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

January 6, 2023

HARMONY HOUSE MANOR INC

RE: HARMONY HOUSE MANOR
601 LAMBERD AVENUE
JOHNSTOWN, PA, 15904
LICENSE/COC#: 31439

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/07/2022, 12/08/2022 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 HOUSE MANOR* **License #:** *31439* **License Expiration:** *05/09/2023*

Address: *601 LAMBERD AVENUE, JOHNSTOWN, PA 15904*

County: *CAMBRIA* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *HARMONY HOUSE MANOR INC*

Address: *2888 CARPENTER PARK ROAD, DAVIDSVILLE, PA, 15928*

Phone: **Email:**

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/25/1994* **Issued By:** *DL&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *29* **Waking Staff:** *22*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *12/08/2022*

Inspection Dates and Department Representative

12/07/2022 - On-Site:

12/08/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served:** *21*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Touchstone* **Capacity:** *26* **Residents Served:** *7*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *21*

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

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

12/07/2022 - Full

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

12/27/2022 - POC Submission

Submitted By: **Date Submitted:** *01/06/2023*

Reviewer: **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/04/2023*

Inspections / Reviews *(continued)*

01/06/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/06/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *01/17/2023*

01/06/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *01/06/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 12/7/2022, the home's copy of 55 Pa.Code Chapter 2600 was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (CR - 01/04/2023)***

Administrator placed the DHS Regulations at front nurses station 12/7/22 and 12/9/22 placed another copy on front bulletin board (see attached).
Beginning 12/30/22, administrator will complete weekly audits to ensure regulations are posted in a public and conspicuous place. If regulations are not posted, a new set of regulations will immediately be posted. (see attached checkoff list).

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

85a - Sanitary Conditions

3. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 12/7/2022 at approximately 10:25 AM, the mechanical air blower in Touchstone Bathroom B was inoperable resulting in an absence of any means of hand-drying options.

Plan of Correction ***Directed (CR - 01/04/2023)***

Administrator placed a roll of paper towels in the bathroom immediately on 12/7/22. Shaffer Electric replaced the air blower on 12/14/22. On 12/30/22, administrator and maintenance checked all remaining bathrooms in the home, resident bathrooms and shared bathrooms, to ensure there are means of hand drying available.

(Directed)

- *Beginning on 1/16/2023, the Administrator and maintenance will complete weekly checks of the home's bathrooms to ensure each bathroom has hand-drying options available.*
- *All Staff members will be re-trained on hand drying options being available in each bathroom by the Administrator no later than 1/16/2023. If staff observe an inoperable air dryer, paper towels or properly labeled hand towel, they will notify the administrator and/or maintenance immediately to replace any item necessary.*

Directed Completion Date: *01/16/2023*

Implemented (CR - 01/06/2023)

87 - Lighting

4. Requirements

2600.

87 - Lighting *(continued)*

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 12/7/2022 at approximately 10:18 AM, the outside doorway on the right side of the home was missing a light bulb.

On 12/7/2022 at approximately 5:15 PM, the home's outside doorways to the side entrance of the home, near the office and the outside steps at the main entrance of the home, did not have operable lighting.

Plan of Correction ***Accept (CR - 01/04/2023)***

Shaffer Electric replaced all front & side exit lights with new dusk-to-dawn fixtures that turn off and on automatically on 12/14/22 (see attached). On 12/30/22, administrator and maintenance will complete weekly checks on all exterior lights to ensure they are operable. On 12/29/22, staff were trained on the requirement for the home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes to be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate. Staff will notify administrator if a light is observed to be inoperable so a repair can be completed immediately.

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

88a - Surfaces

5. Requirements

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

Description of Violation

On 12/7/2022 at approximately 10:20 AM, an area of broken concrete was observed at the exterior smoking ramp, creating a tripping hazard. A portion of the area was covered with plywood which flexed when weight was applied.

On 12/7/2022, the radiator in the Secured Dementia Care Unit (SDCU) Bedroom #7 was observed to be corroded.

On 12/7/2022, the pedestal sink in the SDCU Bedroom #7 was detached from the wall and visibly moved when slight pressure was applied. Water was leaking from the bottom of the sink creating a slipping hazard.

Plan of Correction ***Accept (CR - 01/04/2023)***

1. Maintenance applied gravel on 12/20/22 to even the concrete area and to ensure plywood would not flex and put a large outdoor mat to ensure safety and no tripping hazard (see attached).
2. Maintenance sanded and repainted radiator in SDU Bedroom #7 bathroom on 12/16/22 (see attached).
3. Maintenance secured pedestal sink in SDU Bedroom #7 bathroom on 12/16/22 (see attached).
Beginning on 12/30/22, administrator and maintenance will do weekly checks to ensure floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. (see attached checkoff list). Results of the weekly checks will be discussed at the home's quality management meetings to ensure a plan for repair is in

88a - Surfaces (continued)

place. The next quality management meeting will be held on 4/1/23.

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

89a - Water Pressure

6. Requirements

2600.

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 12/7/2022, the bathroom in Resident Room #7 was observed to have the cold water valve turned off; Bedroom #7 is occupied by a resident.

On 12/7/2022, the Touchstone Bathroom A was observed to have the hot water valve turned off.

Plan of Correction ***Accept (CR - 01/04/2023)***

The owner turned the water valves on during inspection on 12/7/22. On 12/29/22, administrator provided a retraining to all staff members in the home on the requirement for each bathroom to have hot and cold water under pressure in each bathroom, kitchen and laundry area. Staff will notify the administrator of any hot or cold water not working. Beginning 12/30/22 administrator and maintenance will complete weekly checks of each restroom to ensure there is hot and cold water under pressure. Results of the weekly audits will be discussed during the home's next quality management meeting on 4/1/23.

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

91 - Telephone Numbers

7. Requirements

2600.

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

Description of Violation

On 12/7/2022, there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in Bedroom #10.

Plan of Correction ***Accept (CR - 01/04/2023)***

Administrator placed emergency telephone numbers in resident's room during inspection on 12/7/22. On 12/30/22, administrator completed an audit of the entire home to ensure emergency telephone numbers are posted on or by each telephone with an outside line (see attached checkoff/audit list). On 12/30/22, administrator informed the residents in the home of the requirement to have emergency telephone numbers posted on or by each telephone with an outside line (see attached resident file audit). On 12/29/22, administrator provided training to all staff in

91 - Telephone Numbers (continued)

the home on the requirement of 2600.91 (see attached). Staff will notify the administrator of a phone is observed to be missing the emergency numbers. Beginning 12/30/22, administrator will complete weekly audits to ensure emergency numbers are posted on or by each telephone with an outside line, numbers will be posted immediately if found to be missing (see attached).

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 12/7/2022, the knob for the hot water at the middle sink in the Main B Bathroom was not properly attached to the fixture; the knob was observed to fall off when the Licensing Representative attempted to turn the hot water on.

Plan of Correction ***Accept (CR - 01/04/2023)***

Maintenance replaced the faucet on 12/12/22 (see attached). On 12/30/22 administrator and maintenance will check weekly to ensure furniture and equipment is in good repair (see attached checkoff list). Results of the weekly checks will be discussed at the home's quality management meetings to ensure a plan for repair is in place at the next meeting on 4/1/23.

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

183c - Refrigerated Meds Locked

9. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 12/7/2022 at approximately 10:05 AM, Novolog 100 U/M ML prescribed for Resident #1, was unlocked and accessible in the refrigerator behind the nurse's station, in the 1st floor common room.

Plan of Correction ***Accept (CR - 01/04/2023)***

Inspector locked refrigerator on 12/7/22. Beginning, 12/30/22, administrator and lead aides will check on each shift to ensure refrigerator containing medications is locked (see attached checkoff list). On 12/29/22, administrator provided training to staff on the requirement for prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area that is locked (see attached).

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

183e - Storing Medications

10. 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 12/7/2022 at approximately 4:15 PM, a tan/white half tablet was observed to be loose in the PC medication cart.

Plan of Correction ***Accept (CR - 01/04/2023)***

Lead Aid disposed of med on 12/7/22. On 12/30/22, all medication carts in the home were audited to ensure there were no loose pills by the administrator. Beginning 12/30/22, lead aids will complete weekly med checks to ensure there are no loose pills in the medication cart and loose medications will be properly disposed of (see attached).
Beginning 12/30/22, administrator will complete monthly medication cart audits (see attached).
Administrator and lead aids will check monthly during med cart audit to ensure meds are stored properly (see attached checkoff list).

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

191 - Resident Right to Refuse

11. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Directed (CR - 01/04/2023)***

Resident #2 was provided with an education by the administrator on the right to question or refuse a medication if the resident believes there may be a medication error (see attached). On 1/2/23, administrator and lead aid completed an audit for all resident records to ensure they contained documentation of the resident's education (see attached).

(Directed)

- *Resident #2 was provided with an education by the administrator on the right to question or refuse a medication if the resident believes there may be a medication error (see attached).Resident #2 signed attached Resident Rights on 12/12/22.*
- *Beginning on 1/16/2023, the Administrator will complete an admission checklist to ensure resident education is provided during the admission process*

Directed Completion Date: *01/16/2023*

Implemented (CR - 01/06/2023)

225a - Assessment 15 Days

12. Requirements

225a - Assessment 15 Days *(continued)*

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

Description of Violation

Resident #1 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted].

Resident #3 was admitted on 1[redacted] however, the resident's assessment was not completed until [redacted]

Plan of Correction ***Accept (CR - 01/04/2023)***

On 12/29/22, administrator was provided training with the lead aids on the requirement for residents to have an assessment completed within 15 days of admission. Beginning 1/1/23, administrator and lead aids will use a new admission checklist to be completed within 14 days of admission to ensure assessments are completed timely (see attachments).

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)

231e - No Objection Statement

13. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept (CR - 01/06/2023)***

Administrator went over the No Objection Statement with resident on [redacted] see attached). On 12/29/22, administrator was provided with a retraining with the lead aids on the requirement for a No-objection Statement for new admissions/transfers to the SDU. On 12/30/22, administrator audited all remaining resident records who were admitted to the SDU to ensure the records contain a no-objection statement. Beginning on 12/30/22, administrator will complete a resident file checkoff list during admission to the SDU to ensure compliance (see attachments).

Licensee's Proposed Overall Completion Date: *01/04/2023*

Implemented (CR - 01/06/2023)