

Department of Human Services  
Bureau of Human Service Licensing

November 23, 2021

[REDACTED], GENERAL COUNSEL  
[REDACTED]  
[REDACTED]

RE: HARMONY AT STATE COLLEGE  
121 HAVERSHIRE BOULEVARD  
STATE COLLEGE, PA, 16803  
LICENSE/COC#: 22803

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/20/2021, 07/21/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

[REDACTED]  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

Name: *HARMONY AT STATE COLLEGE* License #: *22803* License Expiration Date: *08/05/2021*  
Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*  
County: *CENTRE* Region: *NORTHEAST*

**Administrator**

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

**Legal Entity**

[REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *06/19/2019* Issued By: *Center region*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *73* Waking Staff: *55*

**Inspection**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal* Exit Conference Date: *07/20/2021*

**Inspection Dates and Department Representative**

07/20/2021 - On-Site: [REDACTED]  
07/21/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *125* Residents Served: *53*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *1st floor* Capacity: *38* Residents Served: *18*

**Hospice**

Current Residents: *2*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *53*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *20* Have Physical Disability: *0*

## Inspections / Reviews

07/20/2021 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *09/12/2021*

10/12/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *10/19/2021*

11/23/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

## 26a - Quality Management Plan

### 1. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

### Description of Violation

*The home did not have documentation that a quality management meeting was held in 2020.*

### Plan of Correction

**Accept**

*There was a change in leadership in the community. The documentation of the 2020 Quality Management meetings was not able to be located. The binder for Quality Management meetings for 2021 is on file in the Executive Director's office. Copies of the meeting notes will also be retained by the Business Office Manager after each meeting to ensure that the meeting notes are always available.*

**Completion Date:** 08/31/2021

**Update - 10/12/2021**

*Please send/Attach the Quality Mgt Plan for 2020. 10-12-2021* ■

### Document Submission

**Implemented**

*Attached document.*

## 65a - FS Orientation 1st Day

### 1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

### Description of Violation

*The home did not have documentation that staff person A, who was hired ■■■■■, received training in the topics required under this regulation on the first day of work.*

### Plan of Correction

**Accept**

*There was not an adequate compliance review in place for the documentation of first day work training. Staff person A did attend the first day work orientation however the paperwork that she signed was misplaced.*

*Business Office Manager will review again all the first work day orientation with Staff Person A and have ■■■ sign off on the training by 9/14/21 when ■■■ returns from medical leave.*

*Business Office Manager will audit all current employee files to ensure that the documentation of the training is in the file by September 30, 2021.*

*Going forward, Executive Director will review the completed employee file as a double check for compliance.*

**Completion Date:** 09/30/2021

65a - FS Orientation 1st Day (*continued*)**Document Submission****Implemented***completed*

## 65b - Rights/Abuse 40 Hours

**1. Requirements**

2600.

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

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

*The home did not have documentation that staff person A, who was hired [REDACTED], received training in the topics required under this regulation within 40 hours of the first day of work.*

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

*There was not an adequate compliance review in place for the documentation of the orientation received. Staff person A did attend the 40 scheduled hours of orientation however the paperwork that she signed was misplaced. Business Office Manager will again review the orientation 1. Resident Rights, 2. Emergency Medical Plan, 3. Mandatory reporting of abuse and neglect, 4. Reporting of Reportable Incidents and Conditions with Staff Person A and have her sign off on the training by 9/14/21 when she returns from medical leave. Business Office Manager will audit all current employee files to ensure that the documentation of the training is in the file by September 30, 2021. Going forward, Executive Director will review the completed employee file as a double check for compliance.*

**Completion Date:** 09/30/2021

**Document Submission****Implemented***completed*

## 81b - Resident Personal Equipment

**1. 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**

*The resident's bed in room 215 had enabler bars attached on both sides of the bed. The enabler bars were not covered to prevent possible entrapment.*

81b - Resident Personal Equipment (continued)

Plan of Correction

Accept

Resident 1's family member brought in enabler bars and attached them on the bed without permission and knowledge of Health Care Director. The enabler bars have been covered to prevent possible entrapment. Going forward, all staff including housekeeping will be educated about monitoring the resident rooms for wheelchairs, walker, and other apparatus making sure that they are in good repair and free of hazards. The training will be completed by 9/30/2021 by the Director of Maintenance.

Completion Date: 09/30/2021

Update - 10/12/2021

Please send/Attach proof (picture) of compliance. 10-12-2021

Document Submission

Implemented

Attached picture.

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Near the exit door of stairwell #3 a cluster of dead bugs was observed on the floor.

Plan of Correction

Accept

On 7/19/2021 the monthly contracted pest treatment was conducted by [redacted]. The housekeeping team had not yet completed their daily cleaning of the stairwell when the dead insects were discovered. All stairwells are cleaned daily. Maintenance Director is doing follow up checks daily.

Completion Date: 07/31/2021

Update - 10/12/2021

Please send/Attach proof of pest treatment conducted by Erlich. 10-12-2021

Document Submission

Implemented

Attached picture of invoice.

103g - Storing Food

1. Requirements

2600.

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

Description of Violation

The freezer in the home's kitchen contained 3 cartons of ice cream with lids that were not sealed as well as a plastic bag of frozen breaded chicken that was not closed or sealed.

103g - Storing Food (continued)

Plan of Correction

Accept

The cook and servers were in the midst of service for lunch. They didn't take the time to date and seal the items mentioned. The Dining Services Director immediately took appropriate steps and dated and sealed the chicken and covered the ice cream. Going forward, the Dining Services Director will check the freezers, coolers, and dry storage after each meal service to ensure that all food products are stored appropriately. The Dining Services Director and/or the Lead Cook will do this daily and sign off on a daily checklist. The Dining Services Director will be conducting a training for all staff by 10/15/2021 on the importance of proper storage of food in the kitchen.

Completion Date: 10/15/2021

Document Submission

Implemented

completed

121a - Unobstructed Egress

1. 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

The gate leading from the courtyard located outside the dining area was locked with a key-lock at the time of the initial walk through.

Plan of Correction

Accept

The gate leading from the courtyard was inadvertently locked when the landscapers did their weekly mowing. The maintenance director immediately unlocked the gate. The maintenance director will check the gate daily on his building rounds to ensure that it is open. The gate access will also be checked after the weekly mowing is complete.

Completion Date: 09/01/2021

Document Submission

Implemented

Completed

141a - Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident #1 was admitted to the home on [REDACTED]. The resident's Documentation of Medical Evaluation (DME) form indicated the medical evaluation was completed [REDACTED], which is more than 60 days prior to admission.

141a - Medical Evaluation (continued)

Plan of Correction

Accept

Resident #1 was originally scheduled to move into Harmony and submitted her pre-admission paperwork but the move was delayed. The admission team inadvertently missed getting an updated DME when the move in date was changed.

Going forward, all admission paperwork will be reviewed by the Marketing Director, Health Care Director and Executive Director using the move in checklist.

Completion Date: 09/30/2021

Document Submission

Implemented

Completed

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident #1's annual medical evaluation completed [redacted] was completed more than 12 months after the previous medical evaluation which was completed on [redacted]

Plan of Correction

Accept

Resident #1 changed [redacted] move in date causing [redacted] original paperwork dates to be out of compliance. The admission team inadvertently missed getting an updated DME when the move in date was changed.

Going forward, all admission paperwork will be reviewed by the Marketing Director, Health Care Director and Executive Director using the move in checklist.

Completion Date: 09/30/2021

Document Submission

Implemented

Completed

171b4 - Staff Training

1. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

- 4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff person B was identified as a person who regularly drives the home's van to transport residents to and from medical appointments. Staff person B was not trained as a direct care worker and did not complete the Department's required direct care training course and test.

Plan of Correction

Accept

Upon discovery of Staff Person B's missing training, [redacted] immediately completed the direct care training on July 20, 2021. Going forward, all new hires will be receiving the direct care staff training as part of their Relius Online training. The Business Office Manager will be responsible for checking compliance monthly for the Relius training.

Completion Date: 07/21/2021

171b4 - Staff Training (continued)

Document Submission

Implemented

Completed

182b - Prescription Medication

1. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician’s assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C who is a medication technician did not have a completed annual practicum for 2021. Staff person C’s previous annual practicum was completed 6/21/20. The annual practicum for 2021 had only 1 medication administration observation documented and was therefore incomplete.

Plan of Correction

Accept

Due to Covid the Health Care Director and Medication Trainer did not perform the compliance reviews needed for annual practicum med tech training with the timeframe.

The Medication Trainer immediately provided the training and practicum needed for Staff person C to be in compliance with the medication administration program. Going forward, the Medication Trainer and Health Care Director will use a better tracking system to make sure that annual practicums and observations are completed within the timeframe for compliance.

Completion Date: 09/15/2021

Update - 10/12/2021

Please send/Attach proof of staff training. 10-12-2021

Document Submission

Implemented

Attached document.

187a - Medication Record

1. Requirements

2600.

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

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 has an order for [redacted]. The medication administration record (MAR) did not list a diagnosis for this medication.

187a - Medication Record (continued)

Plan of Correction

Accept

The pharmacy did not include the diagnosis for the medication Alendronate. The nurse in charge is supposed to review and clarify all orders from the pharmacy. The diagnosis for this medication was missed. The Health Care Director provided immediate reeducation for the nurses and med techs. Going forward, nursing staff will review the Medication Administration Record for accuracy and and sign off that they have been reviewed.

Completion Date: 09/15/2021

Document Submission

Implemented

completed

187c - Refusal of Medication

1. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #3 regularly refuses the medication [REDACTED]. The MAR indicates the resident refused the medication on 07/04/21, 07/05/21, 07/07/21, 07/14/21, and 07/15/21. The home did not have documentation that the prescriber was notified of the medication refusals.

Plan of Correction

Accept

Resident #3 resides in Memory Care. [REDACTED] is very challenging to administer medications to and often refuses [REDACTED] medications. The staff have been reeducated to notify the prescriber of all medication refusals as soon as possible. Staff will also notify the Health Care Director of any and all refusals of medication.

Completion Date: 09/30/2021

Update - 10/12/2021

Please send/Attach proof of staff training. 10-12-2021 [REDACTED]

Document Submission

Implemented

attached document

187d - Follow Prescriber's Orders

1. Requirements

2600.

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

187d - Follow Prescriber's Orders (continued)

**Description of Violation**

Resident #3 has an order for [REDACTED] to be taken at noon daily and held if the systolic blood pressure (SBP) is less than 90. On the following dates the resident's SBP was below 90 but the medication was not held as directed:

07/01/21: SBP was 77

07/03/21: SBP was 80

07/06/21: SBP was 74

07/11/21: SBP was 71

07/13/21: SBP was 75

07/17/21: SBP was 75

**Plan of Correction**

**Accept**

Upon review of the MAR for Resident #3 it was discovered that the medication was not given as prescribed by the prescriber. Nursing staff/med techs were immediately reeducated by the Health Care Director about following the directions of the prescriber.

Going forward, Health Care Director and/or LPN's will audit the MAR's weekly to ensure compliance with prescribers orders.

**Completion Date:** 07/31/2021

**Update - 10/12/2021**

Please send/Attach proof of staff training. 10-12-2021 [REDACTED]

**Document Submission**

**Implemented**

Attached document

227d - Support Plan Medical/Dental

**1. Requirements**

2600.

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

**Description of Violation**

A description of the residents' assistance needed with ambulating was not completed on the support plans for the following residents:

Resident #4's support plan dated [REDACTED]—resident uses a rolling walker.

Resident #5's support plan dated [REDACTED]—resident uses a rolling walker

**Plan of Correction**

**Accept**

The Health Care Director missed the section inadvertently noting Resident #4 and Resident #5's use of a rolling walker. The support plans were updated immediately to reflect the use of a rolling walker for each resident. The Health Care Director and Executive Director will work together to review each support plan to ensure accuracy and completion before filing in resident chart.

**Completion Date:** 09/30/2021

227d - Support Plan Medical/Dental (*continued*)**Document Submission****Implemented***completed*

## 227g -Support Plan Signatures

**1. Requirements**

2600.

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

**Description of Violation***The annual support plan for resident #1 dated [REDACTED] was not signed by the person completing the assessment.***Plan of Correction****Accept***The Director of Healthcare Services inadvertently missed signing the support plan after reviewing it with the resident. The support plan was signed immediately upon discovery.**Going forward, the Health Care Director will review the support plan paperwork for signatures and it will also be checked by the Executive Director as a double check for signatures.***Completion Date:** 08/31/2021**Document Submission****Implemented***completed*

## 233c - Key-Locking Devices

**1. Requirements**

2600.

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

**Description of Violation***The courtyard gate located in the home's memory care unit had a code posted next to it that was incorrect and did not open the gate.**The code posted in the memory care unit at the stairwell #2 exit was also incorrect and did not open the door.**The code posted at the hallway exit in the memory care unit was faded and illegible.***Plan of Correction****Accept***It was discovered that the memory care code for the courtyard and stairwell was posted incorrectly. The maintenance director immediately reprogrammed the key pads to reflect the correct code. All the key pads were tested and worked appropriately. The maintenance director redesigned the code postings and posted them where at all key pads in memory care.***Completion Date:** 07/21/2021**Document Submission****Implemented***completed*