



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MOON OPERATIONS, LLC**

LEGAL ENTITY

To operate **HARMONY AT DIAMOND RIDGE**

NAME OF FACILITY OR AGENCY

Located at **3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108**

(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 **107**
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 36**

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 **April 29, 2026** until **October 29, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **456441**

[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



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 29, 2026

[REDACTED]
Moon Operations, LLC
[REDACTED]
[REDACTED]

RE: Harmony at Diamond Ridge
3301 Market Place Boulevard
Coraopolis, Pennsylvania 15108
License/COC #: 456441

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on October 23, 2025, December 19, 2025, December 23, 2025, January 28, 2026, February 3, 2026, and February 4, 2026, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (LICENSE NO. 456440) dated February 10, 2026 – February 10, 2027, 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); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from APRIL 29, 2026 to OCTOBER 29, 2026.

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 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
42(b)	II	56	\$5	\$280	5 calendar days from mailing date of this letter
42(s)	II	56	\$5	\$280	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:

, Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Forum Place, 6th Floor
 PO Box 2675
 Harrisburg, PA 17105-2675
 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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: HARMONY AT DIAMOND RIDGE **License #:** 45644 **License Expiration:** 02/10/2026
Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: MOON OPERATIONS, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: 1 1	Date: 08/24/2024	Issued By: Township of Moon
Type: 1 2	Date: 08/06/2024	Issued By: Township of Moon
Type: Other	Date: 08/06/2024	Issued By: Township of Moon

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 83 **Waking Staff:** 62

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 10/31/2025

Inspection Dates and Department Representative

10/23/2025 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107 **Residents Served:** 49

Secured Dementia Care Unit

In Home: Yes	Area:	Capacity: 36	Residents Served: 21
Harmony Square-1st floor			

Hospice

Current Residents: 8

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 49
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 34	Have Physical Disability: 1

Inspections / Reviews

10/23/2025 Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/29/2025*

12/01/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *12/22/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/05/2025*

12/01/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *12/22/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *12/22/2025*

03/11/2026 - Document Submission

Submitted By: [REDACTED] Date Submitted: *12/22/2025*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

15a - Resident Abuse Report**1. Requirements**

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [REDACTED], direct care staff person A showed numerous other direct care staff persons a video that direct care staff person A received in a group text message, which was sent by direct care staff person B. The video shows resident [REDACTED] acting sexually inappropriate and exposing [REDACTED] in a common area of the home's secured dementia care unit (SDCU); however, this incident was not reported to the local Area on Aging until [REDACTED]

On [REDACTED] direct care staff person A showed numerous other direct care staff persons a video that direct care staff person A received in a group text message, which was sent by direct care staff person B. The video shows resident [REDACTED] sitting on resident [REDACTED]'s lap with resident [REDACTED]'s [REDACTED] exposed in a common area of the home's SDCU; however, this incident was not reported to the local Area on Aging until [REDACTED].

Plan of Correction**Directed [REDACTED] - 12/01/2025)**

The Executive Director and Healthcare Director immediately notified AAA as well as DHS and the Moon Twp. Police department once they became aware that abuse had occurred. Abuse involving Resident 1 was not reported by the staff to leadership until 10/16/2025. Abuse involving Resident 1 and 2 was not reported to leadership by staff until 10/17/2025.

Direct Care Staff Person A was and Direct Care Staff Person B were immediately suspended pending investigation. Both staff persons no longer work for the community as of 11/11/2025 following the conclusion of the internal company investigation. Neither Staff person A or B returned to work from suspension.

On 10/16 and 10/17 Executive Director and Healthcare Director immediately assessed Resident 1 and Resident 2 to determine if harm had occurred due to the actions of Direct Care Staff Persons A and B. It was determined both residents were unharmed and did not remember the incident occurring.

On 10/17, The Executive Director interviewed all other Harmony Square residents to determine if further incidents had occurred. No further incidents were reported.

On 10/17 the Executive Director and Healthcare Director met with clinical staff on shift to discuss abuse/neglect and cell phone policy with everyone. Stand Up sheets for both shifts were kept.

On 11/12/2025 The Executive Director completed a training with all staff regarding abuse/neglect/abuse reporting/resident rights and cell phones in the community. Documentation will be kept in the 2025 training binder.

Beginning 11/12/2025 the Executive Director or designee will make rounds of the community 3x per day at

15a - Resident Abuse Report (continued)

random times for 6 weeks and then daily afterwards to confirm that cell phones are not being used while staff are on duty. Documentation will be kept.

Beginning 11/24/2025- The Executive Director or designee will interview 3 residents per week for 6 weeks to confirm that residents are free from abuse/neglect and that their rights are being honored. Interviews will be held weekly thereafter after the Executive Director's weekly town hall meetings. Documentation will be kept.

Beginning 12/01/2025, the Executive Director or designee will review all internal incidents daily to ensure all allegations of abuse are immediately reported to AAA. The Executive Director or Designee will sign off this has been completed on every report and documentation will be kept.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2026 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented [REDACTED] - 03/11/2026)

15d - Resident Abuse-Notification**2. Requirements**

2600.

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On [REDACTED], direct care staff person A showed numerous other direct care staff persons a video that direct care staff person A received in a group text message, which was sent by direct care staff person B. The video shows resident [REDACTED] acting sexually inappropriate and exposing [REDACTED] in a common area of the home's secured dementia care unit (SDCU); however, this incident was not reported to resident [REDACTED]'s designated person until [REDACTED].

On [REDACTED], direct care staff person A showed numerous other direct care staff persons a video that direct care staff person A received in a group text message, which was sent by direct care staff person B. The video shows resident [REDACTED] sitting on resident [REDACTED]'s lap with resident [REDACTED]'s [REDACTED] exposed in a common area of the home's SDCU; however, this incident was not reported to residents [REDACTED] and [REDACTED]'s designated persons until [REDACTED].

Plan of Correction

Directed ([REDACTED] 12/01/2025)

The incident of abuse involving Resident [REDACTED] was not reported to the Executive Director and Director of Nursing until 10/16/2025. Upon discovery, the POA of Resident [REDACTED] was immediately notified.

The incident of abuse involving Resident [REDACTED] and Resident [REDACTED] was not reported by staff to the Executive Director or

15d Resident Abuse Notification (continued)

Director of Nursing until 10/17/2025. When reported to the Executive Director and Director of Nursing, the POAs for both residents were immediately notified.

Direct Care Staff Person A and B no longer work for the community effective 11/11/2025. Neither returned from suspension.

On 10/17/2025 the Executive Director and Director of Nursing held shift meetings to discuss abuse reporting requirements with direct care staff. Documentation has been kept.

On 10/28/2025 the Executive Director reviewed the reportable incidents for the community for the last month. No other occurrences of late reporting were found.

On 11/24/2025, the Regional Director of Operations provided the Executive Director with training regarding 2600.15.d. Documentation of this training will be kept in the 2025 training binder. The Director of Nursing no longer works for the community as of 10/20/2025.

On 11/12/2025 The Executive Director conducted a training with all staff regarding mandatory reporting requirements. Documentation will be placed in the 2025 training binder.

Beginning 11/24/2025 the Executive Director or designee will review all reportable incidents daily to confirm that all residents and their responsible parties are made aware of all incidents immediately. Documentation will be kept.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2025 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. ■ 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented ■ - 03/11/2026)

16c - Written Incident Report**3. Requirements**

2600.

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

Description of Violation

On ■ direct care staff person A showed numerous other direct care staff persons a video that direct care staff person A received in a group text message, which was sent by direct care staff person B. The video shows resident ■ acting sexually inappropriate and exposing ■ in a common area of the home's secured dementia care unit (SDCU); however, this incident was not reported to the Department until ■

On ■ direct care staff person A showed numerous other direct care staff persons a video that direct care staff

16c - Written Incident Report (continued)

person A received in a group text message, which was sent by direct care staff person B. The video shows resident [REDACTED] sitting on resident [REDACTED]'s lap with resident [REDACTED] exposed in a common area of the home's SDCU; however, this incident was not reported to the Department until [REDACTED].

Plan of Correction**Directed [REDACTED] - 12/01/2025)**

On 10/16/2025 Direct Care staff informed the Executive Director and Healthcare Director of the incident involving Staff person B and Resident 1. Immediately the community reported the incident to DHS and AAA by oral report and written report.

On 10/17/2025, Direct Care staff informed the Executive Director and Healthcare Director regarding the incident that occurred with Staff Persons A and B as well as Residents 1 and 2. Immediately the community reported the incident to DHS and AAA by oral and written report.

On 10/17/2025 the Executive Director and Healthcare Director met with Clinical staff regarding reporting requirements. Documentation was kept.

On 10/28/2025 the Executive Director reviewed all reportable incident reports for the last month to confirm they were sent within regulated timeframes. No other incidents of late reporting were noted.

On 11/12/2025 the Executive Director provided an In-service to all staff regarding reportable incidents including how and when to report. Documentation will be kept in the 2025 training binder.

On 11/24/2025, the Regional Director of Operations provided the Executive Director with training regarding 2600.16.c. Documentation of this training will be kept in the 2025 training binder.

Beginning 11/24/2025, The Executive Director or designee will review all reportable incidents daily to determine that all reportable documentation is being sent to the appropriate department within 24 hours. The Executive Director or Designee will sign off on all incidents to confirm review and these will be kept.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2025 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented [REDACTED] - 03/11/2026)**42b - Abuse****4. Requirements**

2600.

42b - Abuse (continued)

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

Description of Violation

On [REDACTED], direct care staff person A showed numerous other direct care staff persons 2 different videos that direct care staff person A received in a group text message, which were sent by direct care staff person B. The 1st video shows resident [REDACTED] exposing [REDACTED] in a common area of the home's SDCU and can be heard saying "Do you like it" and "Can I touch your [REDACTED]"? Staff person B can be overheard laughing in the video and telling resident [REDACTED] to "Stop. That is nasty. Put it away". The 2nd video shows resident [REDACTED] sitting on resident [REDACTED]'s lap in a common area of the home's SDCU while resident [REDACTED]'s [REDACTED] are exposed and resident [REDACTED] is massaging and kissing resident [REDACTED]'s [REDACTED]. Both residents [REDACTED] and [REDACTED] reside in the home's SDCU.

REPEAT VIOLATION: [REDACTED]

Plan of Correction

Directed [REDACTED] 12/01/2025)

Direct Care Staff persons A and B involved with the filming and circulating of the video involving the residents were immediately suspended pending investigation upon discovery that abuse occurred. Both staff persons were terminated on [REDACTED] for violation of abuse, dignity and standards of professional conduct. Upon speaking with both staff during the initial suspension, it was determined that the videos could no longer be produced for review by the Moon Twp. Police.

Upon discovery that abuse occurred on 10/16/2025 and 10/17/2025, the Executive Director and Director of Nursing immediately contacted AAA, DHS, the Moon Twp. Police department and both resident's POAs to report abuse as well as the home office.

On 10/16/2025 Resident 1 and on 10/17/2025, Both residents involved were immediately assessed by the Director of Nursing and Executive Director to determine if either resident was harmed by the incident. Neither resident could recall the events occurring. The Executive Director and Director of Nursing then interviewed the other residents in the home's SDCU to ensure there were no additional concerns or reports of inappropriate staff or resident interactions. None were identified.

On 11/12/2025 the Executive Director provided an In-service to all staff regarding 2600.42 abuse regulations, resident rights, mandatory reporting requirements, and cell phone policy. Documentation of this training will be kept in the community's 2025 training binder.

On 11/24/2025, The Executive Director implemented new protocols in the SDCU that include the need for immediate staff intervention when sexualized behavior occurs, separation and redirection of cognitively impaired residents, and requirements for documenting and reporting further instances of sexual behavior to determine the need for increased supervision. Care plans will be updated where needed. Training regarding the new procedures was completed for staff working in the homes SDCU 11/25/2025 and will be continued upon hire and monthly by the Executive Director or designee. Documentation will be kept in the home's 2025 training binder.

The Executive Director or designee will conduct random rounds of the SDCU 2x a day for 6 weeks to ensure staff are supervising residents in common areas, no inappropriate interactions are occurring, and that no staff are using cell phones in resident care areas. (DIRECTED: The random rounds are to begin on 12/3/25. [REDACTED] 12/1/25). Documentation of these rounds will be kept. After 6 weeks, rounds will reduce to weekly for the next 6 weeks.

42b Abuse (continued)

The Executive Director or designee will complete interviews of the 2 staff and 4 residents in both the SDCU and PC neighborhood of the community in private 2x a week beginning 12/01/2025 to confirm that residents are free from abuse and neglect and that no abuse or neglect is occurring in the community. (DIRECTED: The interviews shall also include ensuring resident privacy is met in accordance with 2600.42s and that the home's cell phone policy is being followed. █ 12/1/25). Documentation will be kept and reviewed with the Healthcare Director upon completion of interviews.

Documentation of audits and interviews will be reviewed at the community's 12/22/2025 and 01/20/2026 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept █ 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Not Implemented █ - 03/11/2026)

42s - Privacy

5. 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 █, direct care staff person A showed numerous other direct care staff persons 2 different videos that direct care staff person A received in a group text message, which were sent by direct care staff person B. The 1st video shows resident █ exposing █ in a common area of the home's SDCU and can be heard saying "Do you like it" and "Can I touch your █"? Staff person B can be overheard laughing in the video and telling resident █ to "Stop. That is nasty. Put it away". The 2nd video shows resident █ sitting on resident █'s lap in a common area of the home's SDCU while resident █'s █ are exposed and resident █ is massaging and kissing resident █'s █. Both residents █ and █ reside in the home's SDCU. The home's "telephone monitoring policy" states, "The use of personal cellular phones, in any manner, during the shift, in work areas and in common areas is strictly prohibited". Also, numerous direct care staff persons indicated that they have been asked on numerous occasions to send photographs to members of management after residents have fallen in the home, which violates the home's policy.

REPEAT VIOLATION: █

Plan of Correction

Directed █ - 12/01/2025)

Direct Care Staff persons A and B involved with the filming and circulating of the video involving the residents were immediately suspended pending investigation upon discovery that abuse occurred. Both staff persons were terminated on █ for violation of abuse, dignity and standards of professional conduct. Upon speaking with both staff during the initial suspension, it was determined that the videos could no longer be produced for review by the Moon Twp. Police and were deleted.

42s - Privacy (continued)

Upon discovery that abuse occurred on 10/16/2025 and 10/17/2025, the Executive Director and Director of Nursing immediately contacted AAA, DHS, the Moon Twp. Police department and both resident's POAs to report abuse as well as the home office.

On 10/16/2025 Resident 1 and on 10/17/2025, Both residents involved were immediately assessed by the Director of Nursing and Executive Director to determine if either resident was harmed by the incident. Neither resident could recall the events occurring. The Executive Director and Director of Nursing then interviewed the other residents in the home's SDCU to ensure there were no additional concerns or reports of inappropriate staff or resident interactions. None were identified.

On 11/12/2025, the Executive Director provided an in-service to all staff regarding resident privacy. Documentation will be kept in the community's 2025 training binder.

Beginning 11/24/2025 the Executive Director or designee will conduct random rounds of the SDCU 3x per weeks for 6 weeks and then weekly thereafter to confirm that residents maintain the right to privacy. Documentation will be kept.

The Executive Director or designee will complete interviews of the 2 staff and 4 residents in both the SDCU and PC neighborhood of the community in private 2x a week beginning 12/01/2025 to confirm that residents are free from abuse and neglect and that no abuse or neglect is occurring in the community. (DIRECTED: The interviews shall also include ensuring resident privacy is met in accordance with 2600.42s and that the home's cell phone policy is being followed. [REDACTED] 12/1/25). Documentation will be kept and reviewed with the Healthcare Director upon completion of interviews.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2026 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Not Implemented [REDACTED] 03/11/2026)

60a - Staff/Support Plan

6. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [REDACTED] the home served 50 residents, including 34 residents with mobility needs. Of the 34 residents with mobility needs, 4 residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair and on [REDACTED], 30 residents resided in the home's SDCU. According to the most recent documentation from a fire safety expert, dated [REDACTED] the maximum evacuation time to the home's 12 fire-safe areas is 9 minutes. On [REDACTED]

60a - Staff/Support Plan (continued)

during the 10:00pm-6:00am shift, only 3 staff persons were present in the home, which is not adequate to evacuate all residents in the event of an emergency.

REPEAT VIOLATION: [REDACTED]

Plan of Correction**Directed [REDACTED] - 12/01/2025)**

On 10/28/2025, the Executive Director began immediate recruiting for overnight staff to address mobility and emergency evacuation needs. As of 11/28/2025, the community has extended three offers to ensure strong staffing coverage on the overnight shift.

The community is contracted with ShiftKey to fill any emergency staffing needs to maintain compliance with staffing regulations. If emergency needs arise, the home will contact the home office to obtain approval to use contract labor immediately.

Beginning on 11/18/2025, the community has had 4 direct care aides present in the community during the overnight shift.

On 11/20/2025, the Regional Director of Operations provided the Executive Director with training regarding staffing to mobility needs in the community. Documentation of this training will be kept in the 2025 training binder.

An overnight fire drill was completed on 11/29/2025 at 5:04 am with 4 direct care staff members on the shift. The residents were evacuated in 8 minutes and 43 seconds which is within the 9-minute evacuation time limit set by the Fire Safety Expert for the community.

Beginning 11/24/2025, the Executive Director or designee will audit mobility levels and staffing schedules daily for the to confirm proper staffing is maintained. Documentation will be kept. (DIRECTED: The daily review of the direct care staffing schedules shall also include ensuring compliance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. [REDACTED] 12/1/25).

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2025 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Not Implemented [REDACTED] 4/22/2026)**132a - Monthly Fire Drill****7. Requirements**

132a - Monthly Fire Drill (continued)

2600.

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

Description of Violation

The home's fire system is monitored by a fire alarm company 24-hours-a-day. Per the company's fire alarm report, the home has only conducted a monthly fire drill on [REDACTED] at 3:00pm and on [REDACTED] at 3:34pm since January, 2025; however, the home presented fire drill records to an agent of the Department indicating the following fire drills were conducted:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

According to the company's fire alarm report, the home conducted an unannounced fire drill in the home on [REDACTED] at 3:34pm; however, the fire drill record indicates the fire drill was conducted on [REDACTED] at 12:00pm.

Plan of Correction

Directed [REDACTED] - 12/01/2025)

Upon review of fire drill logs and the detailed alarm logs from the alarm monitoring company, and staff interviews, it was identified that several fire drills were completed as the alarm was activated, but the home's maintenance director failed to place the required notifications to the monitoring company which resulted in missing vendor logs which resulted in missing name. The community also noted that one of the fire drill logs was incorrectly completed with an incorrect date and time listed. The log has been corrected to reflect the accurate day and time per the alarm monitoring company.

The community will have a new Maintenance Director starting on 12/01/2025. The Executive Director will educate [REDACTED] 12/01/2025 on proper fire drill processes including the need to call the alarm company prior to conducting a drill. Documentation of this training will be kept in the HR file.

On 11/04/2025 the Vice President of Facility Maintenance provided a training to the Executive Director and staff regarding fire safety procedures. Documentation will be kept in the 2025 training binder.

Effective 12/01/2025, the Executive Director or designee will be present when the Maintenance Director calls the alarm company to initiate a fire drill, and both the Executive Director and Maintenance Director will sign off that this is completed resulting in dual verification. Documentation will be kept.

Beginning 12/01/2025, The Executive Director or designee will audit all fire drill documentation monthly to verify compliance with 2600.132. Documentation of Audits will be kept.

132a - Monthly Fire Drill (continued)

The Fire drill process will be reviewed at the home's monthly quality assurance meetings beginning with the 12/22/2025 meeting to ensure compliance is maintained. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented [REDACTED] - 03/11/2026)

132e - Fire Drill Sleeping Hours**8. Requirements**

2600.

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

Description of Violation

The home has not conducted a fire drill during sleeping hours within the past 6 months.

Plan of Correction

Directed ([REDACTED] - 12/01/2025)

The Community had completed an overnight fire drill at 10:30 on 06/22/2025 during the 10p-6a overnight shift, however it was not accepted by the Department because staffing levels during the drill did not accurately reflect overnight staffing patterns due to shift change.

A new overnight fire drill is scheduled for 11/29/2025 during standard overnight staff coverage. The drill was completed at 5:04 am with 4 staff members present. Evacuation time was 8 minutes and 43 seconds which is within the designated 9- minute time range. Overnight drills will then continue to be completed at least every 6 months. Prior to conducting each drill, the Maintenance Director or designee will review staffing to confirm that accurate staff levels are present.

The community will have a new Maintenance Director starting on 12/01/2025. On 12/01/2025 The Executive Director will educate [REDACTED] on proper fire drill processes including the need to call the alarm company prior to conducting a drill. (DIRECTED: The education shall also include ensuring an unannounced fire drill is conducted during sleeping hours at least once every 6 months in accordance with 2600.132e. [REDACTED] 12/1/25). Documentation of this training will be kept in the HR file.

On 11/04/2025 the Vice President of Facility Maintenance provided a training to the Executive Director and staff regarding fire safety procedures. Documentation will be kept in the 2025 training binder.

Beginning 11/28/2025 the Executive Director or designee will be present at all overnight drills to confirm both accurate staff levels and that drills are taking place. Documentation of this will be maintained.

The Executive Director will review all fire drill records monthly to ensure compliance with 2600.132 regulations. Documentation of audits will be kept.

The Fire drill process will be reviewed at the home's monthly quality assurance meetings beginning with the

132e - Fire Drill Sleeping Hours (continued)

12/22/2025 meeting to ensure compliance is maintained. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented [REDACTED] - 03/11/2026)

231b - Medical Evaluation**9. Requirements**

2600.

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

Description of Violation

Resident [REDACTED] was admitted to the home's SDCU on [REDACTED] however, resident [REDACTED]'s medical evaluation was not completed until [REDACTED].

Plan of Correction

Directed [REDACTED] 12/01/2025)

Resident [REDACTED]'s medical evaluation was completed outside of the required 60 day time frame due to a misunderstanding of the timeline required by 2600.231 (b). To prevent reoccurrence, the Executive Director created a move-in checklist for all residents admitted to the SDCU to be used prior to admission by the Healthcare Director. (DIRECTED: The move-in checklist shall be implemented on 12/3/25 and be used for all new resident admissions. Copies of the completed checklists shall be kept in each resident's record. [REDACTED] 12/1/25). The home is currently without a Healthcare Director and Harmony Square Director, so until these positions are filled, responsibility for these audits will fall to the Executive Director. Documentation will be kept on an admissions tracking log and will be reviewed by the Executive Director 24 hours prior to move in.

On 11/20/2025, the Regional Director of Operations provided an education to the Executive Director regarding 2600.231B. Documentation will be kept in the community's 2025 training binder.

On 12/1/2025, the Executive Director will conduct an audit of all DMEs of residents in the SDCU to confirm no other DMEs were accepted out of required compliance dates. Documentation will be kept.

Beginning 12/01/2025, the Executive Director or Designee will audit 3 DMEs per week for 6 weeks to confirm compliance to the regulation, then audits will be completed 24 hours prior to new resident move in. Documentation will be kept.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2025 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

231b - Medical Evaluation (continued)

Implemented [REDACTED] - 03/11/2026)

234a - Admission Support Plan

10. 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 [REDACTED] was admitted to the home's SDCU on [REDACTED]; however, resident [REDACTED]'s support plan was not completed until [REDACTED]. Also, resident [REDACTED]'s medical evaluation, dated [REDACTED], includes diagnoses of [REDACTED] and [REDACTED] however, these diagnoses are not indicated on resident [REDACTED]'s support plan, dated [REDACTED].

Resident [REDACTED] was admitted to the home's SDCU on 6/30/25; however, resident [REDACTED]'s support plan was not completed until [REDACTED]. Also, resident [REDACTED]'s medical evaluation, dated [REDACTED], includes diagnoses of [REDACTED] and [REDACTED]; however, these diagnoses are not indicated on resident [REDACTED]'s support plan, dated [REDACTED].

Plan of Correction

Directed ([REDACTED] 12/01/2025)

The community identified a gap in the admissions process where the support plans were mistakenly completed within 15 days of admission per PCH regulations instead of within 72 hours as per SDCU regulations. The Executive Director will audit all SDCU resident charts starting on 12/01/25 to confirm they are compliant to the SDCU regulation. During this audit the ED will also confirm that all diagnoses are present on the RASP that are on the DME.

The Executive Director will add the missing diagnoses to Resident 1 and Resident 2's RASP on 11/28/2025.

The Regional Director of Operations educated the Executive Director regarding the requirements associated with 2600.234.a. Documentation of the training will be kept in the home's 2025 training binder.

To prevent reoccurrence, the Executive Director created a move-in checklist for all residents admitted to the SDCU to be used prior to admission by the Healthcare Director. (DIRECTED: The move-in checklist shall be implemented on 12/3/25 and be used for all new resident admissions. Copies of the completed checklists shall be kept in each resident's record. [REDACTED] 12/1/25). The home is currently without a Healthcare Director and Harmony Square Director, so until these positions are filled, responsibility for these audits will fall to the Executive Director. Documentation will be kept on an admissions tracking log and will be reviewed by the Executive Director 24 hours prior to move in.

Beginning 11/28/2025, the Executive Director will implement a 72-hour support plan verification process for all new SDCU admissions. An interdisciplinary review of each new resident's support plan will occur by day 3 to confirm compliance and full inclusion of all medical diagnoses. Documentation will be kept.

Beginning 12/01/2025 The Executive Director or designee will audit 1 SDCU RASP per week for 6 weeks against

234a - Admission Support Plan (continued)

the DME to confirm continued compliance to the regulation. Documentation will be kept. Audits will then be completed 72 hours post admission.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2026 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented ([REDACTED] 03/11/2026)

254a - Records Discharge/Active**11. 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 [REDACTED] at 9:26am, numerous resident records, including resident [REDACTED]'s hospice binder, were unlocked, unattended and accessible in the 1st floor nurse's station.

On [REDACTED] at 9:34am, approximately 22 resident records, including the records for residents [REDACTED] 3, [REDACTED] and [REDACTED] were unlocked, unattended and accessible in the 2nd floor nurse's station.

On [REDACTED] at 9:50am, numerous resident records and resident information were unlocked, unattended and accessible in the 3rd floor nurse's station, to include the following:

- 7 resident record binders, including the records for residents [REDACTED] 10, and [REDACTED]
- A 3rd floor shower binder and skim binder, which included care notes for resident [REDACTED]
- Incident reports for residents [REDACTED] and [REDACTED]

Plan of Correction

Directed ([REDACTED] - 12/01/2025)

On 10/28/2025 the Lead Housekeeper relocated all resident records and binders to the Med Room which is locked to protect resident information.

Beginning 10/28/2025, the Executive Director completed unannounced rounds daily to confirm that resident information had not been left out or unattended. Documentation was kept.

On 11/12/2025, the Executive Director Provided an education to all staff regarding resident records confidentiality.

254a Records Discharge/Active (continued)

Documentation of this training will be kept in the community's 2025 training binder.

Beginning 11/28/2025, the Executive Director or designee will complete 2 rounds on daylight and 2 rounds on afternoon shift per day for the next 6 weeks to confirm all resident records are secure and inaccessible. Rounds will then continue daily indefinitely. Documentation will be kept.

Documentation of audits will be reviewed at the community's 12/22/2025 and 01/20/2025 Quality Assurance meetings to determine compliance. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 12/1/25).

Proposed Overall Completion Date: 01/20/2026

Directed Completion Date: 12/22/2025

Implemented [REDACTED] 03/11/2026)

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

Facility Information

Name: HARMONY AT DIAMOND RIDGE **License #:** 45644 **License Expiration:** 02/10/2026
Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: MOON OPERATIONS, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: 1 1	Date: 08/24/2024	Issued By: Township of Moon
Type: 1 2	Date: 08/06/2024	Issued By: Township of Moon
Type: Other	Date: 08/06/2024	Issued By: Township of Moon

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 81 **Waking Staff:** 61

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident, Monitoring **Exit Conference Date:** 01/28/2026

Inspection Dates and Department Representative

01/28/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107 **Residents Served:** 56

Secured Dementia Care Unit

In Home: Yes	Area:	Capacity: 36	Residents Served: 24
1st floor Harmony Square			

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 56
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 25	Have Physical Disability: 1

Inspections / Reviews

01/28/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *02/11/2026*

02/11/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *02/27/2026*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *02/17/2026*

02/17/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *02/27/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *03/01/2026*

03/11/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *02/27/2026*

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 numerous occasions, resident [REDACTED] was [REDACTED] towards resident [REDACTED]. Both residents [REDACTED] and [REDACTED] resided in the home's secured dementia care unit (SDCU). One incident occurred in the home's SDCU living room on [REDACTED] at approximately 10:20am where resident [REDACTED] was observed by staff persons standing over resident [REDACTED] and hitting resident [REDACTED] in the head numerous times while resident [REDACTED] was fighting off and kicking resident [REDACTED]. After the altercation, resident [REDACTED] sustained a [REDACTED] and reported [REDACTED]. Another incident occurred in the home's SDCU dining room on [REDACTED] at approximately 8:30am where resident [REDACTED] was observed by staff persons standing behind resident [REDACTED] while resident [REDACTED] had both their hands wrapped around resident [REDACTED]'s shoulders and neck area and shaking resident [REDACTED].

REPEAT VIOLATION: [REDACTED]

Plan of Correction

Directed [REDACTED] - 02/17/2026)

On 2/11/2026, Healthcare Director educated direct care staff on regulation and training on behavior expressions, interventions and reporting. (DIRECTED: Documentation of the staff education shall be kept. [REDACTED] 2/17/26).

On 1/18/2028, Resident [REDACTED] was discharged from the community.

By 2/18/26, Healthcare Director or Designee will review and update Resident [REDACTED] RASP's to ensure interventions are addressed for potential behaviors.

By 2/18/2026, Healthcare Director or Designee will providing training to all direct care staff on the behaviors expression form that is utilized in the SDCU. (DIRECTED: Documentation of the staff education shall be kept. [REDACTED] 2/17/26).

By 2/18/2026, Life Enrichment Director or Designee will complete TSO Life Interviews (resident insight and experience platform) for Residents [REDACTED] and [REDACTED] to help create individualized programming to their personal interests, and improve overall engagement.

Beginning 2/16/2026, Healthcare Director or Designee will review prior day incidents/behavior expression forms, involving SDCU residents, at morning meeting and take appropriate steps to ensure RASP is updated accordingly. Healthcare Director or Designee will review incidents/behavior express forms during monthly QA meeting, ongoing. The monthly QA meeting takes place prior to the 20th day of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 2/17/26).

Proposed Overall Completion Date: 03/01/2026

Directed Completion Date: 02/20/2026

Not Implemented [REDACTED] - 03/11/2026)

141a - Medical Evaluation

4. Requirements

2600.

141a - Medical Evaluation (continued)

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.

Description of Violation

Resident █'s medical evaluation, dated █, does not include a determination resident █'s needs can be met safely at the personal care home. This section of resident █'s medical evaluation is blank.

Plan of Correction

Accept █ 02/17/2026)

On 2/11/2026, Regional Director of Operations educated the Healthcare Director, Harmony Square Director, and Director of Sales & Marketing, on the requirement to have a medical evaluation within 60 days prior to admission or within 30 days after admission to the community.

By 2/20/2026, Healthcare Director or Designee will conduct staff education regarding regulation 141.a - Medical Evaluation.

By 2/28/2026, Healthcare Director or Designee will conduct an initial audit of the DME of all residents admitted to the home since November 1, 2025, to ensure that the residents needs can be safely met at the personal care home.

By 2/16/2026, Healthcare Director or Designee will obtain an updated DME for Resident █, to ensure █ needs can be safely met at the community.

Beginning 3/1/2026, Healthcare Director or Designee will conduct a weekly review of all new admissions to ensure the medical evaluation determines that the community can safely meet the needs of the resident.

Proposed Overall Completion Date: 03/01/2026

Licensee's Proposed Overall Completion Date: 03/01/2026

Implemented █ 03/11/2026)

225c - Additional Assessment**5. Requirements**

2600.

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

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident █'s medical evaluation, dated █ indicates numerous diagnoses, to include obesity, unspecified Epilepsy, Arthrodesis status, constipation and spasms; however, these diagnoses are not indicated on resident █'s most recent assessment, dated █.

Plan of Correction

Directed █ - 02/17/2026)

On 2/11/2026, Regional Director of Operations educated the Healthcare Director and Harmony Square Director on the requirement to have an additional assessment if the condition significantly changes prior to the annual assessment -and all diagnoses must be identified and addressed on the residents assessment/care plan. (DIRECTED: Documentation of the staff education shall be kept. █ 2/17/26).

By 2/20/2026, Healthcare Director or Designee will conduct a staff education on regulation 225.c. - Additional Assessments. (DIRECTED: Documentation of the staff education shall be kept. █ 2/17/26).

By 2/28/2026, Healthcare Director or Designee will conduct an initial audit of all annual assessments/care plans since November 1, 2025, to ensure all diagnoses are identified and addressed accordingly.

By 2/16/2026, Healthcare Director or Designee will update assessment/care plan for Resident █, to ensure all

225c - Additional Assessment (continued)

diagnoses are identified and addressed.

Beginning 3/1/2026, Healthcare Director or Designee will conduct a weekly review for a period of 4 weeks, of all annual assessments/care plans to ensure residents diagnoses are identified and addressed. (DIRECTED: Immediately following the weekly reviews, the Healthcare Director/designee shall audit at least 4 different resident records monthly to ensure compliance with 2600.225c. █ 2/17/26.) Ongoing review will be conducted at the monthly QA meeting. The QA meeting takes place prior to the 20th day of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. █ 2/17/26).

Proposed Overall Completion Date: 03/01/2026

Directed Completion Date: 03/01/2026

Implemented █ 03/11/2026)

231c - Preadmission Screening**6. Requirements**

2600.

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

Description of Violation

Resident █'s cognitive preadmission screening, dated █, does not include a determination that resident █ requires secured care due to █ or other █. This section of resident █'s cognitive preadmission screening is blank. Resident █ was admitted to the home's SDCU on █.

Plan of Correction

Directed █ - 02/17/2026)

On 2/11/2026 Regional Director of Operations educated Healthcare Director and Harmony Square Director of the requirement of a completed preadmission screening to be completed within 72 hours prior to admission to the SDCU. The form must indicate the need for a resident to be admitted to a SDCU. (DIRECTED: Documentation of the staff education shall be kept. █ 2/17/26).

By 2/20/2026, Healthcare Director or Designee will conduct a staff education on regulation 231.c. - Preadmission Screening. (DIRECTED: Documentation of the staff education shall be kept. █ 2/17/26).

By 2/16/2026, Healthcare Director or Designee will obtain an updated preadmission screening for Resident █ that determines █ need to be admitted to the SDCU.

By 2/28/2026, Healthcare Director or Designee will conduct an audit of all SDCU resident charts to ensure that preadmission screening form supports the need for admission to SDCU.

Beginning 3/1/2026, Healthcare Director or Designee will conduct a weekly review for a period of 4 weeks, of all admissions into SDCU to ensure the need for SDCU has been identified on the preadmission screening form. (DIRECTED: Immediately following the weekly reviews, the Healthcare Director/designee shall audit at least 4 different resident records monthly to ensure compliance with 2600.231c. █ 2/17/26.) To ensure ongoing compliance, the team will review at monthly QA meeting. The QA meeting takes place prior to the 20th day of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. █ 2/17/26).

231c - Preadmission Screening (continued)

Proposed Overall Completion Date: 03/01/2026

Directed Completion Date: 03/01/2026

Implemented [REDACTED] - 03/11/2026)

234a - Admission Support Plan

7. 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 [REDACTED] was admitted to the home's SDCU on [REDACTED]; however, resident [REDACTED]'s support plan was not completed until [REDACTED]

Plan of Correction

Directed [REDACTED] - 02/17/2026)

On 2/11/2026 Regional Director of Operations educated Healthcare Director and Harmony Square Director of the requirement to develop, implement and document a residents support plan within 72 hours of admission to the SDCU. (DIRECTED: Documentation of the staff education shall be kept. [REDACTED] 2/17/26).

By 2/20/2026, Healthcare Director or Designee will conduct staff education on regulation 234.a.- Admission Support Plan. (DIRECTED: Documentation of the staff education shall be kept. [REDACTED] 2/17/26).

By 2/16/2026, Healthcare Director or Designee will conduct an initial audit of all SDCU residents admitted since November 1, 2026, to ensure a support plan is developed within the 72 hour period.

Beginning 3/1/2026, Healthcare Director or Designee will conduct a weekly review for a period of 4 weeks, of all admissions into SDCU to ensure support plans have been developed, implemented and documented within the 72 hours timeframe. (DIRECTED: Immediately following the weekly reviews, the Healthcare Director/designee shall audit at least 4 different resident records monthly to ensure compliance with 2600.234a. [REDACTED] 2/17/26.) To ensure ongoing compliance, the team will review at monthly QA meeting. The QA meeting takes place prior to the 20th day of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 2/17/26).

Proposed Overall Completion Date: 03/01/2026

Directed Completion Date: 03/01/2026

Implemented [REDACTED] - 03/11/2026)

234b - Support Plan Needs Elements

8. Requirements

2600.

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

234b Support Plan Needs Elements (continued)

Description of Violation

Resident [REDACTED]'s medical evaluation, dated [REDACTED], indicates numerous diagnoses, to include protein [REDACTED], [REDACTED] and [REDACTED]; however, these diagnoses are not indicated on resident [REDACTED]'s assessment and support plan, dated [REDACTED].

Plan of Correction**Directed [REDACTED] - 02/17/2026)**

On 2/11/2026, Regional Director of Operations educated Healthcare Director and Harmony Square Director of the requirement for the support plan to identify the resident's physical, medical, social, cognitive and safety needs. (DIRECTED: Documentation of the staff education shall be kept. [REDACTED] 2/17/26).

By 2/16/2026, Healthcare Director or Designee will complete a support plan for Resident [REDACTED] and identify all diagnoses and safety needs of the resident, as identified on the DME.

By 2/20/2026, Healthcare Director or Designee will conduct staff education on regulation 234.b. Support Plan Needs Elements. (DIRECTED: Documentation of the staff education shall be kept. [REDACTED] 2/17/26).

By 2/28/2026, Healthcare Director or Designee will conduct an audit of all support plans to ensure the plan identifies and addresses the needs of the resident.

Beginning 3/1/2026, Healthcare Director or Designee will conduct a weekly audit, for a period of 4 weeks, of all admissions to ensure support plans address all residents' physical, medical, social, cognitive and safety needs.

(DIRECTED: Immediately following the weekly reviews, the Healthcare Director/designee shall audit at least 4 different resident records monthly to ensure compliance with 2600.234b. [REDACTED] 2/17/26.) To ensure ongoing compliance, the team will review at monthly QA meeting. The QA meeting takes place prior to the 20th day of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 2/17/26).

Proposed Overall Completion Date: 03/01/2026

Directed Completion Date: 03/01/2026

Not Implemented [REDACTED] - 03/11/2026)

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

Facility Information

Name: HARMONY AT DIAMOND RIDGE **License #:** 45644 **License Expiration:** 02/10/2026
Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: MOON OPERATIONS, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: 1 1	Date: 08/24/2024	Issued By: Twp. of Moon
Type: 1 2	Date: 08/06/2024	Issued By: Twp. of Moon
Type: Other	Date: 08/06/2024	Issued By: Twp. of Moon

Staffing Hours

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

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 03/04/2026

Inspection Dates and Department Representative

12/19/2025 On Site: [REDACTED]
12/23/2025 On Site: [REDACTED]
02/03/2026 On Site: [REDACTED]
02/04/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107 **Residents Served:** 60

Secured Dementia Care Unit

In Home: Yes **Area:** Harmony Square First Floor **Capacity:** 36 **Residents Served:** 25

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 60
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 27	Have Physical Disability: 1

Inspections / Reviews

12/19/2025 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *03/16/2026*

03/24/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/16/2026*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *03/31/2026*

04/22/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/25/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

23a Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [REDACTED], for resident [REDACTED] indicates the resident requires assistance of 2 staff for all transfers. However, according to numerous interviews, [REDACTED] is frequently transferred by 1 staff.

According to numerous interviews, staff working the 10:00 pm to 6:00 am shift occasionally put 2 incontinence briefs on resident [REDACTED] which is not the home's protocol for incontinence care.

Plan of Correction

Accept [REDACTED] - 03/24/2026)

On 02/04/2026, resident [REDACTED]'s assessment and support plan were reviewed and updated by the Healthcare Director.

On 03/09/2026, resident [REDACTED]'s support plan was reviewed with direct care staff and staff were re-educated that resident [REDACTED] requires the assistance of two staff for all transfers per the support plan. Staff were instructed that transfers must always follow the resident's assessed level of assistance.

On 3/09/2026, resident [REDACTED]'s incontinence care was reviewed with staff. Staff were re-educated that applying multiple incontinence briefs is not permitted and that incontinence care must follow the home's standard of care.

By 3/30/2026, the Healthcare Director/Designee will conduct an audit of all resident assessments and support plans to ensure that transfer assistance levels and incontinent care needs are accurately documented and being followed by care staff.

Beginning 3/09/2026, the Healthcare Director/Designee will conduct transfer assistance audits for resident [REDACTED] and incontinence care audits for resident [REDACTED]. These audits will be conducted 1 time weekly, for four weeks, then once monthly for 3 months.

All monitoring activities, findings, and corrective actions will be reviewed at the community's QA. The results of audits, resident interviews, and operational checks will be documented in the QA meeting minutes. Documentation of all staff education and re-education sessions will be kept in accordance with 2600.65. to ensure ongoing compliance and continuous improvement.

The community's next QA meeting will be held on March 20, 2026

Licensee's Proposed Overall Completion Date: 03/31/2026

Implemented [REDACTED] 4/22/2026

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 the evening of [REDACTED], while escorting resident [REDACTED] to [REDACTED] bedroom after dinner, staff person A and staff person B were poking resident [REDACTED] in the stomach and laughing. They continued to do so after the resident asked them to stop. Once in resident [REDACTED]'s bedroom, they broadcast [REDACTED] screams over the walkie-talkie for other staff to hear, and took [REDACTED] call bell and placed it out of reach once resident [REDACTED] was in bed. Resident [REDACTED] was unable to access [REDACTED] call bell until the following morning due to it being placed out of reach.

42b - Abuse (continued)

REPEAT VIOLATION: 4/8/25

Plan of Correction

Accepted - 03/26/2026)

On 2/4/2026 resident [REDACTED] was immediately assessed following the incident and the resident's safety and well being were ensured. The resident's call bell access was reviewed with staff to ensure it remains within reach at all times. Upon discovery of the incident, the employees involved were immediately suspended from duty pending investigation and removed from the schedule. The employees did not return to the community during this time and were terminated following completion of the investigation.

The Executive Director/designee will train newly hired staff, upon hire and annually, regarding abuse and neglect. Beginning 3/9/2026, The Executive Director/designee will review incident reports, complaints, and grievance logs monthly for three months to identify any similar concerns related to staff conduct or call bell access.

On 3/9/2026, the Healthcare Director began providing re-education to all direct care staff on the following topics: Resident rights, abuse, neglect. Re-education will be completed by 3/31/2026.

Beginning 3/9/2026, the Executive Director/designee will observe staff interactions with residents, weekly, for four weeks, to ensure residents are treated with dignity and respect and that call bells remain accessible. Any concerns will be addressed immediately.

All monitoring activities, findings, and corrective actions will be reviewed at the community's QA. The results of audits, resident interviews, and operational checks will be documented in the QA meeting minutes. Documentation of all staff education and re-education sessions will be kept in accordance with 2600.65. to ensure ongoing compliance and continuous improvement.

The community's next QA meeting will be held on March 20, 2026

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented [REDACTED] 4/22/2026

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's call bell response time for a number of residents has exceeded one hour on numerous occasions, to include the following:

Resident	Day	Time	Wait time
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

REPEAT VIOLATION: [REDACTED]

60a Staff/Support Plan (continued)**Plan of Correction****Accept** [REDACTED] - 03/23/2026)

On 2/4/2026 upon discovery of the incident, the Executive Director and Health Care Director reviewed the community call bell response reports and assessed resident needs to ensure staff are responding promptly to resident requests for assistance. The Executive Director and Health Care Director also reviewed the staffing schedule and staff assignments to ensure that adequate staffing coverage is in place to meet resident care needs and support timely response to call bells. Staff were immediately reminded that call bells must be answered promptly and residents requiring assistance must receive support without delay.

On 3/09/2026 the Executive Director/Healthcare Director reviewed call bell response reports for the prior 30 days for all residents to identify any patterns of delayed response.

Beginning 3/09/2026 Direct care staff will receive re education on expectations for prompt call bell response and providing timely staff support to residents.

Beginning 3/09/2026 the Executive Director and Health Care Director will meet weekly, for four weeks, to review staffing schedules and staff assignments to evaluate resident care needs and ensure appropriate staffing coverage is maintained to support timely response to resident requests for assistance.

Beginning 3/09/2026 the Executive Director/Healthcare Director will review call bell response reports weekly for four weeks, to ensure response times remain within acceptable limits. Any concerns will be addressed with additional staff training or corrective action as needed.

All monitoring activities, findings, and corrective actions will be reviewed at the community's Quality Assurance meetings. The results of audits, resident interviews, and operational checks will be documented in the QA meeting minutes. Documentation of all staff education and re education sessions will be kept in accordance with 2600.65. to ensure ongoing compliance and continuous improvement.

The community's next QA meeting will be held on March 20, 2026

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented [REDACTED] 4/22/2026

100b - Removal Snow/Obstructions**4. Requirements**

2600.

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On the morning of [REDACTED], the following outside conditions were observed:

There was an approximately 2 inch accumulation of snow covering the landing at the Stairwell 2 exit door from home's secure dementia care unit (SDCU) to the outdoor area.

There was an approximately 2 inch accumulation of snow covering the landing at the Stairwell 3 exit door from the home's SDCU to the outdoor area.

There was an approximately 10 foot stretch of sidewalk leading from the SDCU wing to the main parking lot that

100b - Removal Snow/Obstructions (continued)

was partially covered with accumulated snow ranging in depth between a dusting to approximately 2 inches.

- Approximately 30% of the surface of the rear patio outside of the personal care dining room was covered with snow ranging from a dusting to approximately 2 inches deep.

-The sidewalk at the rear of the patio outside of the personal care dining room was covered with snow ranging from a dusting to approximately 2 inches deep.

Plan of Correction**Accept** [REDACTED] - 03/26/2026)

1. Facility Maintenance Director corrected all identified areas at the time of this discovery.
2. Executive Director educated the Maintenance Director on this regulation on 3/12/2026, documentation of the education will be kept.
3. Maintenance Director met with contracted landscaping company on 3/11/2026 to ensure that all egresses will be shoveled appropriately per agreement and the Maintenance Department is aware to double check and shovel as needed as well.
4. All Community Egresses will be audited daily starting 3/16/26 by the Maintenance Director or designee to ensure no obstruction exists around exit doors.
5. A facility egress shoveling plan was established by the Executive Director, outlining the Maintenance Director or their designee to be the point person who shovels all the egresses in the event the contracted landscaping company does not arrive in a timely fashion. The plan entails that all outside walkways, ramps, steps and recreational areas as well as exterior escapes will be cleared. The Executive Director will be the back up to the Maintenance Director and their designee in the event of an unexpected absence.
6. Results of the audits will be brought to the monthly QAPI Committee Meeting and reviewed by the Executive Director on April 16th, 2026 for any recommendations.

Licensee's Proposed Overall Completion Date: 03/31/2026**Implemented** [REDACTED] 4/22/2026**121a - Unobstructed Egress****5. Requirements**

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [REDACTED] at approximately 9:22 am, the keypad lockbox swipe card to unlock the exit door at the common SDCU kitchenette to the outdoor courtyard, was missing so the door could not be opened.

On [REDACTED], at approximately 9:35 am, there was approximately 6 inches of snow blocking both sides of the exit gate in the SDCU courtyard.

On [REDACTED], at approximately 9:47 am, a table and 4 chairs were in front of the exit doors closest to the kitchen from the ground floor personal care dining room to the rear courtyard.

REPEAT VIOLATION: [REDACTED]**Plan of Correction****Accept** [REDACTED] - 03/26/2026)

1. Facility Maintenance Director corrected the identified areas at the time of discovery.

121a Unobstructed Egress (continued)

2. Executive Director educated the Maintenance Director on this regulation on 3/12/2026, documentation of the education will be kept.
3. Kitchenette lockbox functionality and keycard presence will be audited daily starting 3/16/2026 by the Maintenance Director or designee to ensure compliance.
4. SDCU courtyard gate and Personal Care Dining Room exit doors will be audited daily starting 3/16/2026 by the Maintenance Director or designee to ensure compliance.
5. Results of the audits will be brought to the monthly QAPI Committee Meeting and reviewed by the Executive Director on April 16th, 2026 for any recommendations.

Implemented [REDACTED] 4/22/2026

Licensee's Proposed Overall Completion Date: 03/31/2026

183e - Storing Medications**6. Requirements**

2600.

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

Description of Violation

On [REDACTED], at approximately 1:40 pm, resident [REDACTED]'s open and in use 1/4 full bottle of [REDACTED] was not labeled with the date it was opened. It was not able to be determined if the medication was expired.

Plan of Correction

Accept [REDACTED] 03/26/2026)

On 2/4/2026 the Health Care Director removed the open bottle of [REDACTED] eye drops from the medication cart and requested a refill from the pharmacy. New bottle of [REDACTED] eye drops were received on 2/4/2026 and dated when opened on the same day by [REDACTED] Healthcare Director. Staff were reminded of proper labeling and storage requirements for all opened medications.

On 3/9/2026 The Health Care Director or designee audited all current resident medications to ensure that each opened or in use prescription and over the counter medication is labeled with the date opened and stored according to manufacturer instructions. Any discrepancies were corrected immediately.

Beginning 3/9/2026, Med techs will be re educated on proper medication storage, including labeling of opened medications with the date opened and adherence to manufacturer instructions. The Health Care Director/Designee will continue to oversee medication storage practices to ensure compliance by completing weekly cart audits for four weeks then monthly ongoing.

Beginning 3/16/2026, The Health Care Director or designee will audit medication storage weekly, for four weeks, to ensure proper labeling and storage. The Health Care Director/designee will continue ongoing oversight of medication storage practices to ensure compliance and address any concerns immediately through staff education or corrective action.

All monitoring activities, findings, and corrective actions will be reviewed at the community's Quality Assurance meetings. The results of audits, resident interviews, and operational checks will be documented in the QA meeting minutes. Documentation of all staff education and re education sessions will be kept in accordance with 2600.65. to ensure ongoing compliance and continuous improvement.

183e - Storing Medications (continued)

The community's next QA meeting will be held on March 20, 2026

Licensee's Proposed Overall Completion Date: 03/31/2026

Implemented [REDACTED] 4/22/2026

187b - Date/Time of Medication Admin.**7. 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 [REDACTED] is prescribed [REDACTED] tablets, 'take one tablet by mouth at bedtime'. Various staff persons initialed resident [REDACTED]'s January 2026 medication administration record to indicate that this medication was administered on the evenings of [REDACTED], and [REDACTED]; however, this medication was not administered on these dates.

Plan of Correction

Accept [REDACTED] - 03/23/2026)

Upon identification of the incident, the medication administration record for Resident [REDACTED] was immediately reviewed. Staff were counseled and re-educated that medications may only be initialed on the MAR at the time the medication is administered and may not be documented if the medication was not given. The resident's current medication orders and MAR were reviewed to ensure accuracy moving forward.

On 03/09/2026 Med Techs were re-educated on proper medication administration documentation procedures and regulatory requirements under 2600.187(b). Education included documenting medications only at the time of administration and appropriately documenting medications that are refused, held, or not administered. Med Techs will ensure that medications are documented on the MAR at the time they are administered in accordance with physician orders and regulatory requirements.

Beginning 03/09/2026 the Healthcare Director, or designee will conduct weekly MAR audits for 30 days to verify medications are documented accurately at the time of administration. Following this period, MAR audits will be conducted monthly to ensure ongoing compliance with regulation 2600.187(b). Any discrepancies identified will be addressed with additional staff education or corrective action as needed.

All monitoring activities, findings, and corrective actions will be reviewed at the community's Quality Assurance meetings. The results of audits, resident interviews, and operational checks will be documented in the QA meeting minutes. Documentation of all staff education and re-education sessions will be kept in accordance with 2600.65. to ensure ongoing compliance and continuous improvement.

The community's next QA meeting will be held on 3/20/2026

Licensee's Proposed Overall Completion Date: 03/31/2026

Implemented [REDACTED] 4/22/2026

187d - Follow Prescriber's Orders**8. Requirements**

2600.

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

Description of Violation

Violation withdrawn [REDACTED] 4/22/2026

Resident [REDACTED] has a physician's order to be weighed every other day. However, there have been numerous dates where resident [REDACTED] was not weighed.

187d - Follow Prescriber's Orders (continued)

REPEAT VIOLATION [REDACTED]

Plan of Correction

Accept [REDACTED] - 03/23/2026)

On 2/10/2026 resident [REDACTED]'s physician order for every-other-day weights was reviewed with the physician following the survey finding and the order was discontinued by the physician. The updated order was communicated to staff and documented appropriately.

On 2/10/2026 the Health Care Director reviewed physician orders for all residents to ensure that any required monitoring, including weights, is being completed as ordered.

Beginning 3/9/2026, Direct care staff will be re-educated on the requirement to follow and document all prescriber orders as written to ensure compliance with physician instructions.

Beginning 3/9/2026 the Health Care Director or designee will conduct weekly audits of resident MARs for four weeks to ensure orders are followed and documented. Any concerns identified will be addressed immediately through staff education and/or corrective action.

Violation withdrawn [REDACTED] 4/22/2026

All monitoring activities, findings, and corrective actions will be reviewed at the community's Quality Assurance meetings. The results of audits, resident interviews, and operational checks will be documented in the QA meeting minutes. Documentation of all staff education and re-education sessions will be kept in accordance with 2600.65. to ensure ongoing compliance and continuous improvement.

The community's next QA meeting will be held on March 20, 2026

Licensee's Proposed Overall Completion Date: 03/31/2026