

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

April 10, 2024

[REDACTED], OWNER/ADMINISTRATOR
EJ MARK PROPERTIES LLC
[REDACTED]

RE: HARMONY HAUS SENIOR LIVING
1329-1339 MERCHANT STREET
AMBRIDGE, PA, 15003
LICENSE/COC#: 45018

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/09/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HARMONY HAUS SENIOR LIVING License #: 45018 License Expiration: 05/18/2024
 Address: 1329 1339 MERCHANT STREET, AMBRIDGE, PA 15003
 County: BEAVER Region: WESTERN

Administrator

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

Legal Entity

Name: EJ MARK PROPERTIES LLC
 Address: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 02/22/1999 Issued By: Dept L & I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 44 Waking Staff: 33

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 02/09/2024

Inspection Dates and Department Representative

02/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 43 Residents Served: 39
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 3
 Number of Residents Who:
 Receive Supplemental Security Income: 6 Are 60 Years of Age or Older: 2
 Diagnosed with Mental Illness: 5 Diagnosed with Intellectual Disability: 1
 Have Mobility Need: 5 Have Physical Disability: 1

Inspections / Reviews

02/09/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/01/2024

03/04/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/03/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/11/2024

Inspections / Reviews *(continued)*

03/18/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/03/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/04/2024

04/10/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/03/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The carbon monoxide detector was approximately 8 feet from the gas furnace in the basement.

Plan of Correction

Accept ([redacted]) - 03/18/2024)

Immediately on 02/09/2024, The Administrator relocated the Carbon Monoxide alarm from the 8 foot location to approximately 17 feet away from the gas furnace prior to the exit interview.

On 02/09/24, The administrator placed dated signage stating, "Please, do not remove - 02/09/2024" next to the detector. By March 1, 2024, the Maintenance Supervisor will ensure the placement and proper operation of the alarm on the monthly furnace/appliance inspections list (see attachment). Maintenance Supervisor will Inspect and document in the Maintenance Binder on the 1st of every month. starting March 1, 2024.

By 03/01/2024, if at any time the alarm is disabled, inoperable, or not conducive to regulation 2600.18 (within 15 ft of the gas furnace) throughout monthly inspections or otherwise, the maintenance supervisor will immediately relocate the alarm to more than 15 ft. from the gas furnace within 1 hour of finding the violation. Administrator will be notified prior to the end of the work day; administrator will document the finding by the end of the work day in the Maintenance Binder.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented ([redacted]) - 04/10/2024)

25c1 - Personal Needs Allowance

2. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

- 1. Each resident shall retain, at a minimum, the current personal needs allowance as the resident's own funds for personal expenditure. A contract to the contrary is not valid. A personal needs allowance is the amount that a resident shall be permitted to keep for his personal use.

Description of Violation

The contract for resident #1, dated [redacted] indicates the current personal needs allowance retained monthly is \$0.

Plan of Correction

Accept ([redacted]) - 03/18/2024)

On 02/09/24, the Administrator and resident #1 immediately amended the resident contract between the resident and Harmony Haus Senior Living prior to the exit interview.

Immediately on 02/09/2024, the administrative assistant audited and amended all contracts of residents receiving Social Security Income benefits to reflect compliance of regulation, 2600.25c. The audit revealed that resident #1 was the only non-compliant contract.

Effective immediately on 2/9/23, all new admissions receiving SSI will be notified during the admission process of regulation 2600.25c by the Administrator/Administrator Assistant who is conducting the admission. In addition to,

25c1 Personal Needs Allowance (continued)

the administrative assistant will audit all new contracts in their entirety within the first week of admission date and prior to him properly filing the residents file. If a discrepancy within the contact is found by the administrative assistant, he will have until the end of the work day to correct the contract and ensure proper signatures from both parties; as well as, notifying the administrator of the mistake.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented ([redacted]) - 04/10/2024)

65f - Training Topics

3. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Staff person A, hired [redacted], did not complete safe management techniques in the training year 2023.

Plan of Correction

Accept [redacted] - 03/18/2024)

Immediately on 02/09/2024, The Administrator trained staff person A in the topic of "Safe Management Techniques."

By 02/10/2024, the Administrator trained all staff members in "Safe Management Techniques." In addition, by 02/11/2024, the Administrative Assistant reviewed all staff trainings to ensure all staff trainings were in compliance with DHS regulation.

On 02/09/2024, the Administrative Assistant reviewed the staff training plan for 2024 ensuring all training required per the regulation were included on the annual training. Staff training requirements will be reviewed and submitted by Administrative Assistant at scheduled bi annual quality management meetings. If a staff member was absent or missed training, said person will be removed from the work schedule by the administrator, and must complete the training, giving by the administrator, within 48 hours of previously scheduled training. Administrator will remove the staff member from the schedule until training is met. Administrator will place them back on the schedule once training is completed.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented ([redacted]) - 04/10/2024)

65g - Annual Training Content

4. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person A, hired [redacted] did not completed fire safety training nor falls and accident prevention training in the training year 2023.

Staff person B, hired [redacted], did not completed fire safety training nor falls and accident prevention training in the training year 2023.

65g Annual Training Content (continued)

Plan of Correction

Accept ([redacted]) - 03/18/2024)

Immediately on 02/09/2024, The Administrator trained staff person A and B in the topics of "Fire Safety Trainings," and "Falls and Accident Prevention."

By 02/10/2024, The Administrator trained all staff members in "Fire Safety Trainings," and "Falls and Accident Prevention." By 02/11/2024, all staff trainings were audited by the Administrative Assistant to ensure all staff trainings were in compliance with DHS regulation and Harmony Haus Annual Staff Training Plan.

On 02/09/2024, the Administrative Assistant reviewed the staff training plan for 2024 ensuring all training required per the regulation were included on the annual training. Staff training requirements will be reviewed and submitted by Administrative Assistant at scheduled bi annual quality management meetings. If a staff member was absent or missed training, said person will be removed from the work schedule by the administrator, and must complete the training, giving by the administrator, within 48 hours of previously scheduled training. Administrator will remove the staff member from the schedule until training is met. Administrator will place them back on the schedule once training is completed.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented ([redacted]) - 04/10/2024)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

A used towel was observed on the shower chair, in the common bathroom #4, near bedroom 109F.

Plan of Correction

Accept ([redacted]) - 03/18/2024)

Immediately on 02/09/2024, Administrator removed the used towel from the bathroom and placed the used towel in the sealed "used linens" container.

On 02/09/2024, Team supervisor lead a training on the importance of all sanitary conditions to the team. By 02/11/24, all direct care staff were re trained by the administrator on sanitary conditions.

On 02/10/2024, the Administrator reconstructed the supervisors "check list," ensuring that bathroom checks are now completed three times per day (opposed to twice). The first check will occur at 9:00am (during morning hygiene), instead of at 11:00am (post morning hygiene routine). Bathrooms will be checked by the supervisor at 9:00am, 11:00a, and 4:00pm. Documentation will be kept daily in the Daily Leadership Book by the supervisor. Verbal warnings by the supervisor will be given at the time of first and second offenses, third offense will result in a written warning by the administrative assistant (per Harmony Haus policy and procedures). Administrator Assistant will keep documentation in each individual employee file by the end of the work day.

85a - Sanitary Conditions (continued)

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented (████) - 04/10/2024)

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At approximately 10:37 a.m., the double refrigerator in the kitchen measured 42 degrees Fahrenheit and at 2:30 p.m. it measured 42 degrees Fahrenheit.

Plan of Correction

Accept (████) - 03/18/2024)

Immediately on 02/09/2024, Administrator adjusted refrigerator temperature to 38 degrees. Administrator asked Kitchen staff to monitor temperature hourly to ensure a decrease in temperature occurred. The refrigerator thermostat read 39 degrees by 4pm on 02/09/2024.

02/11/24, Administrator directed training for all kitchen staff. The training entailed: proper monitoring and recording of daily temperatures of all refrigerators and freezers in the kitchen by the end of each shift on the required template; proper food labeling and storage teaching and weekly auditing; food disposal.

By 2/11/24, Kitchen staff will report any out-of-range measurement at the time of findings to the Administrator for immediate resolution including: (a) Continuous hourly measurements for the next 12 hours by kitchen staff, and (b) notification of maintenance repair to Maintenance supervisor, if needed, by the end of the 12 hours. Measurements are reviewed and filed at the time of the occurrence in the quality management binder by the administrative assistant.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented (████) - 04/10/2024)

103i - Outdated Food

7. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

A box of ice cream and chicken patties were opened and undated in the double freezer in the kitchen.

Plan of Correction

Accept (████) - 03/18/2024)

Immediately on 2/9/24, the administrator disposed of the ice cream and chicken patties. He audited all food storage areas and no other undated/improperly sealed food was found.

On 02/11/2024, Administration held a staff training meeting with all kitchen staff, implementing daily refrigerator/freezer audits and disposal of outdated, not dated or not vacuum sealed food. The audits will be conducted by the kitchen staff prior to the end of each shift, properly documented and checked for completion by the team supervisor prior to the end of the shift.

103i - Outdated Food (continued)

Effective on 02/11/2024, If any inadequately stored/labeled food/drink is found, it will be immediately disposed of by the kitchen staff member who found it. These audits will be reviewed by the shift supervisor and recorded in the Daily Leadership Book under "Kitchen Concentrated Cleaning" for both the morning and evening shift. These audits will be reviewed by the administrator at the scheduled bi-annual quality management meetings.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented [redacted] - 04/10/2024)

132f - Alternate Exit Routes

8. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The front door exit was used on 6 consecutive fire drills including 4/21/23, 5/23/23, 6/20/23, 7/17/23, 8/25/23, and 9/13/23.

Plan of Correction

Accept [redacted] - 03/18/2024)

Immediately on 2/9/2024, the administrator scheduled a fire drill for 02/10/2024 at 10am utilizing the right back door closest to the street as the exit.

On 02/10/24, the administrator executed the scheduled fire drill at 10am. All staff were re-trained by the administrator by 2/10/24 on successful components of a fire drill; as well as, fire safety training.

On 02/11/2024, the administrator created a monthly fire drill schedule for the rest of the year, effective 03/01/2024. This schedule will include alternating exits to ensure that no exit route can be duplicated consecutively, the exact day and time the fire drill will be ran, and who the designated staff member is responsible for running the drill. This schedule will be held in the fire safety log binder for easy reference and prevention of violations during drills. Administrator will review fire-drill records bi-annually at the quality management meeting. If any discrepancy is found, an amending fire drill will be held within 72hours and staff retraining within 24 hours by the administrator . See attachment.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented [redacted] - 04/10/2024)

144c2 - Smoking Area Distance

9. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

At approximately 8:55 a.m., an agent of the Department observed resident #2 smoking on a bench directly outside

144c2 - Smoking Area Distance (continued)

the main entrance of the home. This is not the designated smoking area. The designated smoking area is around the side of the building.

At approximately 1:05 p.m., a male and female resident of the home were observed smoking directly outside of the main entrance of the home. This is not the designated smoking area. The designated smoking area is around the side of the building.

Plan of Correction

Accept (████) - 03/18/2024)

Immediately on 2/9/24, administrator held a meeting with all tobacco-using residents concerning the importance of utilizing the designated smoking area.

By 2/10/24, The administrator has drafted a letter to all residents and their designated persons, including an attachment of the Home Rules that were signed upon admission, highlighting the importance of using the designated-smoking area. All staff have been trained by the administrator in Policy and procedures concerning: Smoking and Sanitary Conditions on 02/09/2024 through 02/11/2024. The training included their responsibility to ensure the safety of all residents by redirecting anyone smoking outside of the designated area, to the designated smoking area. The administrative assistant mailed the letter to the designated persons on 2/15/2024.

Beginning 2/12/2024, the Administrator will host weekly meetings with all tobacco-using residents/staff. These meetings will consist of the next four weeks (ending on 3/4/2024) with all smokers (staff and residents), regarding the use of the designated smoking area and repercussions of violating this policy. Administrator will host monthly meetings on the first Monday of each month after the 4 week probationary period to ensure compliance of the regulation until 12/01/2024. If a resident remains consistently uncompliant, family and/or designated person will be contacted by the administrator. This meeting will determine whether or not the issuance of a 30-day notice will be necessary.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented (████) - 04/10/2024)

183e - Storing Medications

10. Requirements

2600.

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

Description of Violation

An opened ██████ belonging to resident #1, did not have an opened date. According to the manufacturer's instructions the shelf-life of this medication indicates dispose of 56 days after first use.

REPEAT VIOLATION: 4/11/23 et al

Plan of Correction

Accept (████) - 03/18/2024)

On 2/9/24, The administrator immediately disposed of and reordered the medication.

On 2/10/24, the Administrator amended the monthly Med-Cart Audit to include a specific sub-section of

183e Storing Medications (continued)

"Medication Labels." effective 3/1/2024, The administrator and supervisor will perform a monthly med cart audit on the first Friday of each month.

Effective 3/1/24, At the monthly routine med cart audit, the auditor (supervisor/administrator/administrative assistant) will observe all medications in need of dates and amend accordingly via disposal, appropriate date, or reordered. This log will be alongside of the med cart and filled out by the auditor at the end of each audit. After the December audit, the auditor will file annually in the quality management binder. In addition to, effective on 2/15/24, the administrator will also conduct an independent med cart audit of medication storage and labels, ensuring proper conditions suitable for medications. The original/comprehensive med cart audit will take place on first friday of the month by the auditor (supervisor/administrator/administative assistant), effective 3/1/24. The administrators audit will take place on the 3rd friday of the month, effective 3/15/24. The administrator will initial the new/last column of the amended audit form. See attachment.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented ([REDACTED] - 04/10/2024)