





CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: MARCH 26, 2024

[REDACTED]  
Hampden Operations LLC  
[REDACTED]

RE: Harmony at West Shore  
[REDACTED]

License #: 333812

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 December 20-21, 2023 and February 22-23, 2024 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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 SECOND PROVISIONAL license is enclosed.

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.


<u>55 Pa. Code Chapter 2600:</u>	<u>Class of Violation</u>	<u>Census at Inspection</u>	<u>Fine Per resident X Per day</u>	<u>Calculated Fine = Per day</u>	<u>Mandated Correction Date (to avoid Fine)</u>
2600.42(b)	II	77	\$5	\$385	5 calendar days from mailing date of this letter
2600.82(c)	II	77	\$5	\$385	5 calendar days from mailing date of this letter
2600.183(e)	II	77	\$5	\$385	5 calendar days from mailing date of this letter
2600.187(d)	II	77	\$5	\$385	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. 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:

  
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.

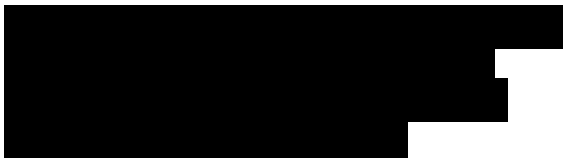
Sincerely,



Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summaries

cc:



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

**Facility Information**

Name: *HARMONY AT WEST SHORE* License #: *33381* License Expiration: *03/26/2024*  
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: *102* Waking Staff: *77*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #: *0*  
Reason: *Complaint, Incident, Interim* Exit Conference Date: *12/21/2023*

**Inspection Dates and Department Representative**

12/20/2023 - On-Site: [REDACTED]  
12/21/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *115* Residents Served: *72*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Harmony Square* Capacity: *35* Residents Served: *22*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *72*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *30* Have Physical Disability: *1*

**Inspections / Reviews**

**12/20/2023 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/18/2024*

01/24/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/09/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 01/30/2024

01/31/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 02/07/2024

03/15/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/09/2024

[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 11/24/23 at approximately 12:15 pm, Staff Member D observed Resident 6 hitting Resident 10 on the side of [redacted] r head. The home did not report this incident to the department until 11/27/23.

Repeated Violation- 7/20/23

Plan of Correction

Accept [redacted] - 01/30/2024)

On 12/20/2023 ED educated the HSD on incident reporting. ED posted online website address to be used for all incident reporting submissions in wellness offices on 12/21/2023. Beginning 1/18/24 the ED will audit all incident reports to ensure reports submitted timely weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented ([redacted] - 02/29/2024)

42b - Abuse

2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident 6 was observed by staff members in multiple altercations with other residents as follows:

On 11/24/23 at approximately 12:15 pm, Staff member D witnessed Resident 6 hit Resident 10 on the side of [redacted] face.

On 12/01/23 at approximately 1:01 pm, Staff member E witnessed Resident 6 grab Resident 7 by [redacted] shirt, telling [redacted] r to "shut up" and smacked [redacted] in the face.

On 12/3/23 at approximately 7:45 am, Staff member F witnessed Resident 6 hit Resident 5 on [redacted] shoulder.

On 12/10/23 at approximately 6:00 pm, Staff member G heard yelling "help me" down the hallway. Upon investigation, Staff member G witnessed Resident 2 yelling that Resident 6 slapped [redacted] in the face and slammed [redacted] against the wall in Resident 2's bedroom. Resident 2 sustained bruising under [redacted] right eye. as a result of the incident.

Repeated Violation-10/17/23 and 7/20/23

Plan of Correction

Accept ([redacted] - 01/30/2024)

On 12/22/2023 ED educated the HSD and staff on abuse. Resident #6 went to the ER and never returned to the community. Beginning 1/30/24 ED will conduct continuing education training monthly x 3 months to staff in monthly staff meetings.

Licensee's Proposed Overall Completion Date: 03/18/2024

Not Implemented ([redacted] - 02/29/2024)

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

On 12/9/23, from 11:00 pm to 7:00 am, 72 residents were present in the home. During this time, no staff persons were present in the home who were certified in first aid and CPR.

Repeated Violation-3/8/23, et al

Plan of Correction

Accept [redacted] - 01/23/2024)

On 12/21/23 the ED educated the HSD and BOM on requirements for first aide and CPR. On 1/17/24 ED/BOM audited all current personnel files to review that first aide and CPR completed. CPR class to be scheduled on 1/24/24for all current employees to attend. Beginning 01/31/2024 BOM will audit all new hires for first aide and CPR monthly x 3 months.

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

Implemented [redacted] - 02/29/2024)

65a - FS Orientation 1st Day

4. Requirements

2600.

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

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

Description of Violation

Staff persons A, B and C whose first day of work was [redacted] and [redacted] did not receive orientation on the following topics:

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

## 65a - FS Orientation 1st Day (continued)

**Plan of Correction**

Accept [REDACTED] - 01/23/2024)

On 12/21/2023 ED educated the BOM on day one training requirements. On 1/15/24 BOM audited all current employee files to ensure everyone has completed day 1 orientation requirements. Beginning 1/22/2024 ED or designated person will audit all new hire files to ensure day 1 orientation requirements are fulfilled weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/14/2024

Implemented [REDACTED] - 02/29/2024)

## 65b - Rights/Abuse 40 Hours

**5. Requirements**

2600.

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

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

**Description of Violation**

Staff person A completed [REDACTED] 40th scheduled work hour. However, this staff person did not complete training in the following topics:

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

**Plan of Correction**

Accept [REDACTED] - 01/23/2024)

On 12/21/2023 ED educated BOM on first 40hrs on the job requirements. On 1/22/2024 BOM will audit all current employee files to ensure all current employees have completed necessary requirements of new hire training. Beginning 1/30/2024 ED or designated person will audit all new hire files to ensure staff have completed new hire training in required time frame weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/14/2024

Implemented [REDACTED] - 02/29/2024)

## 82c - Locking Poisonous Materials

**6. Requirements**

2600.

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

**Description of Violation**

On 12/21/23, a tube of Zinc Oxide Ointment USP, with a manufacture's label indicating "Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center immediately

82c - Locking Poisonous Materials (continued)

" was unlocked, unattended, and accessible to Resident 7. Not all the residents of the home, including Resident 7, have been assessed capable of recognizing and using poisons safely.

Repeated Violation-5/30/23, et al and 4/26/23

Plan of Correction

Accept [redacted] - 01/23/2024)

Resident #7 was not harmed nor suffered any effects from having poisonous materials in their possession. On 12/20/23 HSD immediately removed and locked zinc oxide ointment from Resident 7 possession. On 1/30/24 ED will educated staff on locking poisonous materials for those residents who cannot safely use or avoid poisonous materials. Beginning 1/31/24 ED or designated person will round residents rooms and unit for poisonous materials weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/14/2024

Not Implemented [redacted] - 02/29/2024)

107d - Procedure Emergency Management Agency Submission

7. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed and sent to the local emergency management agency (EMA) since 11/9/22.

Plan of Correction

Accept [redacted] - 01/23/2024)

On 12/26/23 regional ops specialist educated the ED and MD on emergency management submission. On 1/30/24 ED updated and submitted emergency management information to local parties. Beginning 1/31/24 ED or designated person to review/update and submit changes to local appropriate department monthly x 3 months

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented [redacted] - 02/29/2024)

132c - Fire Drill Records

8. Requirements

2600.

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

Description of Violation

The fire drill record for the drill conducted on 9/11/23 does not include evacuation times, number of staff participating, and number of residents evacuated.

Plan of Correction

Accept [redacted] - 01/23/2024)

On 12/21/2024 ED educated MD on fire drill requirements. On 1/22/2024 ED reviewed Oct, Nov and Dec fire drills to ensure requirements were filled out completely for drills. Beginning 1/30/24 MD or designated person will

132c - Fire Drill Records (continued)

audit fire drill forms for accuracy during safety committee meetings month x 3 months.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented ( ) - 02/29/2024)

132d - Evacuation

9. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 08/18/23 at 4:07 pm, there were 87 residents in the home and only 85 residents evacuated. In addition, the home maximum evacuation time as designated by the fire safety expert is 15 minutes and 00 seconds. The home exceeded the maximum evacuation time during this drill.

Plan of Correction

Accept ( ) 01/23/2024)

On 12/21/23 ED educated MD and staff on evacuation requirements. On 1/22/24 ED reviewed Oct, Nov and Dec drills to ensure evacuation requirements were conducted correctly. Beginning 1/30/24 ED will review evacuation times and requirements required under 2600.132.d during safety meetings monthly x 3 months

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented ( ) - 02/29/2024)

141a - Medical Evaluation

10. Requirements

2600.

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

Description of Violation

The initial medical evaluation (DME) for Resident 3 was completed on ( ) 23. However, resident was not admitted to the home until 11/30/23.

Plan of Correction

Accept ( ) - 01/23/2024)

On 12/21/23 ED educated HSD and DSM on medical evaluation requirement dates. On 1/22/2024 ED and designated person audited all current resident DME for accuracy of current dates. Beginning 1/30/24 ED or designated person will review new/and or annual DME for completion dates in requirement guidelines weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented ( ) - 02/29/2024)

183d - Prescription Current

11. Requirements

2600.

183d - Prescription Current (continued)

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/21/23, the following prescribed medications were expired:

Resident 4's PRN Acetaminophen (325mg) expired on 9/27/23.

Resident 8's PRN Ondansetron HCL (4 mg) expired on 9/20/23.

Resident 9's PRN anti-diarrheal expired on 12/4/23.

Plan of Correction

Accept ( ) - 01/30/2024

On 12/20/23 Staff immediately removed and disposed of expired medications for residents 4, 8 and 9 as listed in violation. On 12/21/23 ED educated the HSD and med techs on requirements 2600.183.d. On 12/21/23 HSD completed cart audit to ensure no additional medications expired. Beginning 1/30/24 ED or designated person will conduct med cart audits weekly x 8 weeks to confirm no expired meds are stored in the medication cart.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented ( ) - 02/29/2024

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

On 12/21/23, 3 loose pills were found in the home's medication carts.

Repeated Violation-3/8/23, et al

Plan of Correction

Accept ( ) - 01/30/2024

Immediately on 12/20/23 the 3 loose pills were removed from the medication cart by the HSD. On 12/21/23 ED educated the HSD on the requirements of 2600.183.e On 1/30/24 Med techs educated on checking the medication cart for loose pills at the beginning and end of their med pass. HSD or designated person will conduct weekly medication cart audits starting on 1/22/24 weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/18/2024

Not Implemented ( ) - 02/29/2024

184a - Resident's Meds Labeled

13. Requirements

2600.

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

184a - Resident's Meds Labeled (*continued*)**Description of Violation**

The home had opened Tresiba Flex touch insulin pen 100u/ML for Resident 2. No opening date had been recorded on the medication or packaging to ensure that the insulin was used within 28 days.

**Plan of Correction**

Accept (████) - 01/30/2024)

Immediately on 12/20/23 a new Tresiba Insulin pen for Resident #2 placed in the medication cart by HSD with Resident #2's name and date open sticker with date placed on Tresiba pen. On 12/21/23 ED educated the HSD on requirements of 2600.184.a. On 1/30/24 ED educated the med techs on the having all insulin pens labeled with resident's name and ensuring a date open sticker placed on insulin pen. Weekly medication cart audits to be completed starting 1/22/24 weekly x 8 weeks by HSD or designated person.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented (████) 02/29/2024)

## 185a - Implement Storage Procedures

**14. 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 1 is prescribed blood sugar (BS) testing twice daily. The following discrepancies were observed between the resident's glucometer and medication administration record (MAR):

12/7/23 BS number in glucometer was 87, transcribed in MAR as 84.

12/8/23 BS number in glucometer was 94, transcribed in MAR as 93.

**Plan of Correction**

Accept (████) - 01/30/2024)

Immediately on 12/20/2024 the ED educated HSD on glucometers needing to match the MAR. On 1/30/2024 ED educated the med techs on transcribing the number on the glucometer to the electronic medical record immediately after checking blood sugar. ED or designated person to audit EMAR system to check that blood sugars are inputted correctly starting on 1/22/24 weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented (████) - 02/29/2024)

## 187b - Date/Time of Medication Admin.

**15. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

**Description of Violation**

Resident 4 is prescribed Zolpidem Tartrate 10 mg PRN. The resident was administered the medication on 1/19/23 and 12/20/23. However, the date, time, and staff member's initials were not recorded in the home's control substance log.

**Plan of Correction**

Accept (████) - 01/30/2024)

Immediately on 12/21/23 the controlled substance count sheet corrected with the missing signatures by HSD. On

187b - Date/Time of Medication Admin. (continued)

12/21/23 the ED educated the HSD on the requirements of 2600.187.b. On 1/30/24 the ED educated the med techs on ensuring they are immediately signing out the controlled substance on the narcotic count sheet by writing the date, time controlled substance given. HSD or designated person will audit narcotic count sheets starting on 1/22/24 weekly x 8 weeks.

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented [redacted] - 02/29/2024)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident 5 is prescribed Breo Elipta (100-25 mg) 1 puff daily. However, this medication was not administered on 12/5, 12/6 and 12/19/23 because the medication was not available in the home.

Resident 3 is prescribed Bupropion HCL (150mg) daily and Colestipol HCL (1gm) twice a day. However, these medications were not administered from 12/8 to 12/12/23 and from 12/16 to 12/19/23 because the medication was not available in the home.

Repeated Violation-3/8/23, et al

Plan of Correction

Accepted [redacted] - 01/30/2024)

Immediately on 12/20/24 the HSD called the pharmacy to have Breo Elipta inhaler be delivered for Resident #5. Immediately on 12/20/2024 HSD called the pharmacy to have Colestipol HCL delivered for Resident #3. ED educated HSD on importance of following prescribers orders on 12/20/2024. ED or designated person will audit MAR / medication cart to ensure prescribed meds are in the medication cart and available starting on 1/22/24 weekly x 8 weeks

Licensee's Proposed Overall Completion Date: 03/18/2024

Not Implemented [redacted] - 02/29/2024)

17. Requirements

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

Description of Violation

Resident 1 is prescribed Lantus Solostar (100mg/ml) 40 units every morning and 10 units in the evening. Insulin is to be held both times if the blood sugar (BS) is < 100.

On the following days at 8 am, the medication was administered to Resident 1 with blood sugar levels that were < 100:  
12/7/23- BS level of 87  
12/8/23- BS level of 93  
12/9/23- BS level of 60

Repeated Violation-3/8/23, et al

Plan of Correction

Directed [redacted] 01/30/2024)

On 12/20/23 ED educated the HSD on importance of ensuring the orders for administering insulin are followed on

187d - Follow Prescriber's Orders (continued)

the MAR. On 1/31/2024 ED educated the med techs on following the orders in the MAR for when to hold insulin and when to administer insulin as per the MD order. ED or designated person to audit the MAR of diabetics weekly to ensure that orders are being followed as per MD prescribed orders weekly x 8 weeks.

Proposed Overall Completion Date: 03/18/2024

[Directed]

- Starting 2/5/24, ED or designated person to audit the MAR of diabetics weekly to ensure that orders are being followed as per MD prescribed orders weekly x 8 weeks.

Directed Completion Date: 03/18/2024

Not Implemented (████ - 02/29/2024)

225c - Additional Assessment

18. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- Annually.

Description of Violation

Resident 1's current assessment was completed on █████ 23. However, the resident's previous assessment was completed on 6/30/22.

Plan of Correction

Accept (████ - 01/23/2024)

On 12/21/23 ED educated HSD on requirements of required annual assessment. On 1/15/24 ED and HSD audited all RASP's to ensure dates were in compliance. Beginning 1/30/24 ED or designated person will audit 5 resident charts weekly to ensure new resident RASP's are complete and or current due RASPS updated monthly x 3 months

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented (████ - 02/29/2024)

227d - Support Plan Medical/Dental

19. 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

Resident 1 has a chest tube that requires drainage 2-3 times a week. However, the resident's current support plan, dated 8/5/23, does not document this medical condition or how the need will be met.

Plan of Correction

Accept (████ - 01/23/2024)

On 12/20/23 ED immediately updated resident #1 support plan to include changes to care needs. On 12/21/23 Ed educated HSD on support plan updating. Beginning 01/30/24 HSD or designated person to audit 5 RASP's weekly x 8 weeks to ensure RASP's are current with residents needs and care requirements.

227d - Support Plan Medical/Dental (continued)

Licensee's Proposed Overall Completion Date: 03/18/2024

Not Implemented [REDACTED] - 02/29/2024)

231f - Assessed Annually

20. Requirements

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident 2 resides in the Secured Dementia Care Unit (SDCU) of the home. The resident's assessment, dated [REDACTED]/23, does not address the need for this level of care.

Plan of Correction

Accept [REDACTED] - 01/23/2024)

On 12/21/23 ED educated HSD on requirements for annual assessment of secured dementia care box checked on DME. On 1/15/24 ED and HSD audited all current residents on secured Dementia unit DME to ensure annual assessments had been completed and residents required secured dementia care unit box checked. Beginning 1/30/24 HSD or designated person will review 5 resident DME's for accuracy monthly x 3 months

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented [REDACTED] - 02/29/2024)

254a - Records Discharge/Active

21. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 12/20/23, the privacy coding sheet from the 7/20/23 inspection, which contained resident names, was posted with the license inspection summary (LIS) in the home.

Repeated Violation-5/30/23, et al and 4/26/23

Plan of Correction

Accept [REDACTED] - 01/30/2024)

On 12/20/23 ED immediately removed privacy coding sheet from location. On 12/26/24 regional ops specialist educated ED on requirements of privacy of current and discharged residents information to remain in confidential manner ongoing. ED or designated person will do weekly walk throughs of community to ensure on-going compliance starting 1/22/24 weekly x 8 weeks

Licensee's Proposed Overall Completion Date: 03/18/2024

Implemented [REDACTED] - 02/29/2024)

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

**Facility Information**

Name: *HARMONY AT WEST SHORE* License #: *33381* License Expiration: *03/26/2024*  
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]

**Certificate(s) of Occupancy**

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

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *123* Waking Staff: *92*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #: *0*  
Reason: *Complaint, Incident, Interim* Exit Conference Date: *02/23/2024*

**Inspection Dates and Department Representative**

02/22/2024 - On-Site: [REDACTED]  
02/23/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *115* Residents Served: *77*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Harmony Square* Capacity: *35* Residents Served: *23*

**Hospice**

Current Residents: *6*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *77*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *46* Have Physical Disability: *1*

**Inspections / Reviews**

**02/22/2024 - Partial**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/14/2024*

03/15/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/14/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

## 28a - Refunds

## 1. Requirements

2600.

28.a. If, after the home gives notice of discharge or transfer in accordance with § 2600.228(b) (relating to notification of termination), and the resident moves out of the home before the 30 days are over, the home shall give the resident a refund equal to the previously paid charges for rent and personal care services for the remainder of the 30-day time period. The refund shall be issued within 30-days of discharge or transfer. The resident's personal needs allowance shall be refunded within 2 business days of discharge or transfer.

## Description of Violation

On 9/30/23, Resident 8 issued a 30-day discharge notice to the home. On [REDACTED]/23, the resident moved out of the home, removing all personal belongings. However, the resident's rent was automatically deducted from [REDACTED] bank account on 11/6/23. A refund was not issued to the resident until 12/22/23.

## Plan of Correction

Accept [REDACTED] - 03/15/2024)

On 2/26/24 the Operations Specialist (OPS) educated the Executive Director (ED) on the requirements of 2600.28a. On 3/4/24 the ED or designated person audited all discharged resident ledgers from 11/1/23 to current to ensure all refunds were issues in a timely manner.

Beginning 3/18/24 the business office manager (BOM) will run a discharge roster report weekly x 8 weeks then monthly ongoing to confirm refunds issued withing 30 days of discharge.

Proposed Overall Completion Date: 04/13/2024

Licensee's Proposed Overall Completion Date: 04/13/2024

## 42b - Abuse

## 2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

## Description of Violation

On 12/22/23 at approximately 7:00 pm, a physical altercation occurred between Resident 1 and Resident 2 in Resident 1's apartment. Both Residents were transported to the emergency room. Resident 1 sustained multiple injuries from the incident to include bite wounds on [REDACTED] left forearm, lacerations to [REDACTED] right hand, bruising and abrasions to [REDACTED] face.

On 1/9/24 at approximately 1:30 pm, a physical altercation occurred between Resident 3 and Resident 4 which resulted in injuries to both residents. Resident 3 sustained bruising to right index finger and bleeding underneath the nailbed of left pinky finger. Resident 4 sustained left lower and upper lip swelling and bruising to the left ear.

Repeated Violation - 10/17/23 and 7/20/23

## Plan of Correction

Directed [REDACTED] - 03/15/2024)

On 12/23/23 the ED reported to DHS the incident and to Adult Services in a timely manner. On 2/26/24 Operations Specialist educated the ED and nursing staff on the requirements of 2600.42b. Beginning 3/18/24 the staff will receive in services 2x month for 2 months then monthly ongoing on ways to identify abuse and how to handle behaviors and or altercations between residents.

Proposed Overall Completion Date: 04/13/2024

42b - Abuse (continued)

(Directed)

- The administrator will complete new assessments and support plans (RASPs) for Residents 1, 2, 3 and 4 by 4/10/2024. The RASPs will include a focus on identified behavioral concerns and the use of positive interventions to prevent aggressive behavior. The administrator will train all staff on the updated RASPs by 4/15/2024.
- The administrator will review progress notes and incident reports daily beginning 4/10/2024 to identify concerns regarding aggressive residents and update RASPs appropriately. The administrator's findings will be reviewed during each quality management meeting.

Directed Completion Date: 04/15/2024

82c - Locking Poisonous Materials

3. Requirements

2600.

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

Description of Violation

On 2/22/24, an Ultra Max deodorant and an Old Spice after shave, with a manufacture's label indicating "get medical help or contact poison control center right away", was unlocked, unattended, and accessible to residents in the bathroom located in the common area next to the nurses' office in the Secure Dementia Care Unit (SDCU). These residents have been assessed as incapable of recognizing and using poisons safely.

On 2/22/24, a housekeeping cart containing poisonous material was unlocked, unattended and accessible near apartment H130 in the SDCU. These residents have been assessed as incapable of recognizing and using poisons safely.

Repeated Violation - 5/30/23, et al and 4/26/23

Plan of Correction

Directed [REDACTED] - 03/15/2024)

No residents suffered any adverse effects of the unlocked poisonous materials as described in the violation listed above.

On 2/22/24 the OPS removed and threw out the unlocked items in the common area bathroom at time of visit. On 2/22/24 the ED educated staff on requirements of 2600.82c. Beginning 2/23/24 for a duration of 14 days then ongoing the HSD and or designated person will spot check the common bathroom and housekeeping carts to ensure no poisonous materials are unsecured.

Proposed Overall Completion Date: 04/13/2024

(Directed)

- Beginning 4/10/23, the administrator or a designated staff person will conduct a twice daily walkthrough of all areas of the building to identify unlocked poisonous materials and secure them as appropriate. The walkthrough will be documented on a form developed by the administrator and available for review by the Department.

82c - Locking Poisonous Materials (continued)

- The training that was conducted on 2/22/24 for all staff will be documented and include staff signatures. This documentation will also be available for review by the Department. Quarterly in-service training will be provided and documented by the administrator beginning 4/15/2024.

Directed Completion Date: 04/15/2024

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/22/24, a pungent odor of urine detected upon entry in bedroom [REDACTED]

On 2/22/24, dried feces were observed on the floors and the outside/base of the toilets in several residents' private bathrooms of the Secure Dementia Care Unit (SDCU) to include bedrooms [REDACTED]

Repeated Violation - 4/26/23

Plan of Correction

Directed [REDACTED] - 03/15/2024)

On 2/22/24 the ED instructed the housekeeper to clean all areas listed in violation. On 2/22/24 the ED educated staff on the requirements of 2600.85a. Beginning 2/26/24 2 times/week for 4 weeks audits will be conducted then ongoing in resident rooms and common areas will be checked and or cleaned and be in clean condition.

Proposed Overall Completion Date: 04/13/2024

(Directed)

- Beginning 4/10/23, the administrator or a designated staff person will conduct a twice daily walkthrough of all areas of the building to identify unsanitary conditions and provide housekeeping as appropriate. The walkthrough will be documented on a form developed by the administrator and available for review by the Department.
- The training that was conducted on 2/22/24 for all staff will be documented and include staff signatures. This documentation will also be available for review by the Department. Quarterly in-service training will be provided and documented by the administrator beginning 4/15/2024.

Directed Completion Date: 04/15/2024

183b - Meds and Syringes Locked

5. 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 2/22/24 at 9:30 am, observed a small, round, white pill on the floor next to bedroom [REDACTED].

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

On 2/22/24 at 9:50 am, there was a small green pill labeled N 403 on the floor of the fourth-floor laundry room.

Repeated Violation - 5/30/23, et al and 3/8/23, et al

**Plan of Correction**

Directed [REDACTED] - 03/15/2024)

Immediately on 2/22/24 the Regional Clinical Specialist removed the pill from the floor by [REDACTED] and disposed of it drug buster. Clinical Specialist did the same for the second pill that was found in the 4th floor laundry room. On 2/26/24 the ED educated the staff on the requirements of 2600.183b. Beginning 2/26/24 daily walk throughs of the community will be done by ED or designated person to ensure no pills are on the floor x 14 days then ongoing.

Proposed Overall Completion Date: 03/31/2024

(Directed)

- Beginning 4/10/23, the administrator or a designated staff person will conduct a twice daily walkthrough of all areas of the building to identify loose pills or unlocked medications and secure them as appropriate. The walkthrough will be documented on a form developed by the administrator and available for review by the Department.
- The training that was conducted on 2/26/24 for all staff will be documented and include staff signatures. This documentation will also be available for review by the Department. Quarterly in-service training will be provided and documented by the administrator beginning 4/15/2024.

Directed Completion Date: 04/15/2024

**183e - Storing Medications****6. 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 2/22/24 at 9:52 am, there was a small round pill labeled "US 4" found loose in the fourth-floor med cart.

Repeated Violation - 3/8/23, et al

**Plan of Correction**

Directed [REDACTED] - 03/15/2024)

Immediately on 2/22/24 the Regional Clinical Specialist removed the loose pill from the 4th floor med cart and placed the pill in drug buster. On 2/26/24 The ED educated the staff on the requirements of 2600.183e. On 2/26/24 medication cart audits to be completed weekly by ED or designated person weekly x 8 weeks then ongoing.

Proposed Overall Completion Date: 04/22/2024

(Directed)

- Beginning 4/10/23, the administrator or a designated staff person will audit the medication cart twice daily to identify loose pills and destroy them as appropriate. The audit will be documented on a form developed by the administrator and available for review by the Department.
- The training that was conducted on 2/26/24 for all staff will be documented and include staff signatures.

**183e - Storing Medications (continued)**

*This documentation will also be available for review by the Department. Quarterly in-service training will be provided and documented by the administrator beginning 4/15/2024.*

**Directed Completion Date:** 04/15/2024

**187c - Refusal of Medication****7. Requirements**

2600.

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

**Description of Violation**

*Resident 5's medication administration record (MAR) indicates that several medications are frequently refused by the resident to include Bumetanide (1mg), Megestrol Acet (40mg/ml) Potassium CL (20 MEQ) on 2/21/24 at 8 am. The home did not document that the doctor was notified of these refusals.*

*Resident 6's MAR indicates that several medications are frequently refused by the resident to include Acetaminophen (325mg), Calcium 600 and Omega -3 (1g) on 2/19/24 at 8 am. The home did not document that the doctor was notified of these refusals.*

*Resident 7's MAR indicates that several medications are frequently refused by the resident to include Atorvastatin (20mg), Dexamethasone (4mg) and Ferrous Sulfate (325mg on 2/22/24 at 8 am. The home did not document that the doctor was notified of these refusals.*

**Plan of Correction**

**Directed** [REDACTED] 03/15/2024)

*Resident #5 and #7 are no longer living in the community. Immediately on 2/22/24 the ED notified the MD of the refusal of medications for Resident #6. On 2/26/24 the ED educated the staff on the requirements of 2600.187.c. On 3/1/24 a new form was created by ED for med techs to use when a resident refuses a medication. ED or designated person will audit the MAR for missed meds and make sure the the Dr. was notified x 4 weeks then ongoing.*

*Proposed Overall Completion Date:* 03/29/2024

*(Directed)*

- Beginning 4/10/23, the administrator or a designated staff person will audit all medication administration records weekly to identify medication refusals and report them as appropriate. The audit will be documented on a form developed by the administrator and available for review by the Department.*
- The training that was conducted on 2/26/24 for all staff will be documented and include staff signatures. This documentation will also be available for review by the Department. Quarterly in-service training will be provided and documented by the administrator beginning 4/15/2024.*

**Directed Completion Date:** 04/15/2024

**187d - Follow Prescriber's Orders****8. Requirements**

187d - Follow Prescriber's Orders (continued)

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

Description of Violation

Resident 7 is prescribed Dexamethasone (4mg) twice a day. However, this medication was not administered to Resident 7 on 2/20, 2/21 and 2/22/24 because the medication was not available in the home.

Repeated Violation - 3/8/23, et al

Plan of Correction

Directed ( - 03/15/2024)

Resident was discharged on..... On /24 ED educated the staff on the requirements of 2600.187d. and also following prescribers orders. On 2/23/24 ED and HSD began reviewing MAR's for missed medications and for reason not available and obtain medications from the pharmacy the same day. Audit to be completed daily x 4weeks and ongoing.

Proposed Overall Completion Date: 04/22/2024

(Directed)

- Beginning 4/10/23, the administrator or a designated staff person will audit all medication carts daily to identify medications that are missing or at low supply and reorder as appropriate. The audit will be documented on a form developed by the administrator and available for review by the Department.
- If staff who administer medications are responsible for this daily audit, then training shall be conducted by 4/15/24, will be documented and include staff signatures. This documentation will also be available for review by the Department. Quarterly in-service training will be provided and documented by the administrator beginning 4/15/2024.

Directed Completion Date: 04/15/2024

224a - Preadmission Screen Form

9. 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 4's preadmission screening form, dated /23, does not include a determination that the needs of the resident can be met by the services provided by the home.

Repeated Violation - 3/8/23, et al

Plan of Correction

Accept ( - 03/15/2024)

Immediately on 2/22/24 the ED fixed the prescreen to show that resident #4's needs can be meet by the home. On 2/26/24 the ED educated the staff on the requirements of 2600.244.a. On 2/26/24 an audit completed by ED and HSD to ensure all prescreens are completed correctly. ED or designated person will audit all new pre-screens prior to admission to ensure full completion x 4 weeks then ongoing.

Proposed Overall Completion Date: 03/25/2024

224a - Preadmission Screen Form (*continued*)

Licensee's Proposed Overall Completion Date: 03/25/2024

## 227d - Support Plan Medical/Dental

## 10. 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 current assessment for Resident 3, dated [REDACTED] 23, indicates the resident has a behavioral need of aggression and agitation. However, the resident's current support plan, dated 11/15/23, does not document how this need will be met.

## Plan of Correction

Accept [REDACTED] - 03/15/2024)

Immediately on 2/22/24 the HSD updated the RASP with interventions on how to redirect resident #3 when having aggression. On 2/26/24 the ED educated the staff on the requirements of 2600.227.d. On 2/26/24 ED and or HSD went through all the memory care assessments and made sure that interventions are clearly stated on the assessment. ED or HSD will spot check assessments weekly x 4 weeks to update assessments based on the needs of the residents.

Proposed Overall Completion Date: 04/22/2024

Licensee's Proposed Overall Completion Date: 04/22/2024

## 233c - Key-Locking Devices

## 11. Requirements

2600.

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

## Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door at the main exit of the Secure Dementia Care Unit (SDCU).

## Plan of Correction

Accept [REDACTED] - 03/15/2024)

On 2/22/24 the directions were immediately placed on the exit door of the SDCU. On 2/26/24 the ED educated the staff of the requirements of 2600.233c. Beginning 2/26/24 the ED and or designated person will do spot checks daily x 14 days then ongoing as needed to ensure directions are posted.

Proposed Overall Completion Date: 03/31/2024

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