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

January 6, 2023

HERSHEY OPERATIONS LLC

RE: HARMONY AT HERSHEY
75 EAST CANAL STREET
HERSHEY, PA, 17033
LICENSE/COC#: 33741

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/27/2022, 09/28/2022, 09/27/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HARMONY AT HERSHEY* **License #**: *33741* **License Expiration**: *06/14/2023*

Address: *75 EAST CANAL STREET, HERSHEY, PA 17033*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *HERSHEY OPERATIONS LLC*

Address: *4423 PHEASANT RIDGE RD,STE 301, Suite 301, ROANOKE, VA, 24014*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/02/2021* **Issued By**: *Labor and Industry*

Type: *I-2* **Date**: *04/02/2021* **Issued By**: *Labor and Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *09/28/2022*

Inspection Dates and Department Representative

09/27/2022 - On-Site:

09/28/2022 - On-Site:

09/27/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *129* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *MC* **Capacity**: *39* **Residents Served**: *21*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *59*

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

Have Mobility Need: *24* **Have Physical Disability**: *1*

Inspections / Reviews

09/27/2022 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/05/2022*

Inspections / Reviews *(continued)*

11/14/2022 - POC Submission

Submitted By: [redacted]
Date Submitted: *11/17/2022*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *11/21/2022*

11/17/2022 - POC Submission

Submitted By: [redacted]
Date Submitted: *11/17/2022*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *11/24/2022*

01/06/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *11/17/2022*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] Resident #1 was admitted to the hospital after falling in the home, sustaining fractured ribs and moderate hemothorax. The home did not report this incident to the Department.

Resident #2 did not receive their 8:00 AM Vitamin D-3 2,000 unit tablet on 9/22/22 due to "waiting on refill". This medication error was not reported to the Department.

Resident #3 did not receive their Gabapentin 400 mg dose on 9/21/22 at 2:00 PM, 9/22/22 at 2:00 PM, 9/24/22 at 8:00 AM, 9/24/22 at 8:00 PM, 9/25/22 at 8:00 AM, 9/26/22 at 8:00 AM, 9/26/22 at 2:00 PM, 9/26/22 at 8:00 PM or 9/27/22 at 8:00 AM. These medication errors were not reported to the Department.

Resident #4 did not receive their 5:00 PM dose of Metformin ER 500 mg on 9/22/22. Note in the MAR states "waiting on it". This medication error was not reported to the Department.

Plan of Correction ***Accept (NC - 11/16/2022)***

The Executive Director reviewed the requirements for state reportable events with all team members on 11/10/2022. All state reportable events will be reported to the state licensing agency within 24 hours, by the Executive Director. We have reviewed resident #2, #3 and #4's medications and all medications are all available for administrations as ordered as of 9/27/2022. The Healthcare Director will be conducting weekly audits beginning on 09/27/2022. The audits will consist of reviewing all medications for all residents, to ensure that all medications are in the building and available for administration, this will be ongoing.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

25a - Written Contract and Review

3. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1, admitted on [redacted] did not have a resident-home contract completed until [redacted].

Plan of Correction ***Accept (AS - 11/16/2022)***

The Executive Director re-educated the home's admission team on the time frames for signing contracts on 11/10/2022. Going forward, the Executive Director will complete the contract prior to admission or within 24

25a - Written Contract and Review (continued)

hours after admission. Beginning on 12/1/22, the Executive Director will complete a quarterly audit of all resident records to ensure compliance.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care Staff Member A, hired on [redacted], does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (NC - 11/16/2022)***

Staff member A's high school diploma and direct care staff certificate was provided on 11/10/2022 and has been placed in [redacted] personnel file. All employee files have been audited for proof of eligibility and no other ineligible employees were found as of 10/28/2022. All applicants will have proof of HS diploma, GED or positive registry status prior to an offer of employment. Beginning 10/28/22 the Business Office will ensure that a copy of the necessary documents is in the employee file. Beginning 10/28/22 the Executive Director will review the new employee records after the file is completed by the Business Office Manager.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AS - 01/06/2023)

57c - 2 Hours/Day

5. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

Staffing levels were not sufficient to provide 2 hours of personal care services for immobile residents.

On 9/12/22, There was a total of 80 hours provided for 58 residents, 24 of whom are immobile. 82 hours were required.

On 9/13/22, there was a total of 73.5 hours provided for 58 residents, 24 of whom are immobile. 82 hours were required.

On 9/17/22, there was a total of 74.50 hours provided for 62 residents, 26 of whom are immobile. 88 hours were required

57c - 2 Hours/Day (continued)

Plan of Correction ***Accept (NC - 11/16/2022)***

Immobile residents were reviewed and updated on 09/30/2022 by the Executive Director. Staffing has been adjusted to include enough staff hours to meet the 2 hours per day per immobile resident as of 11/1/22. The list of immobile residents will be reviewed daily beginning 11/14/22 by the Healthcare Director, Harmony Square Director, and Executive Director and staffing will be adjusted on an ongoing basis to meet the required staffing levels. The administrator hired new staff by 11/14/22 and contracted agency from [redacted] and [redacted].

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

57d - Waking Hours

6. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 9/13/22, 60.5 waking hours of direct care were provided for 58 residents, 24 of whom have a mobility need. 61.5 total waking hours were required.

On 9/17/22 61.5 waking hours of direct care were provided for residents, 26 of whom have a mobility need. 61.5 hours were provided.

Plan of Correction ***Accept (NC - 11/16/2022)***

Staffing levels have been adjusted as of 9/30/22 to meet the requirement for waking hours. Beginning on 9/30/22, staffing schedules will be reviewed by the Executive Director and staff will be scheduled to maintain the appropriate number of staff during waking hours. Staffing hours were adjusted by using agency and hired new staff and also used staff from our other community. Staffing schedules were reviewed on 9/30/22 by the Executive Director.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

60a - Staff/Support Plan

7. 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

Overnight staffing levels were not adequate to meet the needs of the residents based on their resident assessment support plans and also in the event of an emergency.

On 9/18/22 between the hours of 12:00 AM to 7:00 AM, there were 2 staff on shift. There was a total of 62 residents.

60a - Staff/Support Plan (continued)

26 of those residents were immobile, 21 in the secure unit and 5 in personal care.

On 9/14/22 between the hours of 12:00 AM to 7:00 AM, there were 2 staff on shift. There was a total of 58 residents. 24 of those residents were immobile, 19 in the secure unit and 5 in personal care.

On 9/13/22 between the hours of 12:00 AM to 4:00 AM, there were 2 staff on shift. There was a total of 58 residents. 24 of those residents were immobile, 19 in the secure unit and 5 in personal care.

On 9/29/22, there were 3 staff scheduled for overnight shift. 2 staff members left at 7:16 AM and 7:17 AM, leaving only 1 staff person until 7:22 AM. No staff person was in the secure unit during this time. There was a total of 61 residents. 25 of those residents were immobile, 20 in the secure unit and 5 in personal care.

Plan of Correction ***Accept (NC - 11/16/2022)***

Staffing levels have been adjusted as of 9/30/22 to meet the needs of the residents according to their support plans and in case of emergency. Staffing levels have been adjusted by staff that were hired, agency and staff from our other community. Staff were reeducated by the Executive Director on 11/10/22 on not leaving their floor until all staff for the upcoming shift have arrived and been given report. Staff have been reeducated that at no time is the secured dementia unit to be left unattended. Beginning 11/14/22, Staffing schedule will be reviewed daily by Executive Director/and or the Harmony Square Director to ensure sufficient staffing hours are in place to meet the needs of our resident support plans, immobile residents, and in case of emergencies.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

63a - First Aid/CPR Training

8. Requirements

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

Description of Violation

During the inspection from 9/27-9/29/22, representatives of the Department were presented with nine First Aid/CPR Certificates for staff persons who currently are employed by the home. The training date listed on all of the certificates is 5/31/22. All the certificates contain the same eCard Code number (#226015773739). Per the American Heart Association, a separate unique eCard code number is generated for each staff person who registers for the First Aid/CPR training. Staff persons D, E, F and G provided written statements to representatives of the Department, stating that they did not participate in First Aid/CPR training on 5/31/22. Staff persons D, H and I were hired by the home after the 5/31/22 training date. Due to the information presented above, these nine staff members were not counted

63a - First Aid/CPR Training (continued)

when assessing compliance with regulation 2600.63(a).
Based on the census of the home on the dates listed below, which was greater than 50 residents, two staff persons were required to be present at all times in the home that are trained and certified in first aid and CPR. The following dates and times listed below, represent times that the home did not have the minimum required two staff persons present in the home who were trained and certified in first aid and CPR.

- *0 CPR/First Aid certified staff from 7 PM on 9/4/22 to 7 AM on 9/5/22.*
- *1 CPR/First Aid certified staff from 7 PM on 9/4/22 to 6 AM on 9/6/22.*
- *1 CPR/First Aid certified staff from 7 AM to 9 AM on 9/6/22.*
- *1 CPR/First Aid certified staff from 6 PM to 7 PM on 9/6/22.*
- *1 CPR/First Aid certified staff from 7 PM on 9/6/22 to 7 AM on 9/7/22.*
- *1 CPR/First Aid certified staff from 3 PM to 4 PM on 9/7/22.*
- *0 CPR/First Aid certified staff from 4 PM to 7 AM on 9/7/22.*
- *0 CPR/First Aid certified staff from 7 PM on 9/7/22 to 7 AM on 9/8/22.*
- *1 CPR/First Aid certified staff from 7 AM to 9 AM on 9/8/22.*
- *1 CPR/First Aid certified staff from 3 PM to 7 PM on 9/8/22.*
- *1 CPR/First Aid certified staff from 7 PM on 9/8/22 to 3 AM on 9/9/22.*
- *1 CPR/First Aid certified staff from 7 PM to 9 PM on 9/9/22.*
- *0 CPR/First Aid certified staff from 9 PM on 9/9/22 to 3 AM on 9/10/22.*
- *1 CPR/First Aid certified staff from 3 AM to 7 AM on 9/10/22.*
- *1 CPR/First Aid certified staff from 3 PM to 7 PM on 9/10/22.*
- *1 CPR/First Aid certified staff from 9 PM on 9/10/22 to 7 AM on 9/11/22.*
- *1 CPR/First Aid certified staff from 8 PM on 9/11/22 to 12 AM on 9/12/22.*
- *1 CPR/First Aid certified staff from 4 AM to 9 AM on 9/12/22.*
- *0 CPR/First Aid certified staff from 7 PM on 9/12/22 to 7 AM on 9/13/22.*
- *1 CPR/First Aid certified staff from 7 AM to 7 PM on 9/13/22.*
- *0 CPR/First Aid certified staff from 7 PM on 9/13/22 to 9 AM on 9/14/22.*
- *1 CPR/First Aid certified staff from 9 AM to 11 AM on 9/14/22.*
- *1 CPR/First Aid certified staff from 11 PM on 9/14/22 to 9 AM on 9/15/22.*
- *1 CPR/First Aid certified staff from 7 PM to 10 PM on 9/15/22.*
- *0 CPR/First Aid certified staff from 10 PM on 9/15/22 to 7 AM on 9/16/22.*
- *1 CPR/First Aid certified staff from 7 AM to 9 AM on 9/16/22.*
- *1 CPR/First Aid certified staff from 9 PM on 9/16/22 to 12 AM on 9/17/22.*
- *0 CPR/First Aid certified staff from 12 AM to 7 AM on 9/17/22.*
- *1 CPR/First Aid certified staff from 7 PM to 9 PM on 9/17/22.*
- *0 CPR/First Aid certified staff from 9 PM on 9/17/22 to 12 AM on 9/18/22.*

Plan of Correction ***Accept (NC - 11/16/2022)***

All schedules have been updated by the Executive Director by 9/30/22 to include at least 1 person with the required training and certification for every 50 residents. Schedules reflecting the CPR trained staff are attached. Staff schedules will be reviewed daily beginning 11/14/22 by the Health Care Director and/or Executive Director to ensure that the correct number of staff are present at all times with CPR and First Aid Training. Attached is the CPR/First Aid training for staff members D,E,G, and I all had CPR/First Aid training on 10/18/22-10/19/22 and have attached documentation. F, H have not received their CPR/First training will be completed by 11/30/2022.

63a - First Aid/CPR Training *(continued)*

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

65d - Initial Direct Care Training

9. Requirements

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

Description of Violation

Direct care staff member A, hired on [redacted], did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept (NC - 11/16/2022)***

Staff person A has completed the direct care training course and passed the competency test which is attached on [redacted]. The Executive Director reviewed all direct care staff files by 11/14/22 have to ensure completion of the direct care training program. Going forward, all applicants for direct care positions will complete and provide proof of completion for the training before being put on the schedule to work. All audits completed by 9/30/2022 by the Executive Director.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AS - 01/06/2023)

82c - Locking Poisonous Materials

10. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 9/27/22 at 9:34 AM the housekeeping room in the Secure Dementia Care Unit (SDCU) was unlocked. The following chemicals were found in the room on a shelf: Reliable Carpet Spot and Stain RZU, Reliable Clean Bowl, Reliable Classic Furniture Polish, Crystal Foam Glass Cleaner, Ecolab Hand Sanitizer Gel, Ecolab Advance Anti-Bacterial Cleaner, Ecolab Hand Sanitizer, Ecolab Peroxide Cleaner and Disinfectant, Ecolab bio–Enzymatic Odor Eliminator, Great Value Disinfectant Spray. All of these chemicals either say to seek medical treatment or call Poison Control on the containers.

On 9/28/22 at 9:35 AM, room H115 in the Secure Dementia Care Unit (SDCU) had Reliable Cinnamon Scent spray can in an unlocked cabinet under the sink in the bathroom. There was also petroleum jelly found in an unlocked drawer under the sink in the bathroom. Both containers state to contact Poison Control if ingested.

On 9/28/22 at approximately 2:45 PM, room H134 in the Secure Dementia Care Unit (SDCU) had two bottles of Renew Skin Repair Cream was found on resident's night stand. Both bottles state to contact Poison Control if ingested.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept (AS - 11/16/2022)***

The housekeeping room on the secured unit was locked and secured immediately on 9/27/22. The scented spray H115 and the 2 bottles of renew repair cream in H134 were also removed and placed in a secured location on 9/27/2022. The secured unit, the common areas, bathrooms and resident apartment had been observed and all poisonous material have been removed and placed in a locked area. The Executive Director re-educated all staff on 11/10/2022 to not leave poisonous materials to not leave in resident apartments and must be stored in a secured area that is not accessible to residents. Beginning on 9/30/22, the secured unit will be monitored daily by the Executive Director that no poisonous material is left unsecured and accessible to residents.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

On 9/29/22 at approximately 10:00 AM, resident #5 had a soiled urine pad which was wet to the touch and strongly smelled of urine.

On 9/29/22 at approximately 10:05 AM, resident #6's room had a strong smell of urine. A used urine pad was crumpled up on the floor in front of resident's bed.

Plan of Correction ***Accept (NC - 11/16/2022)***

On 9/27/22 support plans for residents #5 has been reviewed and updated by the Harmony Square Director to ensure that incontinence care needs are included. Resident #6 has been discharged on [redacted]. Staff providing direct care were reeducated by the Harmony Square Director on 11/10/22 on the incontinence care needs for both residents including ensuring the residents are dry throughout the shift, appropriate skin care is provided, proper disposal of soiled products, and providing additional housekeeping and trash removal when needed to remove soiled pads. All residents with incontinent care needs will have the appropriate support plans undated by the Healthcare Director or Harmony Square Director by 11/30/22. The Healthcare Director and Harmony Square Director will be responsible for doing Q 2-hour checks to ensure pads are not soiled, skin is clean and dry, and trash removal of soiled products is removed from the room.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

85d - Trash Receptacles

12. Requirements

2600.

85d - Trash Receptacles *(continued)*

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

Description of Violation

The trash receptacle in the bathroom of room [redacted], which is shared by 2 people, was not covered.

Plan of Correction **Accept (AS - 11/16/2022)**

The trash bin in the bathroom of Room [redacted] has been replaced with a covered one on 9/29/22 by the Maintenance Director. The Maintenance Director re-educated all staff that all trash receptacles in the kitchen and bathrooms must be covered on 11/10/2022. Beginning on 11/10/22, the Maintenance Director will conduct daily checks on [redacted] rounds to ensure that all trash receptacles are covered.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AS - 01/06/2023)

89b - Hot Water Temperature

13. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The hot water at the sink in the 2nd floor activity room, which is used by residents, was measured at 124.1 degrees Fahrenheit.

Plan of Correction **Accept (AS - 11/16/2022)**

The hot water temperature has been adjusted by the Maintenance Director and to measure below 120 degrees on 9/27/2022. Beginning on 11/21/22, the Maintenance Director will be checking water temperatures weekly. The Executive Director will review the temperature log weekly to ensure that temperatures are compliant.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

96a - First Aid Kit

14. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit located at the front desk did not contain scissors, thermometer, breathing shield or band aids.

The first aid kit labeled "8" in the Secure Dementia Care Unit (SDCU) did not contain tape or eye coverings.

The first aid kit labeled "MC" in the Secure Dementia Care Unit (SDCU) did not contain a thermometer.

Plan of Correction **Accept (AS - 11/16/2022)**

The First aid kits have been restocked and replaced all required items by the Health Care Director and Harmony

96a - First Aid Kit (continued)

Square Director on 9/28/22. All staff have been reeducated for emergencies and staff will need to notify the healthcare director to restock on 11/10/2022. Beginning on 12/1/22, the healthcare director will check the status of the first kits monthly to ensure they contain all items.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AS - 01/06/2023)

123b - Emergency Procedures Posted

15. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (AS - 11/16/2022)***

The emergency preparedness and response plan are in a large red colored binder and maintained at the front desk, nursing stations and also the nursing station in the SDCU was placed by the Executive Director immediately on 9/27/22. All staff will be reeducated to the contents of the emergency preparedness and response plan on 11/10/2022, by the Executive Directos. Beginning on 12/1/22, the Administrator will monitor that the plan is in their proper locations quarterly.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

132a - Monthly Fire Drill

16. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

There was no fire drill held in December 2021.

POC Submission ***Accept (AC - 11/14/2022)***

A fire drill for December 2021 was inertially missed due to a change in staff in the maintenance department. Going forward the maintenance director is conducting monthly drills per the state regulations. The executive director will review the fire drill logs monthly to ensure that the drills are completed properly and documented.

Licensee's Plan Completion Date: *11/11/2022*

Implemented (AC - 12/07/2022)

132c - Fire Drill Records

17. Requirements

132c - Fire Drill Records *(continued)*

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records from January 2022 through July of 2022 do not include the exit route(s) used for any of the drills. The fire drill record for the drill held on 8/26/22 does not include the time the drill was held, number of staff who participated in the drill, number of residents present during the drill and number of residents evacuated during the drill.

Plan of Correction ***Accept (NC - 11/16/2022)***

Beginning in December 2022, the maintenance director is conducting monthly drills per the state regulations and hired Fire Life and safety solutions to train staff on fire drills. He will be educating the staff on 11/17/2022. The exit routes are now being included for all drills and include the time, number of staff, number of residents present during the drill. Beginning 12/1/22, The executive director will review the fire drill logs monthly to ensure that the drills are completed properly and documented by the maintenance director. The monthly fire drill reviews were started immediately on 9/27/22.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

141a 1-10 Medical Evaluation Information

18. Requirements

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

In resident #7's medical evaluation dated [redacted], section 4 "Special Needs or Dietary Needs" is not completed.

Plan of Correction ***Accept (AS - 11/16/2022)***

Resident #7's medical evaluation has been amended by the Executive Director to include Special Needs and Dietary Needs on [redacted]. All residents' medical evaluations will be reviewed and updated to include information in all sections by 11/30/22 by the Executive Director. Beginning on 12/1/22, the Healthcare Director/Harmony Square

141a 1-10 Medical Evaluation Information (continued)

Director will review all medical evaluations for completeness prior to admission. The Executive Director will do a final audit of the resident file to ensure that medical evaluations are completed in their entirety.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

162c - Menus Posted

19. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

A two-week menu was not posted in the Secure Dementia Care Unit (SDCU). In the personal care dining area there was only one week worth of menus posted dated 8/28-9/3/22.

Plan of Correction ***Accept (AS - 11/16/2022)***

The two-weeks worth of menus have been posted in all dining rooms including SDCU on 9/27/2022, by the Executive Director. The dining director has been reeducated by the Executive Director on the requirements for the advanced posting of menus in conspicuous places in all dining rooms each week on 11/10/2022. Beginning on 12/1/22, the Executive Director/Harmony Square Director will do a weekly check to ensure that the menus are posted in the required timeframe required by the regulations.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AS - 01/06/2023)

171b5 - First Aid Kit

20. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit located in the white van used to transport residents did not contain eye coverings or a breathing shield.

The first aid kit in the white bus used to transport residents did not contain a breathing shield.

Plan of Correction ***Accept (AS - 11/16/2022)***

The first aid kits in the white van and the white bus have been restocked by the Healthcare Director and Harmony Square Director and items replaced to include all the required items in the first aid kits, this occurred on 9/27/22. Beginning on 12/1/22, the bus and van first aid kits will be checked monthly by the Maintenance Director to

171b5 - First Aid Kit (continued)

ensure that items are replaced or restocked if used. Items were replaced on 9/27/2022

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

183b - Meds and Syringes Locked

21. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident’s room.

Description of Violation

On 9/29/22 at 11:26 AM, the door to the 3rd floor medication room was open. A cabinet inside the medication room was also open and in plain view from outside the room. A vial of prescribed metformin HCL for resident #8 was on a shelf in the open cabinet. In addition, a container of prescribed Polyethylene Glycol for resident #10 was on the counter top. There were no staff in the vicinity of the medication room.

Plan of Correction ***Accept (AS - 11/16/2022)***

The 3rd floor medication room has been locked and secured on 9/27/2022 by the Executive Director. All staff have been reeducated by the Executive Director on 11/10/2022, on the need for medications, syringes, and other medical supplies to be locked and secured at all times when they are not supervised by staff. Beginning on 12/1/22, the Healthcare Director will monitor compliance daily when making rounds to ensure that everything is locked and secured when not being supervised by staff.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

184a - Resident's Meds Labeled

22. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #7’s insulin (Novalog Flex Pen 100/ml) did not have resident’s name.

Resident #4's insulin (Levemir Flex Touch 100 units) had resident’s initials but not his/her name. Resident #4's Novalog Flex Penn had his/her 1st name, and it was very difficult to read.

Plan of Correction ***Accept (AS - 11/16/2022)***

Resident #7's insulin has been properly labeled including the name of the resident on 9/27/2022, by the Healthcare Director. Resident #4 has been discharged and moved out of the community on [redacted]. Medication staff have been reeducated by the Healthcare Director on the need for all medications to have a proper label from the pharmacy before accepting the medications into the home on 11/10/2022. Beginning on 12/1/22, the Healthcare Director will monitor the medications weekly to ensure all medications contain the proper pharmacy label.

184a - Resident's Meds Labeled (continued)

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

Resident #3's Gabapentin CV 400 mg was not available on site. Per notes on Medication Administration Record (MAR), resident has been out of medication since 9/21/22 due to waiting on order from prescriber.

Resident #4 did not receive 5:00 PM dose of Metformin ER 500 mg on 9/22/22. Note in the MAR states "waiting on it".

Plan of Correction ***Accept (AS - 11/16/2022)***

Resident #3's Gabapentin order and medication were obtained on 09/27/2022 by the Healthcare Director. Medication staff have been reeducated on 11/10/2022 by the Healthcare Director, on the need to either obtain from pharmacy or report to the Healthcare Director each time and immediately if a prescribed medication is not available for administration. Healthcare Director will review medications and medication administration records weekly starting on 12/1/22, to ensure that all medications are available weekly.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

190a - Completion Medication Course

24. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member B ,who administers medications, has not received any training on the medication observations or reviews since [redacted]. Staff Member B administered medications on 9/15/22 at 8:00 AM and 9/21/22 at 8:00 AM.

Plan of Correction ***Accept (AS - 11/16/2022)***

Staff member B has been removed from the schedule on 10/14/2022 by the Exective Director. Files of all staff members who are med techs and administer medications have been reviewed by the Executive Director on 9/28/2022 to ensure they have received the proper training, passed the competency test, and have been reviewed annually by the med tech train the trainer. Beginning 12/1/22, the Executive Director will review the med tech training quarterly with the Healthcare Director to ensure that training is current and up to date.

Licensee's Proposed Overall Completion Date: *11/14/2022*

190a - Completion Medication Course *(continued)*

Implemented (AS - 01/06/2023)

224a - Preadmission Screen Form

25. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #7's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept (AS - 11/16/2022)***

Resident #7's preadmission screening form has been completed as of [redacted] by the Executive Director and includes a determination that their needs can be met by the services provided by the home. All resident preadmission screening forms have been audited to ensure they include all information required and the determination that their needs can be met by the services of the home by the Healthcare Director. Have been completed by 9/30/2022. Beginning on 12/1/22, the Executive Director will perform a final review of all new preadmission screenings and admission paperwork before it is entered into the resident record for accuracy.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

225a - Assessment 15 Days

26. Requirements

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

Description of Violation

An assessment was not completed for resident #1, who was admitted to the home on [redacted].

Plan of Correction ***Accept (AS - 11/16/2022)***

Resident #1's record was reviewed and found to have had an assessment on [redacted] and another on [redacted] All resident records will be reviewed by 9/30/2022 by the Healthcare Director to ensure that an initial assessment was completed within 15 days. Healthcare Director will ensure that all residents moving in will have an assessment completed with 15 days of admission. Executive Director will perform a final audit to make sure that all assessments are completed within the timeframe required. The Executive Director completed the audit.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

227c - Support Plan Revision

27. Requirements

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

Description of Violation

Resident #9 has a covered Enabler Bar installed on [redacted] bed. Resident #9's current support plan dated [redacted], does not address the use of this enabler bar.

Resident#3 has a halo bar installed on [redacted]. Resident #3's current support plan dated [redacted] does not address the use of this halo bar.

Resident #5's has a bed rail installed on [redacted]. Resident #5's current support plan dated [redacted], does not address the use of this bed rail.

Plan of Correction ***Accept (AS - 11/16/2022)***

Residents #3, #9 and #5 have had all their support plans updated to include the use of the assistive devices for bed mobility by the executive director on 9/27/2022. All resident support plans will be reviewed by the Healthcare Director for accuracy and any resident changes or needs have been placed on their support plans. Healthcare Director will ensure that the support plans are updated and accurate within 30 days of the annual assessment or when changes occur. Direct care staff were reeducated on 11/10/2022 to report any bed mobility devices that are not listed in resident support plan to the Healthcare Director or Executive Director to be addressed. Audits were completed by the Executive Director 11/10/2022.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

231b - Medical Evaluation

28. 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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation was completed on [redacted]

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's medical evaluation was completed on [redacted].

231b - Medical Evaluation *(continued)*

Plan of Correction ***Accept (AS - 11/16/2022)***

The admission team has been reeducated by the Harmony Square Director on 11/10/2022 and prior forms of each new move in. Harmony Square Director will ensure that residents moving into the SDCU have a completed medical evaluation on file within 60 days prior to move in. Beginning on 12/1/22, the Executive Director will complete a final review of each resident record to provide a review of compliance for the medical evaluations.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

231c - Preadmission Screening

29. 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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident #2's written cognitive preadmission screening was completed on [redacted]

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident #2's written cognitive preadmission screening was completed on [redacted]

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident #2's written cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept (AS - 11/16/2022)***

The home's admission team has been reeducated by the Harmony Square Director on 11/10/2022 in regard to the move in process for residents and the need for residents moving into the SDCU to have the cognitive prescreen within 72 hours of admission. The Harmony Square Director will ensure that any resident moving into the SDCU has a cognitive prescreen completed and on file within 72 hours of admission. Beginning on 12/1/22, the Executive Director will conduct a final check of all completed final resident records to double check each record for compliance with the cognitive prescreening.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

234a - Admission Support Plan

30. 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.

234a - Admission Support Plan *(continued)*

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted].

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted].

Plan of Correction ***Accept (AS - 11/16/2022)***

The home's admission team has been reeducated by the Harmony Square Director on 11/10/2022 in regard to the move in process for residents and the need for residents moving into the SDCU to have a support plan within 72 hours of admission or within 72 hours. The Harmony Square Director will ensure that any resident moving into the SDCU has a cognitive prescreen completed and on file within 72 hours of admission. Beginning on 12/1/22, the Executive Director will complete an audit of every completed file to ensure that all paperwork is completed and compliant.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)

254a - Records Discharge/Active

31. 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 9/27/22 at approximately 9:50 AM, the third floor laptop computer on top of the medication cart was opened and unlocked. There was no staff in the vicinity. There was information on eight residents on the screen.

On 9/29/22 at approximately 3:37 PM, the third floor medication cart laptop computer had 18 residents' information showing and the laptop.

Plan of Correction ***Accept (AS - 11/16/2022)***

Laptops containing resident information on the medication carts will be logged out and closed. All staff who utilize the laptops on the medication carts or other media containing resident information will be reeducated by the Executive Director on 11/10/2022, resident record privacy and resident's rights to privacy, ensuring that areas that contain resident information including laptops, medication rooms and storage remain secured and inaccessible to others. Beginning on 12/1/22 the Executive Director will monitor daily to ensure that resident records and information is secure at all times when not supervised by staff.

Licensee's Proposed Overall Completion Date: *11/14/2022*

Implemented (AC - 12/07/2022)