pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: SEPTEMBER 26, 2023

[redacted]
Hampden Operations LLC
[redacted]

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

Dear [redacted]

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

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (333810) dated June 8, 2023 to June 8, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible

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

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

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

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

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

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

Administrator

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

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *111* **Waking Staff**: *83*

Inspection Information

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

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

Inspection Dates and Department Representative

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

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

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

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

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

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

Inspections / Reviews

03/08/2023 - Full

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

03/30/2023 - POC Submission

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

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

04/11/2023 - POC Submission

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

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

08/25/2023 - Document Submission

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

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

51 - Criminal Background Check

1. Requirements

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

Description of Violation

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

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

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

Directed Plan:

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

Directed Completion Date: *05/01/2023*

Implemented [redacted] 04/18/2023)

63a - First Aid/CPR Training

3. Requirements

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

Description of Violation

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

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

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

63a - First Aid/CPR Training (continued)

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

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

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

65d - Initial Direct Care Training

4. Requirements

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

Description of Violation

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

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

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

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

Implemented [redacted] - 04/18/2023)

81b - Resident Personal Equipment

5. Requirements

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

Description of Violation

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

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

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

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

Implemented [redacted] - 04/24/2023)

85d - Trash Receptacles

6. Requirements

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

Description of Violation

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

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

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

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

Implemented [redacted] 04/18/2023)

88a - Surfaces

7. Requirements

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

Description of Violation

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

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

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

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

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

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

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

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

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

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

Implemented [redacted] - 04/24/2023)

109b - Rabies Vaccination

9. Requirements

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

Description of Violation

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

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

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

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

Implemented (- 04/18/2023)

[redacted]

WITHDRAWN - NSC, 9/22/23

[redacted]

183b - Meds and Syringes Locked

11. Requirements

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

Description of Violation

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

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

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

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

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

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

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

183e - Storing Medications

12. Requirements

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

Description of Violation

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

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

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

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

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

Implemented [redacted] - 04/18/2023)

185a - Implement Storage Procedures

13. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

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

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

185a - Implement Storage Procedures (continued)

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

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

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

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

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

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

Implemented - 07/26/2023)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

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

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

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

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

Not Implemented (- 07/26/2023)

224a - Preadmission Screen Form

15. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

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

Description of Violation

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

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

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

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

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

Implemented [redacted] - 07/26/2023)

227c - Support Plan Revision

16. Requirements

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

Description of Violation

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

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

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

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

Implemented [redacted] - 04/18/2023)

251c - Standardized Forms

17. Requirements

251c - Standardized Forms *(continued)*

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

Description of Violation

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

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

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

Directed Plan:

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

Directed Completion Date: *04/20/2023*

Implemented [redacted] 04/18/2023)