed insulin. On 03/09/2023 the Healthcare Director requested an order from the Physician to discontinue due to resident 8 refusal. The order to discontinue the insulin was received by the Healthcare Director on 3/9/23. The Healthcare Director or Harmony Square Director will complete weekly Med Cart Audits beginning 4/3/23.

Licensee's Proposed Overall Completion Date: *04/13/2023*

Not Implemented (- 07/26/2023)

224a - Preadmission Screen Form

15. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

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 12's preadmission screening form, dated [redacted]/22, does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident 13 was admitted to the home on [redacted]/22; however, the resident's preadmission screening form was completed on 8/15/22.

Plan of Correction ***Accept [redacted] - 04/06/2023)***

On 3/10/23 the Executive Director provided re-education to the Healthcare Director to ensure all preadmission screenings are completed no more than 30 days prior to resident move in and may be completed on day of admission. Resident 12 preadmission screening form was corrected on 3/10/2023 by the Executive Director to indicate that the needs of the resident can be met by services provided by the home. Resident 13 preadmission screening form was corrected on 3/10/2023 by the Executive Director after confirming with the Healthcare Director that the prescreen was completed prior to resident admission. The Executive Director or Health Care Director will complete an Audit of all current Resident Preadmission screenings to be completed no later than 4/20/23.

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

Implemented [redacted] - 07/26/2023)

227c - Support Plan Revision

16. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident 2's date of admission is [redacted]/22, the Preadmission Screening Form is dated 2/11/22, Part IV of the Preadmission Screening Form is dated 3/28/22. The Significant Change Addendum to RASP states "Date Identified" is 8/29/22 indicating resident is in need of memory care & secure environment.

Plan of Correction ***Accept ([redacted] - 04/06/2023)***

Resident 2's Preadmission Screening Form date was corrected by the Executive Director on 03/10/2023. Part IV of the Preadmission Screening Form was corrected by the Executive Director on 03/10/20. The Significant Change Addendum to the RASP was corrected by the Executive Director on 03/10/2023 to reflect the correct date that Resident 2 moved to the secured environment. The Harmony Square Director will complete an audit of all resident records for the secured environment no later than 4/20/23. The Harmony Square Director or Health Care Director will then complete quarterly audits through 4/20/24.

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

Implemented [redacted] - 04/18/2023)

251c - Standardized Forms

17. Requirements

251c - Standardized Forms *(continued)*

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Residents 1, 2 and 6 through 13 RASP's were not completed on the Department's current standardized form and the personalized RASP developed by the home does not include language detailing if the residents have the "Ability to use and Avoid Poisonous Materials."

Plan of Correction ***Directed [redacted] - 04/06/2023)***

All rasps 1-13 have been updated to include the Ability to use and Avoid Poisonous Materials on 3/10/2023 by the Executive Director. The Executive Director and/or Healthcare Director will complete an audit of all current resident rasps to ensure for accuracy to be completed no later than 4/20/23.

Directed Plan:

- *All RASPs 1 through 13 have been updated to include the Ability to Use and Avoid Poisonous Materials on 3/10/2023 by the Executive Director.*
- *The Executive Director and/or Healthcare Director will complete an audit of all current resident RASPs to ensure each meet the DHS Form Standardization no later than 4/20/23.*

Directed Completion Date: *04/20/2023*

Implemented [redacted] 04/18/2023)

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

Facility Information

Name: *HARMONY AT WEST SHORE* **License #**: *33381* **License Expiration**: *06/08/2023*

Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **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**: *134* **Waking Staff**: *101*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date**: *04/26/2023*

Inspection Dates and Department Representative

04/26/2023 - On-[redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *100*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Harmony Square* **Capacity**: *35* **Residents Served**: *29*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *100*

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

Have Mobility Need: *34* **Have Physical Disability**: *1*

Inspections / Reviews

04/26/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/11/2023*

Inspections / Reviews *(continued)*

05/17/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/24/2023*

05/26/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/05/2023*

08/25/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

On 4/26/23 at 9:24 AM, the bathroom in the SDCU which was unlocked, unattended, and accessible and there was 5oz can of Barbasol Shaving Cream sitting on top of the hand dryer. The safety data sheet indicates if product is ingested to call a physician immediately. The residents in the SDCU have been deemed unable to safely use and avoid poisonous materials.

On 4/26/23 at 9:35 AM, in Resident 1's room, there was a 11.25Fl oz bottle of Softsoap Fresh Citrus Hand Soap and a 2.3 oz Lady Speed Stick Deodorant, unlocked, unattended, and accessible in resident's upper left-hand cabinet above the sink. The product labels for both products state to get medical help or call poison control right away if swallowed. Per resident's current medical evaluation dated 6/20/22 and current support plan dated 6/20/22, resident is unable to safely use and avoid poisonous materials.

On 4/26/23 at 9:42 AM in Resident 2's room, there was 7Fl oz of DG Spice After Shave and a 2.7 oz container of Degree Cool Rush stick deodorant. DG Spice After Shave label says to keep out of reach of children, and the Degree Cool Rush label states if swallowed, to get medical help or call poison control right away. Per resident's current medical evaluation dated 2/7/23 and current support plan dated 3/8/23, resident is unable to safely use and avoid poisonous materials.

Plan of Correction ***Accept ([redacted] - 05/15/2023)***

On 4/27/23 Harmony Square director and Healthcare Director removed all poisonous materials from resident's rooms. On 4/28/23 Toolboxes with locks were received and each resident's items were placed in the toolboxes and locked with a combination lock. Harmony square director will conduct weekly audits of resident's toolboxes and make sure that all poisonous materials are locked up through 4/30/24.

Licensee's Proposed Overall Completion Date: *05/23/2023*

Implemented [redacted] - 06/09/2023)

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/26/23 at approximately 9:24 AM, there was a strong urine smell in the public bathroom in the SDCU and there was a liquid substance on the floor near the toilet. There was also a strong smell of urine in the main SDCU area and near the furniture.

On 4/26/23 at approximately 9:35 AM, there was a strong urine smell in the SDCU in the Hallway outside of Resident 3's room.

85a - Sanitary Conditions (continued)

Plan of Correction ***Accept (- 05/24/2023)***

Immediately the common area bathroom in SDCU was cleaned by the housekeeper. Maintenace Director used the inhouse carpet extractor outside of resident #3 room to remove urine smell on 4/27/23. An audit form was created 04/26/23 that the Harmony Square Director and or housekeeper will complete to ensure that the common area bathroom is clean at all times and there are no urine odors in the hallways daily. Audits to be reviewed starting 04/27/23 by Harmony Square Director and or Executive Director daily. Daily audits to be completed through 4/26/24. Maintenace Director also getting quotes to have carpets cleaned professionally in SDCU by 6/01/23.

Licensee's Proposed Overall Completion Date: *06/01/2023*

*Not Implemented (- **06/09/2023)***

88a - Surfaces

3. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/26/23 at approximately 9:240 AM the Floor in the public bathroom in the SDCU was sticky.

On 4/26/23 at 10:09 AM, the carpet outside of the 2nd floor laundry room was loose creating a tripping hazard.

In Resident 4's bedroom there was pieces of a broken lightbulb glass on the floor near the head of the resident's bed and near the resident's nightstand.

In Resident 5's bedroom there was a hole observed in the ceiling measuring approximately 3 inches.

In Resident 6's bedroom the carpet observed in the living room area of the Resident's Room was extremely stained.

In Resident 7s bedroom there was a liquid Substance observed on the floor at the entrance of room, and tracked into the room, posing a slipping hazard.

Plan of Correction ***Accept - 05/24/2023)***

Immediately on 4/26/23 the bathroom floor and resident # 7's floor in the SDCU was cleaned by the housekeeper. Immediately Resident # 3's floor was cleaned of the broken glass. On 4/27/23 Resident # 5's ceiling was repaired by Maintenace Director. An audit form was created on 4/26/23 for the housekeeper and or Harmony Square Director to complete daily and hand in to the Executive Director for review. Compliance with audit will be done daily through 4/26/24. Immediately after the carpet was found to be a tripping hazard on 4/26/23 outside of the 2nd floor laundry room it was repaired by the Maintenance Director. Carpet in Resident #6 living room was cleaned on 4/27/23 by Maintenace assistant. A daily audit sheet was created 4/26/23 for med techs to report any pealing and or soiled carpet to the Health Care Director. The same audit will ask Med Techs to check rooms for broken glass, drywall in need of repair or any other hazard in a resident's room and report findings to the Health Care Director. Audit to be reviewed by Health Care Director and or Executive Director daily so that repairs can be made. Audit to be ongoing until 4/26/24.

Licensee's Proposed Overall Completion Date: *05/23/2023*

88a - Surfaces *(continued)*

Not Implemented [redacted] ***- 07/27/2023)***

105g - Lint Removal and Duct Cleaning

4. 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 4/26/23 at 10:08 AM, approximately ¼ inch accumulation of lint found in the lint trap of the 1st dryer closest to the entrance of the 2nd floor laundry room. There were no clothes in the dryer at the time and the dryer was cold to the touch.

Plan of Correction ***Accept*** [redacted] ***- 05/24/2023)***

on 4/27/23 the healthcare director completed a walk through to ensure each dryer was free of lint. A check off was added to the Med Tech daily assignment sheet on 04/27/23 to check and remove lint from dryers each shift. This audit began to be completed on 4/28/23 by the med tech and or Health Care Director each shift and reviewed by the Executive Director weekly to ensure compliance through 4/26/24.

Licensee's Proposed Overall Completion Date: *05/23/2023*

Implemented [redacted] ***- 06/09/2023)***

254a - Records Discharge/Active

5. 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 4/26/23 at 10:00 AM, a laptop was observed on top of the Medication Cart in the SDCU and was unlocked, unattended and accessible. There were 16 resident records observed visible and accessible on the laptop screen.

Plan of Correction ***Accept*** [redacted] ***- 05/24/2023)***

Healthcare director reviewed the HIPAA guidelines with the med techs on 4/27/23 and the policy relating to maintaining resident's confidential information by 5/26/23. The Healthcare director and or Executive Director will review this policy with all new team members upon hire and will review annually in scheduled staff meetings with all team members. Daily walk throughs to be completed by Health Care Director and or Harmony Square Director ongoing through 4/26/24.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Not Implemented [redacted] ***- 06/09/2023)***

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

Facility Information

Name: *HARMONY AT WEST SHORE* **License #:** *33381* **License Expiration:** *06/08/2023*

Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*

Address: [redacted]

Email: [redacted]*m*

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *133* **Waking Staff:** *100*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *05/31/2023*

Inspection Dates and Department Representative

05/30/2023 - On-Site: [redacted]

05/31/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served:** *100*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *35* **Residents Served:** *28*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *100*

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

Have Mobility Need: *33* **Have Physical Disability:** *1*

Inspections / Reviews

05/30/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/17/2023*

06/22/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/29/2023*

07/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/11/2023*

08/25/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct Staff Member B, hired [redacted]/2020 did not receive annual training in following topics during training year 2022:

1. Medication self-administration
2. Instruction on meeting the needs (DME & RASP)
3. Care for residents w/dementia & cognitive impair.
4. Infection control/cleanliness/immobility concerns
5. Personal care service needs of the resident
6. Safe management techniques
7. Care for residents with MH or ID, if served

Plan of Correction ***Accept [redacted] - 07/03/2023)***

Immediately the Healthcare Director and Executive Director gave required trainings to staff member B to complete [redacted] training calendar for 2022 on 6/5/23. Healthcare director will complete training on Medication self-administration, Instruction on meeting the needs (DME & RASP), Care for residents w/Dementia &cognitive Impairment, Infection control/cleanliness/Immobility concerns, Personal care service needs of the resident, safe management techniques, and care of residents with MH or ID, if served to all current staff members by 6/30/23 and will begin training all new staff members immediately upon new hire. Healthcare Director and/or Executive Director will complete training annually at "All Staff Inservice Meetings" for all staff members and track completion through signature sheets at "All Staff Inservice Meetings" ongoing through 5/31/24.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/27/2023)

65g - Annual Training Content

2. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Ancillary Staff Member A, hired [redacted]/21 and Direct Care Staff Member B, hired [redacted]/2020 did not receive annual training in the following topics during training year 2022:

1. Fire safety by a fire safety expert or staff trained by FSE
2. Emergency preparedness procedures
3. Resident rights
4. Older Adult Protective Services Act (OAPSA)
5. Falls and accident prevention
6. New population groups (if applicable)

Plan of Correction ***Accept [redacted] - 07/03/2023)***

Immediately the Healthcare Director and Maintenance Director gave required trainings to staff member A & B to complete [redacted] training calendar for 2022 on 6/5/23. Maintenance Director will complete fire safety training for all staff members by 6/30/23. Maintenance Director will complete fire safety training for all new staff members upon orientation beginning 6/12/23. The Healthcare director and/or Maintenance Director will complete Emergency

65g - Annual Training Content (continued)

preparedness training, Resident Rights, Older Adult Protective Services Act, Falls and accident prevention and new population (if applicable) to all staff members by 6/30/23 and will implement in new hire orientation immediately and ongoing through 5/31/24. Healthcare Director and Maintenace Director will complete training annually at "All Staff Inservice Meetings" for all staff members and track completion through signature sheets at "All Staff Inservice Meetings" ongoing through 5/31/24.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/27/2023)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 5/30/23 at 10:50 am, Resident 1 had an uncovered enabler bar installed on the left side of the bed. The opening of the enabler bar was 5 ½ inches high and 18 inches wide, posing an entrapment risk.

On 5/30/23 at 11:11 am, Resident 2 had an uncovered enabler bar installed on the left bottom corner of the bed. The opening of the enabler bar was 12 inches high and 13 inches wide, posing an entrapment risk.

Plan of Correction ***Accept ([redacted] - 07/03/2023)***

Resident 1 has since moved out of the community on 6/11/23. The enabler bar was removed on 5/30/23 by the maintenance director. The enabler bar on resident 2 bed was removed by maintenance director on 5/30/23. To Begin on 5/31/23 the maintenance director will measure enabler bars and report the measurements to the Executive Director and / or Health Care Director. Communication to be sent to families by Executive Director by 6/30/23 informing them of the requirements for enabler bars and that they must bring in any device to be inspected by Maintenance Director prior to being installed. The Maintenance Director will maintain, and update as needed a list of all Personal Care residents possessing enabler bars ongoing through 05/31/24.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented ([redacted] - 07/27/2023)

82c - Locking Poisonous Materials

4. 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 5/30/23 at 9:48 am there was a 100 count package of Aloe FitRight Cleansing Cloths found unlocked, unattended, and accessible on the back of the resident toilet in Resident 3's room. Per the safety data sheet for this product, if ingested, it states to get immediate medical help or call poison control. Per the resident's current medical evaluation (DME) dated 9/18/22, the resident is unable to safely use or avoid poisonous materials.

On 5/30/23 at 9:56 am there was an 18fl oz container of Aveeno Skin Relief Moisturizing Lotion found unlocked, unattended, and accessible on the nightstand by Resident 4's chair. The product label states to get immediate medical

82c - Locking Poisonous Materials (continued)

help or call poison control if swallowed. Per the resident's current DME dated 5/11/23, the resident is unable to safely use or avoid poisonous materials.

On 5/30/23 at 10:06 am there was a 100 count package of Aloe FitRight Cleansing Cloths found unlocked, unattended and accessible on the back of resident 5's toilet. Per the safety data sheet for FitRight Cleansing Cloths, if ingested, to get immediate medical help or call poison control. Per the resident's current DME dated 12/14/22, the resident is unable to safely use and avoid poisonous materials.

Plan of Correction ***Accept [redacted] - 07/03/2023)***

On 5/30/23 Resident 3, 4 and 5 had poisonous materials removed by the Harmony Square Director immediately and placed in locked toolbox in above resident's rooms. Harmony Square Director to hold Inservice by 6/30/23 with all staff that work in the memory care area to educate staff on poisonous materials and how to keep them locked up. Harmony Square Director on 5/30/23 implemented weekly audits of resident's toolboxes and will make sure that all poisonous materials are locked up through 5/30/24

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/27/2023)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/30/23 at approximately 10:47am, the Continuous Positive Airway Pressure (CPAP) mask for Resident 6 was observed to have a yellow/brownish discoloration.

On 5/30/23 at approximately 10:55 am, soiled "Depends" Undergarments were observed in the uncovered trash can in the Resident 1's and Resident 6's shared bedroom.

Plan of Correction ***Accept ([redacted] - 07/03/2023)***

Resident # 6 moved out of the community on [redacted]/23. Immediately the Healthcare Director changed out the CPAP mask on 6/1/23. The Healthcare director and/or Executive director to educate all current staff members on 6/22/23 to clean continuous Positive Airway Pressure (CPAP) mask weekly and to replace monthly and as needed. Audits to be created by 6/30/23 and completed by med techs weekly. Audits to be reviewed weekly by Health Care Director and or Executive Director weekly to ensure compliance ongoing through 5/30/24. Immediately the Healthcare Director emptied the trash in resident # 6's room on 5/30/23. Health Care Director will educate all current staff to remove trash from resident rooms every shift and as needed by 6/30/23. Healthcare director and/or executive director will educate all new staff members upon orientation effective immediately ongoing through 5/30/24

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] 07/27/2023)

88a - Surfaces

6. Requirements

88a - Surfaces *(continued)*

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 5/30/23 at approximately 10:36 am blue X's were observed taped on the carpeting throughout the hallway on the 2nd floor in Personal Care. These X's were used to identify areas where the floor has settled creating low spots under the carpet and posing a potential tripping hazard.

On 5/30/23 at approximately 11:24 am a large crack in the dry wall was observed in the wall toward the ceiling in the 4th floor hallway in personal care.

On 5/30/23 at approximately 9:33 am there were bird's nests observed outside obstructing two dryer vents on the independent living side of the building, posing a potential safety hazard.

On 5/31/23 at 2:31pm, in Resident 8's bedroom the carpet observed in the living room area of the resident's room was extremely stained.

Plan of Correction ***Accept ([redacted] - 06/20/2023)***

Immediately on 5/31/23 the Executive Director spoke with the Regional Director of Operations about the low points in the flooring on the 2nd floor. Plan being devised to have an independent contractor come out and ensure the community is structurally safe and give recommendations on repairs by 7/15/23. On 6/1/23 the crack in the dry wall in the 4th floor hallway in personal care was repaired by the maintenance director. On 6/1/23 the carpet in resident #8's room deep cleaned by the maintenance director. Immediately on 6/1/23 the Maintenance Director to obtain quotes for scissor lift, and schedule time to have scissor lift delivered to community to remove the two bird nests in the Independant Living Building by 7/1/23. A daily walk-through audit created on 6/1/23 for the maintenance director to walk the interior and exterior of the community looking for cracks in dry wall, dirty carpets, bird nests in exterior dryer vents and checking for low spots in flooring daily. Audit to be reviewed by the Executive Director weekly ongoing until 5/31/24.

Licensee's Proposed Overall Completion Date: *07/15/2023*

Not Implemented [redacted] 07/31/2023)

101j3 - Bed/Linens/Pillows/Blankets

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 5/30/23 at approximately 10:48 am, Resident 1's and Resident 6's blue fitted mattress sheet was observed on the bed, with two dried brownish spots and 4 dried white spots on the left-hand side of the sheet.

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Plan of Correction ***Accept (- 07/03/2023)***

Immediately on 5/30/23 the Health Care Director removed the sheets from resident #1 and #6 bed and laundered them and replaced back on the bed. Healthcare director and/or executive director to educate current staff members to check each resident's bed linens daily, if soiled to launder as needed to ensure all residents linens are clean and in good repair on 6/22/23. Healthcare director and/or executive director to educate new staff members to check each resident's bed linen's daily, if soiled to launder as needed to ensure all residents linens are clean and in good condition daily upon orientation starting 6/5/23. Will continue ongoing through 5/31/2024

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented 07/27/2023)

183b - Meds and Syringes Locked

8. 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 5/30/23 at 10:46 am, a long white oval pill was found unlocked, unattended, and accessible in on the carpet beside Resident 1's nightstand.

Plan of Correction ***Accept - 07/03/2023)***

Immediately on 5/30/23 the Healthcare Director removed the pill from the floor in resident #1's room. Healthcare Director and/or Executive director will educate all staff members on prescription medications, OTC medications, CAM and syringes to be kept in a secure area by 6/30/23. Healthcare Director and/ or Executive Director will educate each new staff member upon orientation, effective immediately ongoing through 5/31/2024

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented - 07/27/2023)

187a - Medication Record

9. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

On 5/30/23 at approximately 10:40 am, Resident 1 had a bottle of Amlodipine (10 mg) with a prescription label on the dining table in resident's room. However, Resident 1's Medication Administration Record does not list Amlodipine as a current medication.

Plan of Correction ***Accept - 07/03/2023)***

Immediately on 5/30/23 the Amlodipine was removed from resident #1's room by health care director. Healthcare director and/or Executive director will educate all current staff members that each resident must have a doctor's order for any and all medications in their possession by 6/30/23 and continue education annually. Med tech audit updated 6/26/23 to include checking the resident's room for non-prescribed medications daily. Healthcare director and/or Executive director will educate each new staff member to begin 06/12/23 and ongoing through 5/31/2024

Licensee's Proposed Overall Completion Date: *06/30/2023*

187a - Medication Record *(continued)*

Not Implemented [redacted] - 07/27/2023)

254a - Records Discharge/Active

10. 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 5/30/23 at 10:35 am, Resident 7's record was found were unlocked, unattended, and accessible on the desk at 3rd floor nurse's station. In addition, the 3rd cabinet from the top, labeled "4th floor charts" was unlocked unattended ad accessible.

Plan of Correction ***Accept [redacted] 06/20/2023)***

Immediately on 5/30/23 the Executive Director removed the chart from the desk and placed it back in the chart rack. Healthcare director and/or Executive director will educate each staff member to maintain each resident record in a confidential manner by 6/30/23, and will continue annually, Healthcare director and/or Executive director will educate each new staff member to maintain each resident record is kept in a confidential manner effective immediately. Training to be ongoing through 5/31/2024

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] - 07/27/2023)

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

Facility Information

Name: *HARMONY AT WEST SHORE* **License #**: *33381* **License Expiration**: *06/08/2024*

Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **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**: *125* **Waking Staff**: *94*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/20/2023*

Inspection Dates and Department Representative

07/20/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *93*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *35* **Residents Served**: *27*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *93*

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

Have Mobility Need: *32* **Have Physical Disability**: *1*

Inspections / Reviews

07/20/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/05/2023*

Inspections / Reviews *(continued)*

08/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/18/2023*

08/25/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

The home sent a reportable incident form to the Department on 7/17/23 that describes an injury of Resident 1 in the secured courtyard on 7/16/23. The incident report form read, in part: "[Resident 1] was outside in our secured courtyard and had a fall. [redacted] was found by the care associate [Staff Person A] in the multched (sic) area of the courtyard with minor cuts to [redacted] feet and hands." The incident report fails to accurately describe the event, which includes the fact that the resident had eloped from the building between approximately 2:30 p.m. and 2:40 p.m. Resident 1 was not found by Staff Person A until approximately 4:30 p.m. Furthermore, the resident suffered a multitude of injuries, including heat stroke, dehydration, second degree burns to both feet and had an internal body temperature of 102.5 degrees Fahrenheit when [redacted] arrived at the hospital on 7/16/23 at 5:34 p.m.

Plan of Correction ***Directed[redacted] - 08/14/2023)***

upon exit conference 07/20/2023 the Healthcare Director and Executive Director will send initial state reportable to DHS within 24 hours. Healthcare Director and/or Executive Director will send a follow up report with additional pertinent information related to the event in a timely manner.

[Directed]
- On 7/20/23, the Executive Director, the Healthcare Director and the Harmony Square Healthcare Director were educated on this violation by Inspectors during the exit conference.
- Starting 8/18/23, the Executive Director will collect as many details as possible about the incident within 24 hours of the incident occurring. Details will include extent of injuries and timeline of the incident. Executive Director will obtain these details by obtaining and reviewing documentation as well as completing interviews. Then the Executive Director will complete an incident reporting form, including the details obtained through investigation, and send it to DHS within 24 hours of the incident occurring.
- Starting 8/18/23, incident reports will be reviewed at the Quality Management meetings to ensure details of an incident are accurately reported on the incident report.

Directed Completion Date: *08/18/2023*

Not Implemented[redacted] - 08/25/2023)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 07/16/2023, Resident 1 fell in the secured courtyard of the Secure Dementia Care Unit (SDCU). It is estimated that the resident entered the secured courtyard between 2:30 p.m. and 2:40 p.m. and was found by Staff Person A at approximately 4:30 p.m. The average high temperature for that day was 87 degrees Fahrenheit.

42b - Abuse (continued)

Resident 1 was transported to the hospital due to multiple injuries, including cuts, scrapes, abrasions and 2nd degree burns on [redacted] lower extremities as documented in the hospital care notes. Upon admission to the hospital, it was also noted that the resident had a rectal temperature of 102.5 degrees Fahrenheit and was diagnosed with heat exhaustion and dehydration.

Plan of Correction ***Directed [redacted] - 08/14/2023)***

Immediately on 7/17/23 the Healthcare Director and Executive Director implemented an audit of all exterior doors to ensure locking mechanisms are working and codes are posted. On 07/17/2023 door check audit form was implemented to ensure all exteriors are secure. Also, on 07/17/2023 a head count of residents was implemented at the beginning and end of each shift. Abuse and Neglect in-service and training held by Health Care Director with all staff on 7/27/23. Audits will continue through 07/20/2024.

[Directed]
- On 7/17/23, the Healthcare Director and Executive Director completed an audit of all Secure Dementia Care Unit (SDCU) exterior doors to ensure locking mechanisms are working and codes are posted.
- On 07/17/23, a door check audit form was implemented to ensure all exteriors of the SDCU are secure. Starting 7/17/23, an audit of all the exteriors of the SDCU will be conducted weekly by the Maintenance Director or designee to ensure all exits from the SDCU have working locking mechanisms and codes are posted. Door check audit forms will be completed and kept.
- Abuse and Neglect in-service and training held by Health Care Director with all staff on 7/27/23.
- Starting 07/17/23, SDCU staff will take a head count of all SDCU residents at the beginning and end of each shift.
- All SDCU residents will be assessed for wandering behavior by the Harmony Square Director and/or Healthcare Director. Those residents identified as having wandering behaviors will have a written supervision plan put in place and their support plans will be updated by 8/18/23.
- Starting 8/18/23, SDCU courtyard checks will be completed by staff every 30 minutes.

Directed Completion Date: *08/18/2023*

Not Implemented [redacted] - 08/25/2023)

234b - Support Plan Needs Elements

3. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Staff reported Resident 1 has "manic episodes" which include the following behaviors: constantly moving [redacted] body, exit seeking, not sleeping, not eating and attempting to take off [redacted] clothing. Resident's current support plan, dated 04/24/2023, does not include these behaviors or identify the services required to address them.

234b - Support Plan Needs Elements *(continued)*

Plan of Correction ***Directed [redacted] - 08/14/2023)***

On 07/24/2023 the Harmony Square Director updated Resident 1's support plan to include [redacted] behaviors and the services required to address them . Moving forward all support plans will include any resident behaviors and the services required to address them to be completed by the Healthcare Director or Harmony Square Director as needed for updates. Harmony square director and/or Healthcare Director will continue to audit rasps for appropriate behavioral expression interventions through 07/20/2024

[Directed]
- On 7/20/23, the Harmony Square Director and the Healthcare Director were educated on this violation by Inspectors during the exit conference.
- On 7/24/23, the Harmony Square Director updated Resident 1's support plan to include resident's behaviors and the services required to address them.
- Harmony Square Director will complete an audit of all current Secure Dementia Care Unit (SDCU) resident support plans to ensure all behaviors and services are accurately documented. This audit will be completed by 8/18/23.
- Starting 8/18/23, the Harmony Square Director will complete a quarterly audit of all SDCU resident support plans to ensure all behaviors and services are accurately documented. Documentation of the audits are to be completed and kept.

Directed Completion Date: *08/18/2023*

Not Implemented [redacted] - 08/25/2023)