



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **FOX CHAPEL OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT HARTS RUN**
NAME OF FACILITY OR AGENCY

Located at **3450 HARTS RUN ROAD, GLENSHAW, PA 15116**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **114**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 15, 2024** until **August 15, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **453223**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: FEBRUARY 15, 2024

[REDACTED]
Fox Chapel Operations LLC
[REDACTED]
[REDACTED]

RE: Harmony at Harts Run
3450 Harts Run Road
Glenshaw, Pennsylvania 15116
License/COC #: 453223

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 11, 2023, September 27, 2023, September 28, 2023, and December 19, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD 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); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from February 15, 2024 to August 15, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
231(b)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
231(c)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
234(a)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
103(g)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
187(d)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
141(a)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
185(a)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
224(a)	II	85	\$5	\$425	5 calendar days from mailing date of this letter
225(a)	II	85	\$5	\$425	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED], Workload Manager
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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *01/24/2024*
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *08/23/2021* Issued By: *Township of Indiana*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *101* Waking Staff: *76*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Fine* Exit Conference Date: *08/11/2023*

Inspection Dates and Department Representative

08/11/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* Residents Served: *75*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDU* Capacity: *40* Residents Served: *18*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *74*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *26* Have Physical Disability: *2*

Inspections / Reviews

08/11/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/08/2023*

Inspections / Reviews *(continued)*

09/12/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/18/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/19/2023

09/25/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/18/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/02/2023

01/22/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/18/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

231b - Medical Evaluation

1. 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 #1's medical evaluation dated [REDACTED] does not indicate the need for a secured care dementia unit.

Resident #2 was admitted to the Secure Dementia Care Unit on [REDACTED] However, the resident's medical evaluation was completed on [REDACTED]

Resident #3 was admitted to the Secure Dementia Care Unit on [REDACTED] However, the resident does not have a diagnosis of dementia. Also, the medical evaluation was completed on [REDACTED]

Repeat Violation: 11/29/22 et al

Plan of Correction

Directed ([REDACTED] - 09/25/2023)

The facility will perform an audit of all resident files to ensure that a medical evaluation was completed and on file within 60 days prior to move in, by 9/19/23. Resident #1's clinical chart has been reviewed and is corrected. Resident #1 received an order for the need for a secured unit as of 8/11/12.

[REDACTED] -[See below directed] [REDACTED] 9/25/23

A "Required Forms for New Admission Checklist" has been created to include the requirement of the medical evaluation, including the need of an order for a secured unit (when admitting to Harmony Square), and a diagnosis of dementia (when admitting to Harmony Square). The new Healthcare Director and Harmony Square Director will be educated upon hire, on the required medical evaluation including a diagnosis of dementia and order for a secured unit, documented on a form provided by the department is to be completed within 60 days prior to admission. The Healthcare Director, Harmony Square Director or designee will perform an audit of prospective resident’s new admission paperwork to ensure the compliance of a medical evaluation including a diagnosis of dementia and order for secured unit, prior to admission. The Executive Director or designee will audit the resident files monthly to ensure ongoing compliance.

DIRECTED: Resident #3 diagnosed with dementia as per the resident's CRNP in office visit dated [REDACTED] Within 30 days of receipt of plan of correction - The administrator will ensure the dementia diagnosis is added to the DME by the CRNP or a new DME is obtained that includes this diagnosis. - [REDACTED] 9/25/23

Not Implemented ([REDACTED] - 01/24/2024)

231c - Preadmission Screening

2. Requirements

231c - Preadmission Screening (continued)

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 on [REDACTED]. However, the resident's preadmission screening including the cognitive screening, was completed [REDACTED].

Repeat Violation: 11/29/22 et al.; 1/23/23 et al.

Plan of Correction

Accept ([REDACTED] - 09/25/2023)

The facility will perform an audit of all files of residents that reside or will reside in the secured dementia care unit to ensure that the files include the preadmission screen that is required to be completed within 72 hours prior to admission, by 9/19/23. A "Required Forms for New Admission Checklist" has been created to include the required cognitive screening 72 prior to admission.

The new Healthcare Director and Harmony Square Director will be educated upon hire, on the requirement for a preadmission screening 72 hours prior to admission. The new Healthcare Director will be educated upon hire to ensure that all residents files include the required preadmission screening are to be completed per state guidelines within 72 hours prior to admission.

The Executive Director or designee will perform an audit of prospective residents, and resident admitted in 2023 to ensure completion of the preadmission screening, prior to admission. DIRECTED: This audit will be completed with 30 days of receipt of the plan of correction. - [REDACTED] 9/25/23

The Healthcare Director or Executive Director will audit resident files monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/20/2023

Not Implemented ([REDACTED] - 01/24/2024)

234a - Admission Support Plan

3. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the Secured Dementia Care Unit on [REDACTED]. However, the support plan was completed on [REDACTED].

Repeat Violation: 11/29/22 et al

Plan of Correction

Accept ([REDACTED] - 09/25/2023)

The facility will perform an audit of all files of residents that reside or will reside in the secured dementia care unit

234a - Admission Support Plan (continued)

to ensure that the files include the support plan that is required to be completed within 72 hours before or 72 hours after admission, by 9/19/23. A "Required Forms for New Admission Checklist" has been created to include a resident support plan completed 2 hours before – 72 hours after admission. The new Healthcare Director will be educated upon hire to ensure that all residents support plans are completed per state guidelines within 2 hours prior to admission or 72 hours after admission. The Executive Director or designee will perform an audit of newly moved in residents to ensure compliance of completing the support plan within 30 days of move admission. The Healthcare Director or Executive Director will audit resident files monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/20/2023

Not Implemented (█ - 01/22/2024)

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

Facility Information

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *01/24/2024*
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *08/23/2021* Issued By: *Township of Indiana*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *108* Waking Staff: *81*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Provisional, Incident* Exit Conference Date: *10/10/2023*

Inspection Dates and Department Representative

09/27/2023 - On-Site: [REDACTED]
09/28/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* Residents Served: *76*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *40* Residents Served: *19*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *75*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *32* Have Physical Disability: *2*

Inspections / Reviews

09/27/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/26/2023*

11/02/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/17/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 11/09/2023

11/15/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/17/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 11/22/2023

01/22/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/17/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

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 9/9/2023, staff person A, a medication technician, notified staff person B, that there was a missing tablet of resident #1's Hydrocodone 5-325 mg. The home did not report this incident to the Department until 9/11/2023 at 12:44 pm.

Plan of Correction

Accept (█ - 11/02/2023)

- On 09/09/2023, the ED was made aware of being unable to locate resident #1's Hydrocodone 5-325mg tablet. The ED began investigation by coming to the building and searching the medication cart, verifying medication order and reviewing medication delivery forms. Since this occurred on a weekend day, and the ED was unable to determine if the medication was actually missing or if the correct amount was not delivered, this was not reported until 09/11/2023 after confirmation with the pharmacy of the amount delivered.
- Beginning 08/24/2023, after being re-educated by the surveyor, the ED will ensure that any missing medications will be reported within 24 hours of notification, per DHS regulation 2600 16c.
- On 08/24/2023, the BOM was educated by the ED to check the reportable incident binder every week to ensure all reportable incidents were reported within the required timeframe. (Attachment A)

Licensee's Proposed Overall Completion Date: 12/28/2023

Implemented (█ - 01/24/2024)

19 - Review Waiver

2. Requirements

2600.

19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

The home was granted waivers for the educational requirements for the staff persons C, D, E, F, G, H, I, J. However, the waiver requests and the Department's written decisions are not posted in a conspicuous and public place within the home.

Plan of Correction

Accept (█ - 11/02/2023)

- On 08/23/2024, the ED immediately posted the waivers on the public bulletin board in the home after being informed by the surveyor of the DHS requirement for this. (Attachment B)
- The BOM and the ED were educated by the surveyor on this requirement on 08/23/2023.
- On 08/25/2023, all employee files were audited for waivers by the BOM to ensure all waivers were present. (Attachment C)
- Beginning 08/26/2023, the ED will audit all new employee files upon hire to ensure waivers are posted if one is present.

Licensee's Proposed Overall Completion Date: 12/28/2023

Implemented (█ - 01/24/2024)

54a - Direct Care Staff

3. 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 person K has a non-US high school diploma. The home does not have a waiver indicating the diploma meets the educational requirements of a US high school diploma, GED or active status on the nurse aide registry or that the requirement was waived.

Plan of Correction

Accept () - 11/15/2023

- On 08/24/2023, BOM and ED were informed that Direct Care Staff person K did not have a waiver in their file for a non-US high school diploma.
- On 8/25/23, The BOM was educated by the ED on the waiver requirement for diplomas outside of the US. (Attachment D)
- On 10/19/2023, the BOM submitted for a waiver. (Attachment E)
- Beginning 08/26/2023, the BOM will apply for waivers for all non-US diploma's prior to hiring.
- Beginning 08/26/2023, the ED will audit all new employee files upon hire to ensure waivers are in place and posted
- * On 11/2/2023, this employee was removed from the nursing schedule per the direction of DHS.
- *On 11/9/2023, the waiver was received for this employee and () will be put back on the schedule effective today.

Licensee's Proposed Overall Completion Date: 12/30/2023

Implemented () - 01/24/2024

65i - Training Record

4. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The training records for staff persons A, G, K, L and M do not include the location and use of fire extinguishers, in accordance with 2600.65(a)(5).

Plan of Correction

Accept () - 11/02/2023

- On 10/23/23, our New employee orientation forms were edited to include fire extinguisher training. (attachment F)
- On 10/31/23 at our all staff meeting, staff will be trained on the use of fire extinguishers. Sign in sheet will be added to this POC once completed.
- Effective 10/24/23, our next new employee orientation, the ED will review all orientation check lists upon hire to ensure all staff are trained on fire extinguishers and its signed off on the check list.

Licensee's Proposed Overall Completion Date: 12/28/2023

Implemented () - 01/24/2024

85a - Sanitary Conditions

5. Requirements

85a - Sanitary Conditions (continued)

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/27/2023 at 11:05 am, there were approximately thirty cigarette butts, a plastic bag, and paper wrappers in the dirt of a green flower pot in the receiving area for the home's kitchen and six cigarette butts laying on the ground surrounding the flower pot.

Plan of Correction

Accept () - 11/02/2023)

- At all staff meeting on 10/31/23, staff will be re-educated on Harmony's policy of no smoking on premises and also on no littering. (staff sign in sheet will be attached to this POC once completed).
- Effective 9/28/23, daily checks by the Dining Service Director, of the area outside the back kitchen door will be completed to ensure no trash or cigarette butts are present and documented on a daily audit tool. (Attachment G)
- Effective 9/28/23, the MD will check all outside areas for trash and cigarette butts during their daily rounds.
- Effective 9/28/23, all managers will check outside areas for trash and cigarette butts when working their manager-on-duty weekend.

Licensee's Proposed Overall Completion Date:

Implemented () - 01/24/2024)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 9/27/2023 at 11:40 am, resident #2 did not have a source of lighting that can be turned on/off at bedside.

Plan of Correction

Accept () - 11/02/2023)

- On 8/24/23, Maintenance Assistant immediately put an operable lamp at the resident's bedside. (Attachment H)
- On 10/31/23, All staff were educated on the requirement for all residents to have an operable light source at bedside. (staff sign in sheet will be attached to this POC once completed)
- On 8/24/23, the Maintenance Assist and Maintenance Director audited all resident apartments for compliance to this regulation. (Attachment I)
- Beginning 9/1/23, each manager will use the manager-on-duty checklist to check specific rooms each weekend day. This will enable all rooms to be checked each month. (Attachment J)

Licensee's Proposed Overall Completion Date: 12/28/2023

Implemented () - 01/24/2024)

103g - Storing Food

7. Requirements

2600.

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

103g - Storing Food (continued)

Description of Violation

On 9/27/2023 at 10:55 am, the bag inside of a 10 pound box of frozen peas was opened and unsealed in the commercial freezer in the kitchen.

Repeat Violation 1/23/2023 et al

Plan of Correction

Accept () - 11/15/2023

- On 9/27/23, Violation 2600.103.g. was corrected at time of visit. Bag of peas were thrown away.
- On 9/27/23, the ED in-serviced the Dining Service Director (DSD) and dining staff on the requirements stated within 2600.103.g (Attachment K)
- Beginning 9/28/23, the DSD and or designee will audit refrigerators and freezers in the kitchen weekly to ensure left over food is stored in closed sealed containers (Attachment L)

Licensee's Proposed Overall Completion Date: 12/31/2023

Not Implemented () - 01/24/2024

131f - Fire Extinguisher Inspection

8. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 9/27/2023 at approximately 11:30 am, the fire extinguisher to the left of resident room #130 in the SDCU did not have a tag with the date of inspection.

Plan of Correction

Accept () - 11/02/2023

- On 9/27/23, Violation 2600.131.f., the Maintenance Director called our Fire Inspection Company, () . They mailed extra tags to the Maintenance Director and they arrived on 10/2/23.
- On 9/27/23, the MD checked all extinguishers to ensure a tag was present. In the Memory Care unit, he moved all tags to the back of the extinguisher so the residents don't remove them anymore. (attachment M)
- Beginning 10/2/23, for the duration of 90 days, the MD and/or designee will audit all fire extinguishers weekly. (attachment N)

Licensee's Proposed Overall Completion Date: 01/02/2024

Implemented () - 01/24/2024

183e - Storing Medications

9. 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 9/28/2023, resident #3's Brimontidine-Timolol 0.2-0.5% eye drops were dated as opened on 7/1/2023. According

183e - Storing Medications (continued)

to the manufacturer's instructions, these eye drops should be discarded 4 weeks after opening the bottle.

Plan of Correction

Accept (█) - 11/02/2023)

- On 9/27/23, the Medication Aide discarded the expired eye drops and ordered a new bottle from the pharmacy.
- On 9/28/23, the ED educated all medication aides on the requirements stated within 2600-183e (Attachment O)
- Beginning 10/2/23, for the duration of 90 days, the MT and /or designee will audit all medication carts weekly for expired medications. (Attachment P)

Licensee's Proposed Overall Completion Date: 01/02/2024

Implemented (█) - 01/24/2024)

184a - Resident's Meds Labeled**10. Requirements**

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

There was no pharmacy label with resident #4's insulin pens as follows:

-Levemir Flexpen 100u/ml, 3ml prefilled syringe - inject 25 units 2 times a day.

-Humalog Kwik Pen 100u/ml, 3 ml prefilled syringe - inject 12 units with breakfast.

-Humalog Kwik Pen 100u/ml, 3 ml prefilled syringe - inject 16 units with lunch.

-Humalog Kwik Pen 100u/ml, 3 ml prefilled syringe - inject 16 units with dinner.

Plan of Correction

Accept (█) - 11/15/2023)

- On 9/27/23, the medication aide called the pharmacy and notified them of the need for the medications to be delivered asap with a prescription label on the medication.
- On 9/28/23, the ED in-serviced the Medication aides on the requirements stated within 2600.184.a (Attachment Q)
- On 9/28/23, the medication aides audited all medication carts to ensure labels were present for all medications. (Attachment P)
- Beginning 10/2/23, for the next 90 days, the medication carts will be audited by the medication aides, the Healthcare Director or designee every week to ensure all medications have labels. (Attachment S) Med cart audits will then be done monthly thereafter.

Proposed Overall Completion Date: 02/29/2024

Licensee's Proposed Overall Completion Date: 02/29/2024

185b - Medication Procedures

11. Requirements

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

On 9/7/2023 and 9/8/2023, the home received a medication delivery from the pharmacy to include 90 pills of Hydrocodone-Acetaminophen 5/325 for resident #1, that consisted of 3 cards of 30 pills each. The medication technicians receiving the medication at the home did not count the number of tablets delivered from the pharmacy. The next day, there were only 30 pills remaining - 2 cards of 30 pills each were missing.

Plan of Correction**Accept (█ - 11/15/2023)**

- *On 9/7/23, when medication was reported missing, the ED notified the pharmacy and asked them to send 5 Tablets, which they did and they arrived at 12:15am on 9/8/23.*
- *On 9/11/23, the ED educated all medication aides to verify with pharmacy delivery personnel the number of narcotics delivered and to initial and sign the forms provided only once they are verified.*
- *On 9/11/23, the medication aides verified all narcotics were present in the building that are ordered for residents. (Attachment T)*
- *Beginning 10/2/23, for 90 days, the Healthcare Director and/or designee will check narcotics weekly to ensure all medications are present as ordered. Med cart audits will be done monthly thereafter.*

Licensee's Proposed Overall Completion Date: 02/29/2024

187d - Follow Prescriber's Orders**12. Requirements**

2600.

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

Description of Violation

On 9/27/2023, at approximately 8:00 pm, resident #1 requested a Hydrocodone-Acetaminophen 5-325. However, the medication was not administered because it was not available in the home.

Repeat Violation 4/13/2023 et al, 1/23/2023 et al, 11/29/2022 et al

Plan of Correction**Directed (█ - 11/15/2023)**

- *On 9/7/23, when it was noted that the medication was missing, the pharmacy was notified by the ED and the medication was ordered. It was delivered later that evening. (Attachment U)*
- *On 9/11/23, the ED educated the medication aides that they must notify the HCD or designee if there are ever medications not available.*
- *On 9/11/23, the medication aides audited the medication carts to ensure all medications were available. (Attachment V)*

187d - Follow Prescriber's Orders (continued)

- Beginning 9/18/23, the medication aides, the HCD and/or designee will complete cart audits weekly for 90 days to ensure all medications are present as ordered. Cart audits will be done monthly thereafter.

DIRECTED: Medication audits will be completed at least monthly by the administrator or designee. [REDACTED] 11/15/23

Licensee's Proposed Overall Completion Date: 02/29/2024

227d - Support Plan Medical/Dental

13. 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

The support plan for resident #1, dated [REDACTED] does not address how the home will meet the resident's assessed needs for:

- Transferring in/out of bed/chairs
- Ambulating
- Managing health care
- Understanding instructions

Plan of Correction

Accept ([REDACTED] - 11/15/2023)

- On 10/26/23, the support plan for resident #1 was updated to reflect [REDACTED] care needs. (Attachment W)
- Upon start date of new Healthcare Director on 11/6/23, the ED will ensure [REDACTED] is aware of the requirements within this regulation 2600.227d.
- The new HCD will utilize the tracking tool to ensure there is a current support plan in each chart and that it addresses the resident's needs. (Attachment X)
- All resident charts will be audited by 11/30/23 to ensure all current residents have a support plan present. (attachment X to be sent once completed)

Licensee's Proposed Overall Completion Date: 11/30/2023

Not Implemented ([REDACTED] - 01/24/2024)

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

Facility Information

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *01/24/2024*
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *08/23/2021* Issued By: *Township of Indiana*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *117* Waking Staff: *88*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Monitoring* Exit Conference Date: *12/19/2023*

Inspection Dates and Department Representative

12/19/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* Residents Served: *85*

Secured Dementia Care Unit

In Home: *Yes* Area: *First Floor* Capacity: *40* Residents Served: *19*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *84*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *32* Have Physical Disability: *2*

Inspections / Reviews

12/19/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/09/2024*

Inspections / Reviews *(continued)*

01/12/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 01/22/2024
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/18/2024

01/22/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 01/22/2024
Reviewer: [REDACTED] Follow-Up Type: Bypass Document Submission

01/24/2024 - Bypass Document Submission

Submitted By: [REDACTED] Date Submitted: 01/22/2024
Reviewer: [REDACTED] Follow-Up Type: Enforcement

103g - Storing Food

1. Requirements

2600.

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

Description of Violation

The following frozen food items were open and unsealed in the commercial freezer in the kitchen:

- * *Bag of hamburger patties, inside of the box, 1/2 full*
- * *Bag of pasta shells with cheese, inside of the box, 1/2 full*
- * *Bag of rolls, inside of the box, 1/2 full*
- * *Bag of 12" pizza shells inside of the 15 pound box, 1/2 full*

Repeat violation: 1/23/2023 et al

Plan of Correction

Accept (█) - 01/12/2024)

On 12/19/23, violation 2600.103g was corrected at time of visit. Opened hamburger patties, pasta shells, rolls and pizza shells were all discarded.

On 12/27/23 Staff education was provided on DHS regulation 2600.103g. (see attached)

Beginning 12/20/23, and for 4 weeks, The Dining Services Director or designee will audit freezer daily to ensure all food items are closed and sealed properly per regulation and will use daily audit tool to document. (see attached)

Executive Director or designee will check freezer weekly for 4 weeks to ensure all items are sealed properly and will sign off on audit tool.

Licensee's Proposed Overall Completion Date: 02/02/2024

Not Implemented (█) - 02/08/2024)

141a 1-10 Medical Evaluation Information

2. 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

Resident #1's medical evaluation, dated █ indicates "see attached" for the medication list; however, no list is attached and this area of the form is blank.

Resident #2's medical evaluation, dated █/2023, does not include a list of medications. This area of the form is blank.

141a 1-10 Medical Evaluation Information (continued)

Repeat Violation 1/23/23 et al

Plan of Correction

Accept (█ - 01/18/2024)

Resident #1's and #2's medical evaluations were corrected on 1/2/24 to include the medication list. (see attached) The Sales staff and Healthcare director were re-educated on the regulatory requirement of the medication list being attached to the DME on 1/2/24.(see attached)

A complete audit of current DME's will be completed by the Healthcare Director by 1/12/24 to identify any DME's that do not have a medication list attached.

The ED will review all newly completed DME's to ensure they are completed in their entirety, including a medication list.

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented (█ - 01/24/2024)

184a - Resident's Meds Labeled

3. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #3's Novolog Flexpen insulin did not have a complete pharmacy label. The medication did not have the prescribed dosage and instructions for administration, and the name and title of the prescriber.

Resident #4's Lantus insulin pen did not have a pharmacy label. It was marked "#█" - the resident's previous room number.

Resident #5's Fluticasone nasal spray did not have a complete pharmacy label on the device. It was labeled only with the resident's name, and stored in a baggie with a pharmacy label for another nasal spray - Triamcinolone.

Resident #10's Levemir FlexTouch insulin pen did not have a complete pharmacy label. The medication did not have the prescribed dosage and instructions for administration, and the name and title of the prescriber.

Plan of Correction

Accept (█ - 01/18/2024)

On 12/22/23 █ Pharmacy was notified of no labels on individual insulin pens for residents #3, #4 and #10 and also Fluticasone nasal spray for Resident #5. These medications were disposed of and new medications were ordered and arrived on 12/21/23. (see attached)

All medication aides were re-educated on 12/27/23 on regulation 2600.184(a). (see attached).

Effective 12/20/23, The Healthcare Director will complete medication cart audits weekly for 3 months, then

184a - Resident's Meds Labeled (continued)

monthly thereafter to ensure all medications have labels. (see attached)

Licensee's Proposed Overall Completion Date: 12/20/2024

Not Implemented (████) - 01/24/2024)

185a - Implement Storage Procedures

4. 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 #5 is prescribed Clonidine HCL 0.1 mg, take one tablet every 24 hours, as needed for Systolic Blood Pressure greater than 160. This medication was not available in the home.

Resident #6 is prescribed Hydralazine 25 mg, take one tablet 3 times a day, as needed for Systolic Blood Pressure greater than 180. This medication was not available in the home.

Resident #7 is prescribed Nitroglycerin Spray 0.4 mg, one spray into the mouth every 5 minutes as needed for chest pain. This medication was not available in the home.

Repeat violation: 1/23/23 et al

Plan of Correction

Accept (████) - 01/18/2024)

On 12/21/23, ██████████ Pharmacy was notified to send Resident #5's Clonidine, Resident #6's Hydralazine and Resident #7's Nitroglycerin Spray. Medications arrived on 12/22/23.

All medication aides were re-educated on 12/27/23 on regulation 2600.185(a). (see attached).

Effective 1/2/24, The Healthcare Director will complete medication cart audits weekly for 3 months, then monthly thereafter to ensure all medications are in the cart and available to resident. (see attached)

Licensee's Proposed Overall Completion Date: 12/20/2024

Not Implemented (████) - 01/24/2024)

185b - Medication Procedures

5. Requirements

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's procedures for the safe use of medications and medical equipment indicates that staff will count all controlled substances at the change of shift; however, on 11/27/2023 at 3:00 pm, direct care staff person A did not

185b - Medication Procedures (continued)

count the controlled substances with the staff who was starting the next shift.

The following count sheets for controlled substances were incorrect:

- * Resident #8 is prescribed Alprazolam, take one tablet by mouth 3 times a day as needed. There were 15 tablets remaining on the medication card; however, the count sheet indicated that there were 13 tablets remaining.
- * Resident #9 is prescribed Hydrocodone/Acetaminophen 5-325 mg, take one tablet every 6 hours as needed for breakthrough pain. There were 25 tablets remaining on the medication card; however, the count sheet indicated that there were 24 tablets remaining.

The home has implemented medication procedures to ensure that controlled substances are counted with the delivery driver upon receipt from the pharmacy; however, according to direct staff person A, medications are not counted with the driver upon receipt of the medications from the pharmacy.

Plan of Correction

Accept (█) - 01/18/2024

On 12/19/23, the HCD completed a narcotic count and updated the narcotic sheet to reflect the accurate number of medications.

All medication aides were re-educated on 12/27/23 on regulation 2600.185(b). (see attached).

Effective 1/2/24, The Healthcare Director will complete medication cart audits weekly for 3 months, then monthly thereafter to ensure all medications are in the cart and available to resident. (see attached)

Licensee's Proposed Overall Completion Date: 12/20/2024

Not Implemented (█) - 01/24/2024

224a - Preadmission Screen Form

6. 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 #12 was admitted to the home on █ however, a preadmission screening was not completed for this resident.

Repeat violation: 1/23/2023 et al

Plan of Correction

Accept (█) - 01/12/2024

A preadmission screening for Resident #12 was not completed prior to admission but was completed late. (see attached)

The new HCD/designee was educated on 1/2/24 that the preadmission screening is to be completed the same date of the assessment to determine if residents needs can be met at our community. (see attached)

Effective 1/2/24, The ED will review all new move in paperwork PRIOR to resident moving into community to ensure all required documentation is present.

Licensee's Proposed Overall Completion Date: 03/31/2024

225a - Assessment 15 Days

7. 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

A written initial assessment was not completed for the following residents:

- Resident #1, admitted [REDACTED]
- Resident #11, admitted [REDACTED]
- Resident #12, admitted [REDACTED]
- Resident #13, admitted [REDACTED]
- Resident #14, admitted [REDACTED]
- Resident #15, admitted [REDACTED]

Repeat violation: 1/23/2023 et al

Plan of Correction

Accept [REDACTED] - 01/12/2024)

All RASPS had been completed timely but were not printed and put in the resident files. All have been put in their files as of today, 1/2/23.

On 1/8/24, the HCD audited all resident records to ensure each resident has a current and completed assessment in their record.

On 1/2/24, The new HCD/nurse has been educated by the ED that the assessment will be completed in 15 days of move in. Documentation of education will be kept on file. (see attached)

Effective 1/2/24, The ED will audit all new resident admissions to ensure each new resident has a written initial assessment that is documented on the departments assessment form within 15 days of admission.

Licensee's Proposed Overall Completion Date: 03/31/2024

227a - Support Plan 30 Days

8. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Support plans for the following residents have not been completed:

- Resident #1, admitted [REDACTED]
- Resident #13, admitted [REDACTED]
- Resident #14, admitted [REDACTED]
- Resident #15, admitted [REDACTED]

227a - Support Plan 30 Days (continued)

Plan of Correction

Accept () - 01/12/2024

Support Plans have been completed for the residents listed above.(see attached)

On 1/8/24, The HCD has audited all resident records to ensure each resident has a current and completed support plan in their record. (see attached)

On 1/2/24, The new HCD/nurse has been educated by the ED that the support plan will be completed in 15 days of move in. Documentation of education will be kept on file. (see attached)

Effective 1/2/24, The ED will audit all new resident admissions to ensure each new resident has a support plan that is documented on the departments form within 15 days of admission.

Licensee's Proposed Overall Completion Date: 03/31/2024

231b - Medical Evaluation

9. Requirements

2600.

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

Description of Violation

Resident #12 was admitted to the Secure Dementia Care Unit (SDCU) on 1/3/24; however, the resident's medical evaluation does not indicate the resident's need for the SDCU.

Resident #16's medical evaluation, dated 1/2/24 does not indicate the resident's need for the SDCU.

Plan of Correction

Accept () - 01/12/2024

The previous HCD did not review medical evaluations correctly and thoroughly to ensure they are completed in its entirety for the SDCU.

The new HCD has audited all resident files to be completed to ensure all medical evaluations are accurate and reflect the correct level of care for the resident. (see attached)

Effective 1/2/24, The ED will audit all new admissions required paperwork to ensure the correct level of care is selected on the medical evaluation upon move in.

Resident #12 and Resident #16's DME was updated by the physician on 1/2/24.

Licensee's Proposed Overall Completion Date: 03/31/2024

231c - Preadmission Screening

10. 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 #11 was admitted to the SDCU on 1/2/24; however, the preadmission screening form, dated 1/2/24 does not include a written cognitive preadmission screening. Also, the preadmission screening does not indicate the

231c - Preadmission Screening (continued)

home can meet the needs of the resident.

Resident #12 was admitted to the SDCU on [REDACTED]; however, a written cognitive preadmission screening was not completed for this resident.

Resident #16 was admitted to the SDCU on [REDACTED]; however, the preadmission screening form, dated [REDACTED] does not include a written cognitive preadmission screening.

Repeat violation: 1/23/2023 et al

Plan of Correction

Accept ([REDACTED] - 01/12/2024)

Resident #11, #12 and #16 late cognitive screen portion was completed on 1/2/24.

The HCD/designee was educated on the importance of the timing to complete the cognitive screen portion, 72 hours prior to admission/transfer to the Memory Care Neighborhood.

The ED, HCD and or designee will be responsible to monitor any new admissions or current resident transfers to the memory care neighborhood to assure the cognitive screens are completed correctly and timely.

The audit of all current residents on memory care's files will be completed by the HCD to ensure all PAS are completed accurately. (see attached)

Licensee's Proposed Overall Completion Date: 01/12/2024

Not Implemented ([REDACTED] - 01/24/2024)

234a - Admission Support Plan

11. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

A initial support plan was not completed for the following residents:

- Resident #11, admitted to the SDCU on 10/26/2023.
- Resident #12, admitted to the SDCU on 12/4/2023

Plan of Correction

Directed ([REDACTED] - 01/18/2024)

Support Plans have been completed for the residents listed above.(see attached)

The HCD has audited all resident records to ensure each resident has a current and completed support plan in their record. (see attached)

On 12/22/23, The new HCD/nurse has been educated by the ED that the support plan will be completed in 15 days of move in for Personal Care and within 72 hours prior to or after admission to the SDCU. Documentation of education will be kept on file. (see attached)

Effective 1/2/24, The ED will audit all new resident admissions to ensure each new resident has a support plan that

234a - Admission Support Plan (continued)

is documented on the departments form within 15 days of move in for Personal Care and within 72 hours prior to or after admission to the SDCU.

Proposed Overall Completion Date: 12/31/2023

Not Implemented (█ - 01/24/2024)