pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HAMPDEN OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT WEST SHORE**
NAME OF FACILITY OR AGENCY

Located at **1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050**
(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 **115**
(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 35**

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 **December 16, 2024** until **December 16, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333810**

ISSUING OFFICER

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.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: DECEMBER 16, 2024

[redacted]
Hampden Operations LLC
[redacted]

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

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 1, 2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
<Licensing Inspection Summaries>

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

November 21, 2024

[redacted], REGIONAL DIRECTOR OF OPERATIONS
HAMPDEN OPERATIONS LLC
[redacted]

RE: HARMONY AT WEST SHORE
1910 TECHNOLOGY PARKWAY
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33381

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/02/2024, 07/03/2024, 07/05/2024, 07/09/2024 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 AT WEST SHORE* **License #**: *33381* **License Expiration**: *09/26/2024*

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**: *86* **Waking Staff**: *65*

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *07/09/2024*

Inspection Dates and Department Representative

07/02/2024 - On-Site: [redacted]
07/03/2024 - On-Site:
07/05/2024 - On-Site:
07/09/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *60*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Harmony Square* **Capacity**: *35* **Residents Served**: *16*

Hospice

Current Residents: *5*

Number of Residents Who:

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

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

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

07/02/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/05/2024*

Inspections / Reviews *(continued)*

08/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/13/2024*

08/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/17/2024*

11/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 7/2/2024, at approximately 12:00PM, agents of the Department requested access to records for Residents #1, 2, 3, 4, 5, 6, 7, and 8, including full resident files, June 2024 Medication Administration Records for all but Resident #8, April and May 2024 Medication Administration Records for Resident #8 and five hospice residents, and staff records for Staff Members A, B, C, D, E, F, G. Resident records for Residents #1 and #2 were not available until 2:00PM. Staff records for Staff Members A, C, D, E, F, and G were not available until 2:15PM. An agent of the Department requested remaining resident records again at 3:32PM, at which time records for Residents #3, 5, 8 were observed sitting on a filing shelf by the door in the Executive Director's office. Resident records for Residents #6 and 7 were received at 3:40PM.

An agent of the Department requested Staff Member B's record again at 4:10PM, as well as CPR/First Aid certification and education qualifications for all staff previously requested and criminal history check for Staff Member A. As of 7/2/2024 at 5:40PM, the staff record for Staff Member B, resident contracts, and resident records for Residents #3, 4, 5, 8 had not yet been submitted to agents of the Department.

Contracts for all 8 residents requested were not available to agents of the Department until arrival on 7/3/2024 at 9:00AM.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/31/24, RDO provided education to leadership Team regarding the need to provide representatives of the Department immediate access to resident records and reports upon request.

On 7/31/24, Executive Director or Designee will ensure immediate and ongoing access to resident records and reports will be granted immediately upon request. ED or Designee will immediately communicate any legitimate issues with provision of records with members of the Department.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 5/3/2024 at 7:15PM, a staff-to-resident abuse incident occurred that was reported to the Department. However, the Act 13 Mandatory Abuse Reporting form was not completed and submitted to AAA until 5/8/2024 at 1:12PM.

On 7/2/2024 at 1:09AM, a resident-to-resident abuse incident occurred. The PCHA was notified on 7/3/24. As of 7/9/2024, an Act 13 Mandatory Abuse Reporting form was not completed and submitted to AAA.

15a - Resident Abuse Report (continued)

Repeated Violation - 10/17/2023

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/31/24, RDO provided education to the Leadership Team members and associates regarding the Older Adult Protective Services Act and mandated reporting of suspected abuse.

On 8/13/24, Corporate Operations Specialist completed an Act 13 and submitted to AAA for the incident of abuse that occurred on 7/2/24.

Beginning 8/12/24, Corporate Operations Specialist or Designee will conduct an audit of all internal incidents and reportable incidents back to June 1, 2024 to ensure an Act 13 has been completed and submitted per the regulation. The audit will be completed by 8/30/24.

Beginning 8/12/24, ED or Designee will review all prior day incidents at morning meeting to ensure ongoing compliance.

Beginning 8/1/24, the ED or Designee provide training to all new associates within their first 40 hours of hire. In addition, the ED or Designee will provide semi-annual training to all staff.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

15b - Supervisor Plan

3. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 5/3/2024 at 7:15PM, a staff-to-resident abuse incident occurred that was reported to the Department. The home did not immediately develop a plan of supervision and implement the plan nor suspend Staff Member B, who was involved in the alleged incident. As per the incident report, Staff Member B was reassigned to a different floor to continue their shift. The home was unable to confirm that the staff member was supervised during this time nor whether [redacted] worked again prior to termination on [redacted]

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/30/24, RDO created a policy titled "Suspected Abuse (Associate to Resident), which addresses the need to develop and implement a plan of supervision or suspected a staff member involved in an alleged incident.

On 7/31/24, RDO educated the leadership team on this policy.

Beginning 8/1/24, Executive Director or Designee will be responsible for ensuring that the newly created Suspected Abuse (Associate to Resident) policy is implemented and monitored for effectiveness. ED or Designee will review this policy annually.

15b - Supervisor Plan (continued)

Beginning 8/12/24, ED or Designee will review all prior day incidents at morning meeting to ensure ongoing compliance.

(Directed)

- *Beginning no later than 9/1/24, any allegation of abuse involving a home's staff member will be immediately reported to the Administrator or designee to ensure the home immediately develops and implements a plan of supervision or suspend the staff person involved in the alleged incident. Staff will receive education on this process no later than 8/30/24.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

16c - Written Incident Report

4. 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 5/3/2024 at 7:15PM, a staff-to-resident abuse incident occurred in the home. The home did not report this incident to the Department until 5/6/2024 at 5:00PM.

Repeated Violation - 12/20/2023, et al, 7/20/2023

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/30/24, RDO created a policy titled "Suspected Abuse (Associate to Resident) which addresses the need to report an incident or condition of suspected abuse to the personal care home compliant hotline within 24 hours.

On 7/31/24, RDO educated all Leadership Team members on this policy.

Beginning 8/1/24, Executive Director or Designee will be responsible for ensuring that the newly created Suspected Abuse (Associate to Resident) policy is implemented and monitored for effectiveness. ED or Designee will review this policy annually.

Beginning 8/12/24, RDO began educating all staff members on this regulation. Training will be completed by 8/30/24. In addition, Corporate Operations Specialist will conduct an audit of all internal and reportable incidents from June 1, 2024 through present to ensure proper reporting has occurred. The audit will be completed by 9/15/24. Further more, beginning 8/12/24, ED or Designee will review all prior day incidents daily at morning meeting to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented ([redacted] - 11/21/2024)

42c - Treatment of Residents

5. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 5/3/2024, Resident #9 told Staff Member B to "go to hell." Staff Member B responded "You go first." As per Staff Member G, Staff Member B had been redirected away from the resident prior to this interaction as Resident #9 had stated that they wanted the staff to stay away from them. Staff Member B later stated to Staff Member H that "had [they] been off the clock, [they] would have punched [them]." Resident #9 later told staff that they did not want Staff Member B to come in their room.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO reviewed Residents Rights with all Harmony at West Shore associates.

Beginning 8/1/24, Business Office Manager or Designee will ensure a review of Resident Rights will be conducted with each new associate. BOM or Designee will ensure Resident Rights will be reviewed semi-annually with all staff.

Beginning 8/14/24, ED or Designee will conduct 3 random resident interviews monthly to ensure Resident Rights are being met. Monthly interviews will be conducted for a period of 3 months. In addition, beginning 8/12/24, RDO will review information obtained from the internal investigation as a result of incident on 5/3/24.

(Directed)
In addition to the above plan of correction:

- *Staff Member B was terminated on* [redacted]
- *Documentation of resident interviews and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *08/16/2024*

Implemented ([redacted] - 11/21/2024)

51 - Criminal Background Check

6. Requirements

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

Description of Violation

Staff Member A began working at the home on [redacted] *however, a Pennsylvania State Police Criminal Background Check was not obtained for Staff Member A until* [redacted]

Staff Member F was hired [redacted] *however, a Pennsylvania State Police Criminal Background Check was not obtained for Staff Member A until* [redacted]

51 - Criminal Background Check *(continued)*

Plan of Correction ***Accept (- 08/15/2024)***

On 7/31/24, RDO educated all Leadership Team members on the requirement regarding criminal background checks to be conducted in accordance with the OAPSA effective immediately.

Beginning 8/5/24, Business Office Manager or Designee will conduct an audit of all current employee files to verify that criminal history checks have been conducted in accordance with the OAPSA. Initial audit will be completed by 8/30/24.

Beginning 9/1/24, Business Office Manager or Designee will conduct a monthly audit of each months newly hired associates for a period of 3 months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 11/21/2024)

82c - Locking Poisonous Materials

7. 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 7/9/2024 at approximately 10:40AM, a bottle of MedLine Remedy antifungal powder with a manufacturer's label indicating "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away" was observed in resident bedroom H119. The resident residing in room H119 is not assessed to be capable of recognizing and using poisons safely.

On 7/9/2024 at approximately 10:45AM, a tube of MedLine Remedy zinc oxide with a manufacturer's label indicating "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away" was observed in resident bedroom H110. The resident residing in room H1110 is not assessed to be capable of recognizing and using poisons safely.

On 7/9/2024 at approximately 10:48AM, multiple tablets of Polident 3-minute denture cleaner with a manufacturer's label indicating "IF SWALLOWED: Call Poison Control Center or Doctor" were observed in resident bedroom H108. The resident residing in room H108 is not assessed to be capable of recognizing and using poisons safely.

Repeated Violation - 2/22/2024, 12/20/2023, et al,

Plan of Correction ***Accept (- 08/15/2024)***

On 7/11/24, RDO confirmed that all items identified in apartments H119, H110 and H108 were removed from resident apartments.

On 7/31/24, RDO educated all direct care associates on the regulation regarding poisonous materials being locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Beginning 8/5/24, Corporate Operations Specialist or Designee will conducted an audit of all resident apartments

82c - Locking Poisonous Materials (continued)

in SDCU to ensure all resident hygiene products are secured to ensure resident safety.

Beginning 9/1/24, Healthcare Director or Designee will conduct a weekly audit for a period of 8 weeks to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented ([redacted] - 11/21/2024)

85d - Trash Receptacles

8. Requirements

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

Description of Violation

On 7/2/2024 at approximately 10:25AM, there was a half-full, uncovered, unattended trash can in the common bathroom of the Secured Dementia Care Unit.

Plan of Correction ***Accept ([redacted] - 08/15/2024)***

On 7/2/24, Maintenance Director placed a covered trash receptacle in the SDCU common area bathroom immediately upon finding.

On 7/31/24, RDO educated all Leadership, Maintenance and Housekeeping staff on this regulation.

Beginning 8/5/24, ED or Designee will conduct a weekly audit of all common area bathrooms to ensure that all trash receptacles are covered in accordance with the regulation. Weekly audit will be conducted for a period of 4 weeks to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

88a - Surfaces

9. Requirements

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

Description of Violation

On 7/9/2024 at approximately 11:27 AM, an "X" marked in red ink was observed on the carpet in the 4th floor hallway in Personal Care. The floor where the "X" was located was observed to have a 3 inch divot under the carpet, posing a potential tripping hazard.

Plan of Correction ***Accept ([redacted] - 08/15/2024)***

On 7/10/24, RDO contacted Harmony Senior Services to notify of the 3 inch divot under the carpet in Personal Care.

On 7/31/24, a member of Harmony Senior Services Corporate Construction ([redacted]) visited the community to assess the root cause of the divot.

On 8/1/24, RDO contacted local contractors to schedule repair of the divot in question. Repair to be completed on

88a - Surfaces (continued)

or before 8/30/24.

Beginning 8/5/24, Executive Director or Designee will walk the community on a weekly basis in an effort to proactively identify issues that require immediate attention and repair to ensure community is hazard free.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

91 - Telephone Numbers

10. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 7/2/2024, the telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted by the telephone in the common area exit door in the SDCU nor by the 3rd floor nurse's station telephone.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/11/24, RDO posted emergency telephone numbers above the common area phone in the SDCU.

On 7/31/24, RDO educated all leadership team members on this requirement to have emergency telephone numbers posted by each telephone with an outside line.

Beginning 8/5/24, Executive Director or Designee will conduct an audit of all apartments and common areas with an outside line to ensure that emergency telephone numbers are posted in accordance with the regulation. Audit to be completed by 9/15/24.

(Directed)

- *On 7/11/24, RDO posted emergency telephone numbers above the common area phone in the SDCU.*
- *On 7/31/24, RDO educated all leadership team members on this requirement to have emergency telephone numbers posted by each telephone with an outside line.*
- *Beginning 8/5/24, Executive Director or Designee will conduct an initial audit of all apartments and common areas with an outside line to ensure that emergency telephone numbers are posted in accordance with the regulation. Audit to be completed by 8/30/24.*
- *Beginning no later than 9/1/24, quarterly audits will be completed by the Administrator or designee to ensure emergency telephone numbers remain on or by each telephone with an outside line.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

95 - Furniture and Equipment

11. Requirements

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

Description of Violation

On 07/02/2024, at 10:35AM, the lock systems on the fire doors located next to the laundry room in Secured Dementia Care Unit, were observed to be unscrewed and hanging off of the doors with the screws exposed.

The main doors exiting the Secured Dementia Care Unit were observed with the covers of the lock systems hanging off, exposing the mechanics of the locking systems and electrical components.

Plan of Correction ***Directed (- 08/16/2024)***

On 7/3/24, Maintenance Director screwed in the exposed screws of the fire doors located next to the laundry room in the SDCU.

On 7/31/24, Maintenance Director from sister community assessed the main doors and ordered a part to fix the cover of the lock system located at the main doors exiting the SDCU.

On 7/31/24, RDO conducted education to all leadership team members regarding this regulation.

Beginning 8/12/24, Executive Director or Designee will conduct an initial audit of all the home's furnishings and equipment to ensure they are in good repair, clean and free of hazards. The initial audit will be completed by 8/30/24.

Beginning 9/1/24, ED or Designee will conduct a weekly audit x 8 weeks, of all fire doors and exit doors of SDCU to ensure they are in good repair.

(Directed)
In addition to the above plan of correction:

- *The lock system located at the main doors exiting the SDCU will be repaired and free of hazards by 9/1/2024.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *10/31/2024*

Implemented (- 11/21/2024)

101j7 - Lighting/Operable Lamp

12. 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

Resident rooms H108 and H110 do not have a source of light within reach that can be turned on/off at bedside.

Plan of Correction ***Accept (- 08/06/2024)***

Immediate:
On 7/31/24, RDO educated all Leadership Team members on the regulation regarding requirement of all residents

101j7 - Lighting/Operable Lamp (continued)

to have an operable lamp or other source of lighting that can be turned on at bedside. On 7/23/24, Corporate Operations Specialist installed puck lights in apartments H108 and H110, near bedside.
Ongoing:
Beginning 8/5/24, Executive Director or Designee will conduct a weekly audit x 8 weeks, to ensure all residents in SDCU have an operable light source at bedside.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 11/21/2024)

121a - Unobstructed Egress

13. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 7/2/2024, at approximately 10:25 AM, the egress route from the home's Secured Dementia Care Unit patio was obstructed by a patio chair.

On 7/2/2024, at approximately 10:30 AM, the egress route to the home's Secured Dementia Care Unit exit 31 by bedroom H101 was obstructed by a walker and armchair.

Plan of Correction ***Accept ([redacted] - 08/15/2024)***

On 7/2/24, RDO removed both obstructions from egress routes within the SDCU.

On 7/31/24, RDO educated all SCU associates, activity assistant and leadership team members on the importance on ensuring that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Beginning 8/5/24, Executive Director or Designee will conduct a daily walk through (M-F) x 4 weeks through SDCU to ensure all egress routes are free from obstruction.

On 8/22/24, Corporate Operations Specialist will provide training to all associates at the monthly staff meeting.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

123c - Evacuation Diagrams

14. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 60 residents. However, the emergency evacuation diagrams posted on the 3rd and 4th floors do not include the location of pull stations and fire extinguishers.

123c - Evacuation Diagrams *(continued)*

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/20/24, RDO contacted corporate to request updated evacuation diagrams for the 3rd and 4th floors that designate the location of pull stations and fire extinguishers.

On 8/5/24, RDO updated the existing evacuation diagrams until such time that professionally created, branded evacuation diagrams and received and exiting diagrams replaced.

Beginning 8/12/24, ED or Designee will complete an initial audit of all evacuation diagrams in the home. Audit will be completed by 8/30/24.

ED or Designee will continue to monitor evacuation diagrams as part of their weekly walk through of the community.

(Directed)

- *Beginning no later than 9/1/2024, ED or Designee will continue to monitor evacuation diagrams as part of their weekly walk through of the community.*
- *Documentation of completed initial and on-going audits will be kept by the home.*

Directed Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

141a 1-10 Medical Evaluation Information

15. 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

On 7/3/2024, the initial medical evaluation dated [redacted] for Resident #6 did not include the resident's allergies. The evaluation noted "see attached MAR" but there was no further documentation attached.

On 7/2/2024, the initial medical evaluation dated [redacted] for Resident #1 did not include the resident's diagnosis of Type II diabetes.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Directed (- 08/16/2024)***

On 7/11/24, RDO requested an updated DME for Resident #6 to include residents's allergies. In addition, a request was made for an updated DME for Resident #1 to include the diagnosis of Type II Diabetes.

On 731/24, RDO provided education to all leadership team members regarding this regulation.

Beginning 8/5/24, Healthcare Director or Designee will complete an audit of all resident DME's to ensure completeness and accuracy, as part of the RASP audit. Audit completion date: 9/30/24. Moving forward, a Move In Checklist will be created and utilized to ensure all admission documentation is complete and accurate on or before admission date.

On 8/12/24, RDO followed up with provider for Resident #1. Resident #6 physically moved out of the community on . In addition, on 8/12/24, RDO created a Move In Checklist to be utilized to ensure all admission documents are complete and accurate on or before admission date to PC or SDCU, effective immediately.

(Directed)

- *On 7/11/24, RDO requested an updated DME for Resident #6 to include residents' allergies. In addition, a request was made for an updated DME for Resident #1 to include the diagnosis of Type II Diabetes. On 8/12/24, RDO followed up with provider for Resident #1. Resident #6 physically moved out of the community on*
- *On 7/31/24, RDO provided education to all leadership team members regarding this regulation.*
- *Beginning 8/5/24, Healthcare Director or Designee will complete an audit of all resident current DME's to ensure completeness and accuracy, as part of the RASP audit. Audit completion date: 8/30/24.*
- *On 8/12/24, a Move In Checklist will be created by the RDO and will be utilized starting no later than 8/30/24 to ensure all admission documentation is complete and accurate on or before admission date to the PC or SDCU.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *08/30/2024*

Implemented (- 11/21/2024)

141b1 - Annual Medical Evaluation

16. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #8's most recent medical evaluation was completed on 6/19/2024. The resident's previous medical evaluation was completed on 3/3/2023.

Plan of Correction ***Directed (- 08/16/2024)***

On 7/31/24, RDO trained the Leadership Team on the requirement that a resident shall have a medical evaluation at least annually.

141b1 - Annual Medical Evaluation (continued)

Beginning 8/5/24, Healthcare Director or Designee will complete an audit of all resident DME's to ensure they have been completed in a timely manner, as part of the RASP audit. Audit will be completed by 9/30/24.

Beginning 8/12/24, a tickler of all residents will be created to ensure all residents receive a medical evaluation at least annually.

(Directed)

- *On 7/31/24, RDO trained the Leadership Team on the requirement that a resident shall have a medical evaluation at least annually.*
- *Beginning 8/5/24, Healthcare Director or Designee will complete an audit of all resident DME's to ensure they have been completed in a timely manner, as part of the RASP audit. Audit will be completed by 8/30/24.*
- *Beginning 8/12/24, a tickler of all residents will be created on the Administrator or designee's calendar to ensure all residents receive a medical evaluation at least annually.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

161d - Dietary Needs

17. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

As per Resident #3's medical evaluation dated [redacted], the resident is prescribed a regular diet. However, as per special diets documentation posted in the Kitchen and Staff Member I, the resident is served a mechanical soft diet.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/30/24, RDO requested an updated DME/Diet Order from Resident #3's physician.

Beginning 8/5/24, Executive Director or Designee will audit all resident diet orders and provide an updated special diet list to the Dining Services Director, and the diet board in PC and SDCU will be updated.

On 8/12/24, ED or Designee will provide training to all dietary staff to ensure they know where the diet boards are located and how to read the board to ensure residents are served the proper diet as prescribed by their physician.

Beginning 8/12/24, Healthcare Director or Designee will complete an initial audit of all resident diet orders and communicate the diet orders for each resident to the Dining Services Director. Dining Services Director or Designee will update the diet boards in PC and SDCU accordingly by 9/30/24.

161d - Dietary Needs (continued)

(Directed)
In addition to the above plan of correction:

- *Beginning 8/12/24, Healthcare Director or Designee will complete an initial audit of all resident diet orders and communicate the diet orders for each resident to the Dining Services Director. Dining Services Director or Designee will update the diet boards in PC and SDCU accordingly by 9/5/24.*
- *To ensure on-going compliance, beginning 9/1/24, any new diet orders obtained from a physician will be communicated to the Dining Service Director. The Dining Service Director or designee will updated the diet board by the following meal on the day the diet order is obtained.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/05/2024*

Implemented ([redacted] - 11/21/2024)

183b - Meds and Syringes Locked

18. 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 7/3/2024 at 3:47PM and 7/9/2024 at 11:25AM, ammonia lactate 12% moisturizing cream was unlocked, unattended, and accessible in Resident #2's room. Resident #2 cannot self-administer medications per the resident's Assessment and Support Plan, dated [redacted]

Repeated Violation - 2/22/2024, et al

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 8/1/24, RDO educated leadership team members on the need for all prescription medications, CAM and syringes to be kept in an area or container that is locked.

Beginning 8/5/24, Executive Director or Designee will train all Direct Care Associates on the regulation.

Beginning 8/12/24, Healthcare Director or Designee will complete an audit of all resident apartments to ensure all prescription medications, OTC, sample, CAM and syringes are locked. Audit will be completed 9/15/24.

RDO will create and send out a communication to all residents and family members to provide education on this regulation, to be included in the monthly statements. Mailing will be sent out by 8/30/24.

(Directed)

- *On 8/1/24, RDO educated leadership team members on the need for all prescription medications, CAM and syringes to be kept in an area or container that is locked.*
- *Beginning 8/5/24, Executive Director or Designee will train all Direct Care Associates on the regulation.*

183b - Meds and Syringes Locked (continued)

- *Beginning 8/12/24, Healthcare Director or Designee will complete an initial audit of all resident apartments to ensure all prescription medications, OTC, sample, CAM and syringes are locked. Audit will be completed by 8/30/24.*
- *RDO will create and send out a communication to all residents and family members to provide education on this regulation, to be included in the monthly statements. Mailing will be sent out by 8/30/24.*
- *Beginning 9/1/2024, monthly audits of resident rooms will be completed to ensure medications remain stored in locked containers per the resident's ability to self-administer in the assessment and support plan.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

183d - Prescription Current

19. Requirements

2600.
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 3/6/2024 at 3:50 PM, whole Sertraline 50mg tablets, prescribed for Resident #5, were in the home's medication cart; however, the medication was discontinued on 7/3/2024.

On 7/9/2024 at approximately 10:55AM, multiple tablets of Polident 3-minute denture cleaner were observed in Resident Room H108; however, the box indicated an expiration date of 03/11/2024.

Repeated Violation - 4/17/2024; 12/20/2023, et al

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/11/24, Steraline 50mg tablets prescribed for Resident #5 were destroyed by MT. RDO and MT conducted a sweep of all SDCU resident apartments to ensure no OTC medications, prescription medications, sample or CAM were present.

On 8/5/24, Corporate Operations Specialist conducted an audit of all SDCU apartments to ensure all prescriptions, OTC, samples, CAM or syringes were not present in resident apartments.

Beginning 8/12/24, Corporate Operations Specialist or Designee will conduct an audit of all PC apartments to ensure all prescriptions, OTC, samples, CAM and syringes are not present in resident apartments. Audit will be completed by 8/30/24.

Beginning 8/12/24, Healthcare Director or Designee will conduct weekly Med Cart audits to ensue discontinued medications are removed from cart and disposed of appropriately. Pharmacy to conduct monthly cart audits and report findings to ED or Designee.

On 8/22/24, Corporate Operations Specialist or Designee will conduct training of all Med Techs during monthly staff meeting.

183d - Prescription Current (continued)

Beginning 9/1/24, Healthcare Director or Designee will conduct a monthly audit of all resident apartments for a period of 3 months to ensure ongoing compliance.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented ([redacted] - 11/21/2024)

184a - Resident's Meds Labeled

20. 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.
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

The Lantus Solostar pen label for Resident #2's does not include the resident's name, the date the prescription was issued, the prescribed dosage and instructions for administration, the name and title of the prescriber.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 8/1/24, a request for prescription for Resident #2 was made to the PCP.

Beginning 8/5/24, Executive Director or Designee to train all Med Tech's on proper labeling of all prescription medications. If a medication is received without the pharmacy label, MT to notify the ED or Designee immediately.

Beginning 8/12/24, Healthcare Director or Designee will conduct Med Cart audits weekly, to include review of pharmacy label on all in house medications administered by the home.

(Directed)
In addition to the above plan of correction:
- *Resident #2's Solostar pen will be properly labeled by 8/30/24 by the administrator or designee.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

185a - Implement Storage Procedures

21. 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 #2 is prescribed blood glucose readings via a Freestyle Libre sensor. As per manufacturer's instructions, the sensor automatically stops working after 14 days of wear and must be replaced. On 6/26/2024 and 6/27/2024, sensor patches were not available in the home as evidenced by consecutive glucometer readings for those two days and documentation of application of the new patch on 6/28/2024 on the resident's personal calendar. As per interviews with Resident #2 on 7/9/2024 and 7/5/2024, [redacted] stated that staff would be "jabbing [redacted] fingers" because a new sensor patch was not available and it "upsets" [redacted] noted that they had to use the glucometer the previous week.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO conducted training with Leadership Team on the need to ensure safe storage, access, security, distributions of medications and medical equipment by trained staff persons, per regulation.

Beginning on 8/5/24, Executive Director or Designee will conduct training of all Medication Technicians regarding the regulation/need to ensure residents have the medications/supplies on hand as prescribed by physician. Weekly medication cart audits to include creating a list of all required refills.

On 8/14/24, RDO placed a sign on all med carts to serve as a reminder to request refills at least 7 days in advance to ensure residents have required medications and supplies available as prescribed by physician.

Beginning 9/1/24, Corporate Operations Specialist will secure outside services will be contracted to conduct monthly cart audits for a period of 6 months.

(Directed)
In addition to the above plan of corrections:

- *Beginning 8/20/24, weekly medication cart audits will be completed to include creating a list of all required refills by the Administrator or designee.*
- *Sensor's for Resident #2 will be ordered and available for use by 8/20/24 by the Administrator or designee.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

186a - Authorized Prescriber

22. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

The prescription medication Lorazepam Con 2MG/ML, belonging to Resident #3, was present in the medication cart with documented administrations. However, a prescriber's order for this medication was not available at the home.

186a - Authorized Prescriber (continued)

The prescription medications, Prochlorper tab 10 mg and Hyoscyamine Sub 0.125mg, belonging to Resident #8, were present in the medication cart. However, prescriber's orders for these medications were not available at the home.

Plan of Correction ***Directed (- 08/16/2024)***

By 9/1/24, HCD or Designee will be re-educated on the requirement that all prescription medication for residents must be prescribed in writing by an authorized provider.

By 9/15/24, Healthcare Director or Designee will complete an audit of all resident medications and written physician orders.

Beginning 9/15/24, Healthcare Director or Designee will monitor prescriptions to ensure they are current. Expired prescriptions will be discussed with the physician to determine if they should be renewed or discontinued.

(Directed)
In addition to the above plan of corrections:

- *Written prescribers orders will be obtained for Resident #3's Lorazepam and Resident #8's Prochlorper and Hyoscyamine by the Administrator or designee, no later than 8/30/24.*
- *Beginning 9/15/24, Healthcare Director or Designee will audit all new physician's orders to ensure a written prescribers order is obtained and filed in the home.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/15/2024*

Implemented (- 11/21/2024)

186b - Medication Used by Resident

23. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 7/5/2024 at approximately 2:10PM, a Lantus Solostar 100 units/mL insulin pen with a pharmacy label with Resident #11's name was found in Resident #1's glucometer box. Staff Member J reported that the staff use the pen with Resident #11's name for Resident #1 because the pharmacy only sends insulin pens for Resident #11 and they have not sent any pens for Resident #1.

Plan of Correction ***Directed (- 08/16/2024)***

On 7/31/24, RDO to educated Medication Technicians on the regulation, to include reviewing the 7 Rights of Medication Administration to emphasize, Right Person.

Beginning 8/5/24, Healthcare Director or Designee to contact physician to request prescription for insulin for Resident #1. Order to be submitted to pharmacy to ensure Resident #1 has insulin with required pharmacy label.

186b - Medication Used by Resident (continued)

On 8/22/24, Corporate Operations Specialist will re-educate Medication Technicians on this regulation again, as part of the monthly staff meeting.

(Directed)

- *The Administrator or designee will ensure Resident #1 has the insulin pen as prescribed for Resident #1 no later than 8/30/24.*
- *Beginning 9/1/2024, the Administrator or designee will complete weekly medication cart audits to ensure medications are available as ordered by the physician.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

187a - Medication Record

24. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
7. Route of administration.
11. Special precautions, if applicable.

Description of Violation

Resident #3 is prescribed ABH gel 1/12.5/2mg/1mL - apply 1 mL topically to back of neck or wrist every 4 hours for anxiety or agitation. Resident #3's July 2024 Treatment Administration Record indicates "ABH gel 1/12.5/2 - apply 1 mL to inner wrist 4 times a day for anxiety/agitation" and does not match the route of administration as prescribed.

Resident #6 is prescribed Polymyxin B/TRIM 10,000-0.1 unit/ml-% SO - administer 1 drop into the left eye every 4 hours. Only treat while awake. Resident #6's July 2024 Medication Administration Record indicates "Instill 1 drop into left eye every 4 hours for eye infection" and does not match the route of administration as prescribed.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO to train all Medication Technicians on the 7 Rights of Medication Administration.

By 8/16/24, Corporate Operations Specialist will ensure Resident #3 MAR is updated to include the correct route of administration. Resident #6 has been discharged from the community.

A s of 9/1/24, all medication technicians will be retrained on medication administration by the new HCD. All medication technicians will be observed passing medications by the HCD or Designee at least twice in the 4th quarter of 2024.

187a - Medication Record (continued)

(Directed)
In addition to the above plan of corrections:

- *An initial audit of all resident MAR's will be completed and compared to prescribing orders to ensure the instructions on the MAR are accurate. Audit will be completed by the Administrator or designee by 8/30/24.*
- *Beginning no later than 9/1/24, a sample size of at least 25% of resident MARs will be reviewed on a monthly basis by the Administrator or designee to ensure the MAR includes correct route of administration and any special precautions, as applicable, per the physician's orders.*
- *Education will be provided to all med tech's on regulation 187(a) and ensuring physician's orders match the MAR's. Education to be provided by the Administrator or designee by 9/1/24.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

187c - Refusal of Medication

25. 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

On 6/16/2024 at 8:00AM, Resident #6 refused to take a scheduled dose of Erythromycin eye ointment and Polymyxin eye drops. The home did not report the refusal to the resident's doctor as required.

On 6/25/2024 at 8:00PM, Resident #2 refused to take a scheduled dose of Humalog Kwikpen. The home did not report the refusal to the resident's doctor as required.

Resident #5 refused to take the following scheduled doses of medication:
6/2/2024 at 8:00PM Hydroxyzine 25mg tab
6/9/2024 at 8:00AM Furosemide 40mg tab, Hydroxyzine 25mg tab, Sertraline 50mg tab
6/28/2024 at 8:00AM Furosemide 40mg tab, Hydroxyzine 25mg tab, Sertraline 50mg tab
6/30/2024 at 8:00AM Furosemide 40mg tab, Hydroxyzine 25mg tab, Sertraline 50mg tab
The home did not report these refusals to the resident's doctor as required.

Repeated Violation - 2/22/2024, et al

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/31/24, RDO began training all Medication Technicians on Resident Rights, including the Right to Refuse Medications and the proper provider notification process when a resident refuses medication.

On or by 8/5/24, RDO created a Medication Refusal Notification Form required to be sent to the prescriber when a

187c - Refusal of Medication (continued)

resident refuses medication(s) and to obtain instructions on how the provider prefers to manage future refusals by the resident. Form to be implemented by 8/12/24.

Beginning 8/12/24, Healthcare Director or Designee will conduct a weekly audit for 4 weeks to ensure all missed medications have been communicated to the prescriber as defined by the regulation.

On 8/13/24, Prescriber for Resident #2 was notified of refused scheduled does of Humalog Kwikpen.

On 8/13/24, prescriber for Resident #5 was notified of refusal to take scheduled doses of medication on 6/2/24, 6/9/24, 6/28/24, and 6/30/24.

Notification was not sent to prescriber for Resident #6 as [redacted] has been discharged from the community [redacted]

Proposed Overall Completion Date: 09/30/2024

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 11/21/2024)

187d - Follow Prescriber's Orders

26. Requirements

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

Description of Violation

Resident #1 is prescribed Novolog Flex pen inject 100/U/Ml - check BS with meals and inject according to SSI for DM: 0-200=0U, 201-250=2U, 251-300=4U, 301-350=8U, 351-400=10U
On 6/21/2024 at 4:30PM, the resident's blood sugar reading was 144. However, Resident #1 was administered 10 units.
On 6/26/2024 at 11:30AM, the resident's blood sugar reading was 243. However, Resident #1 was administered 0 units.
On 6/29/2024 at 7:30AM, the resident's blood sugar reading was 208. However, Resident #1 was administered 0 units.

Resident #1 is prescribed Glucose 40% gel contents of 1 tube by mouth if glucose less than 70. On 6/30/2024 at 8:13AM, the resident's blood sugar reading was 73. However, the resident was administered 1 tube by mouth.

Resident #5 is prescribed Hydroxyzine HCL 25mg tablet – take ½ tablet by mouth 2 times a day, Furosemide 40mg tablet – take one tablet by mouth everyday, Sertraline 50mg tablet - take 1/2 tablets =25MG by mouth at bedtime. On 7/4/2024 at 8:00AM , Resident #5 did not receive these medications as ordered as the pills were still present in the blister packs for that day and there were no notes to indicate an exception.

Resident #5 is prescribed Sertraline 50mg tablet - take 1/2 tablets =25MG by mouth at bedtime. However, the resident was administered 1 tablet as the 1/2 tablet was still present in the blister pack for 7/9/2024 and one Sertraline 50mg tablet was popped for 7/9/2024 from a discontinued blister pack that was present in the medication cart at the time

187d - Follow Prescriber's Orders (continued)

of inspection. There were no notes to indicate an exception.

Resident #6 is prescribed Vitamin B-1 100mg tablet - take one tablet by mouth every day, Omeprazole DR 20mg cap - take one capsule by mouth every day, Krill Oil 1,000mg softgel - take 2 capsules =(2000mg) by mouth every day, and Quetiapine Fumarate 25M -take one tablet by mouth every 12 hours. On 7/2/2024 and 7/4/2024, Resident #6 did not receive these medications as ordered as the pills were still in the blister pack for those days and there were no notes to indicate an exception.

Resident #6 was prescribed Nitrofurantoin Mono-MCR 100MG take one capsule by mouth two times a day for infection. As per Medication Notes documented on the June 2024 Medication Administration Record, this medication was not administered to Resident #6 on 6/19/2024 at 8:00PM because the medication was unavailable.

Resident #3 is prescribed ABH gel 1/12.5/2mg/1mL - apply 1 mL topically to back of neck or wrist every 4 hours for anxiety or agitation. As per Medication Notes documented on the June 2024 Medication Administration Record, this medication was not administered to Resident #3 on 7/4/2024 at 12:00PM nor 4:00PM because the home was awaiting arrival of the medication. The Medication Notes indicate on 7/4/2024 at 4:00PM that the medication was on hold; however, there were no prescriber hold orders available. The controlled drug record (RX45634779) shows the last administration was on 7/4/2024 at 8AM. The next administration was documented on 7/4/2024 at 8PM. There were no administrations documented on the controlled drug record for 7/4/2024 12:00PM nor 4:00PM

Repeated Violation - 2/22/2024, et al, 12/20/2023, et al

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO began to discuss the regulatory requirements with the med techs.

On 8/13/24, RDO created a reminder which was placed on each medication cart to serve as a reminder to request refills at least 7 days in advance or if mediation requires a new order, to request new order from prescriber at least 10 days in advance.

Beginning 8/19/24, Healthcare Director or Designee will conduct
weekly medication cart audits to ensue medications are available when prescribed. Refills will be requested at least 7 days in advance.

Beginning 10/1/24, Healthcare Director or Designee will complete at least 2 med administration observations of all certified medication technicians to be completed in 4th quarter of 2024.

By 9/1/24, Corporate Operations Specialist will secure outside service to conduct monthly cart audits for a period of 6 months.

(Directed)
In addition to the above plan of corrections:

- Beginning no later than 9/15/24, Healthcare Director or Designee will complete at least 2 med administration observations of certified medication technicians per week until 12/31/24.
- Beginning no later than 9/1/24, the Administrator or designee will review a sample size of at least 25%

187d - Follow Prescriber's Orders (continued)

resident MAR's each month to ensure medications are being administered per the physicians order. Review to include passing of medications as well as proper insulin administration and documentation.

- *Documentation of completed education, medication administration observations and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/15/2024*

Implemented ([redacted] - 11/21/2024)

225a - Assessment 15 Days

28. 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

Resident #1's current assessment, dated [redacted], does not include the resident's need for a wheelchair.

Resident #6's current assessment, dated [redacted] does not include the resident's need for Secure Dementia Care Unit (SDCU) nor the need for a mechanical soft diet.

Resident #12's current assessment dated [redacted] does not include the resident's need for a Hoyer lift, hospital bed and Broda chair as per the resident's medical evaluation dated [redacted] The assessment also indicates that the resident can self-administer medication, which is inaccurate as per the resident's medical evaluation dated [redacted] Staff Member K reported that all medications are administered to Resident #12 by staff.

The assessment for Resident #12, dated [redacted] indicates the resident is bedbound, unable to leave their room and therefore is not able to participate in group activities. Staff Member K reported that the resident's private duty aide utilizes a Broda chair for the resident's mobility. Staff Member K reported that the resident has a wheeled hospital bed and that they have been feeling depressed and lonely. The resident's assessment does not accurately document the resident's need nor how this need can be met.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO conducted training of all leadership team members on this regulation.

Beginning 8/5/24, Executive Director or Designee will conduct an audit of all resident assessments to ensure assessment reflects needs of the resident. Audit will be completed by 9/30/24.

Beginning 8/5/25, Healthcare Director or Designee will ensure initial assessments are conducted within 15 days of admission, reviewed by designated Clinical Director or Executive Director for completeness and accuracy.

Assessment and RASP's to be updated and completed by Healthcare Director or Designee for Resident #1 and Resident #2 by 8/30/24; Resident #6 was physically moved on [redacted].

(Directed)

225a - Assessment 15 Days (continued)

In addition to the above plan of corrections:

- *Beginning 8/5/24, Executive Director or Designee will conduct an audit of all resident assessments to ensure assessment reflects needs of the resident. Audit will be completed by 8/30/24.*
- *Assessment and RASP's to be updated and completed by Healthcare Director or Designee for Resident #1 and Resident #12 by 8/30/24; Resident #6 was physically moved out on* [redacted]
- *Beginning no later than 9/15/24, quarterly audits on resident assessments will be completed by the Administrator or designee to ensure assessments continue to have correct information for each resident's need.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/15/2024*

Implemented ([redacted] - 11/21/2024)

227d - Support Plan Medical/Dental

29. 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 #12, dated [redacted]*, indicates the resident requires total physical assistance from staff to evacuate the residence or to request emergency assistance, requires total physical assistance from staff to transfer in/out of a bed/chair, requires total physical assistance from staff to ambulate and has a need for coping with irritability and agitation. Resident #12's support plan, which is not dated, does not document how these needs will be met.*

Repeated Violation - 2/22/2024, et al, 12/20/2023, et al

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/31/24, RDO conducted training of all leadership team members on the regulation.

Beginning 8/5/24, Executive Director or Designee will conduct an audit of all RASP's to ensure assessment reflects the needs of the resident and provide documentation as to how the resident needs will be met. Healthcare Director or Designee will conduct a new assessment and RASP for Resident #12 by 8/30/24.

Beginning 8/12/24, Healthcare Director or Designee will review all initial/annual medical evaluations to ensure that the assessment and support plan addresses and meets the residents needs.

Proposed Overall Completion Date: 08/30/2024

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented ([redacted] - 11/21/2024)

227g -Support Plan Signatures

30. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #7 participated in the development of the support plan on [redacted]. The resident did not sign the support plan, nor did the home make a notation regarding the resident's inability or refusal to sign.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO conducted training of leadership team members regarding this regulation.

Beginning 8/5/24, Executive Director or Designee will conduct an audit of all RASP's to ensure support plan has been reviewed with and signed by creator, resident and responsible parties.

Beginning 8/12/24, Healthcare Director or Designee will schedule care plan meetings with residents and responsible parties to review support plans and obtain feedback and signatures.

Resident #7 has a physical move out date of [redacted]

(Directed)
In addition to the above plan of correction:

- *Beginning 9/1/24, quarterly audits of resident assessment and support plans will be completed by the Administrator or designee to ensure proper signatures have been obtained.*
- *Beginning 8/5/24, Executive Director or Designee will conduct an initial audit of all RASP's to ensure support plan has been reviewed with and signed by creator, resident and responsible parties. Initial audit to be completed by 8/30/24.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/30/2024*

Implemented ([redacted] - 11/21/2024)

227i - Support Plan Accessible

31. Requirements

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 7/3/2024, Staff Member M reported that they had never seen a resident assessment and support plan and did not know where they were located. On 7/9/2024, Staff Member I reported that only Med Techs have access to resident assessment and support plans.

Plan of Correction ***Accept ([redacted] - 08/06/2024)***

Immediate:

227i - Support Plan Accessible (continued)

On 7/31/24, RDO conducted training of all direct care staff and leadership team members regarding location of and access of resident support plans.
Ongoing:
Beginning 8/5/24, Executive Director or Designee will have keys made to secured areas to allow direct care staff access to support plans during scheduled hours to support resident care.

Licensee's Proposed Overall Completion Date: *09/16/2024*

Implemented (- 11/21/2024)

231f - Assessed Annually

32. 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 #3 was last assessed for the need for Secure Dementia Care Unit (SDCU) on ; as of 7/3/2024, this assessment has not been reviewed.

Repeated Violation 12/20/2023, et al

Plan of Correction ***Accept (- 08/16/2024)***

On 7/31/24, RDO education leadership team members on this regulation.

Beginning 8/5/24, Executive Director or Designee will conduct an audit of al SDCU resident files to ensure assessment has been completed for the continuing need for residency in SDCU. The need for a resident's continued residency in the SDCU will be evaluated during the annual assessment. The nursing team will use the electronic health record dashboard to monitor due dates for annual assessments.

On 8/5/24, RDO requested a new assessment by physician of Resident #3 to ensure continued need for residency in SDCU.

Beginning 8/12/24, Healthcare Director or Designee will review all initial/annual/significant change evaluations to ensure residents are assessed and appropriate for residency in SDCU.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented (- 11/21/2024)

233c - Key-Locking Devices

33. 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 exit door from the gated Secure Dementia Care Unit (SDCU) patio area.

233c - Key-Locking Devices (continued)

Repeated Violation - 2/22/2024, et al

Plan of Correction ***Accept ([redacted] - 08/15/2024)***

On 7/9/24, RDO conducted a review of all electronic systems to ensure directions for operation are conspicuously posted near device. RDO posted access code near the exit door from the gated SDCU patio area.

Beginning 8/5/24, Executive Director or Designee will conduct weekly audit, for a period of 8 weeks, to ensure access codes are conspicuously located at all access points of SCDU.

Beginning 8/12/24, Corporate Operations Specialist will conduct training will all staff regarding this regulation. Training will be completed by 8/30/24.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented ([redacted] - 11/21/2024)

234b - Support Plan Needs Elements

34. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #3's current assessment and support plan was completed on [redacted] and does not provide how the home will meet the service needs within the resident's support plan. Resident #3 was observed during the inspection to utilize a high-back wheelchair and require full staff assistance to ambulate. The resident's assessment indicates moderate problem with ambulating but does not include the use of the wheelchair under the plan to meet the service need. The assessment states the resident has moderate problem with irritability and agitation. However, the support plan does not include the support the home's plan to meet these service needs and states "personalize". The resident's assessment in the area of judgment indicates moderate problem and "frequent poor judgment issues". The plan to meet the service need states "resident may resist care often. Needs protection and supervision because participate makes unsafe or inappropriate decisions. May have behavior management plan in place." How the home will meet this service need is not indicated on the support plan.

Repeated Violation - 7/20/2023

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

On 7/31/24, RDO conducted training of all leadership team members on this regulation.

Beginning 8/5/24, Executive Director or Designee will conduct an audit of all RASP's to ensure assessments reflects needs of the resident and provides documentation as to how the resident needs will be met.

By 8/30/24, Healthcare Director or Designee will conduct a new assessment and RASP for Resident #3.

(Directed)
In addition to the above plan of correction:

- *Beginning 8/5/24, Executive Director or Designee will conduct an audit of all RASP's to ensure assessments*

234b - Support Plan Needs Elements (continued)

reflects needs of the resident and provides documentation as to how the resident needs will be met. Initial audit to be completed by 8/30/24.

- *Beginning no later than 9/1/24, quarterly reviews of resident assessment and supports will be completed by the Administrator or designee to ensure the assessment appropriately reflects the residents needs and supports to be provided by the home.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

252 - Record Content

35. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #1's record does not include identifying marks.

Plan of Correction ***Directed ([redacted] - 08/16/2024)***

Beginning 8/5/24 and ongoing, Healthcare Director or Designee will ensure all resident assessments will include identifying marks as part of the assessment (initial and future).

On 7/31/24, RDO conducted training on this regulation with all leadership team members.

By 8/30/24,Healthcare Director or Designee will conduct a review of Resident #1's RASP will be updated with resident identifying marks.

(Directed)

- *On 7/31/24, RDO conducted training on this regulation with all leadership team members.*
- *Beginning 8/5/24, Healthcare Director or Designee will complete an initial audit on all resident records to ensure the record includes identifying marks. Audit to be completed by 8/30/24.*
- *By 8/30/24,Healthcare Director or Designee will conduct a review of Resident #1's RASP will be updated with resident identifying marks.*
- *Beginning 9/1/24, the Administrator or designee will review new admission records within 1 week of resident's move in date to ensure the resident's record contains required information per 2600.252.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 11/21/2024)

254a - Records Discharge/Active

36. Requirements

2600.

254a - Records Discharge/Active *(continued)*

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

Description of Violation

On 7/2/2024, resident records including Medication Administration Records, notes regarding podiatry visits, and lists of resident care needs were unlocked, unattended, and accessible in the 2nd floor nursing area.

On 7/2/2024, resident records including pharmacy receipts and staff communication books with resident-specific information pertaining to ADL assistance and behavior were unlocked, unattended, and accessible in the 3rd floor nursing area.

On 7/2/2024, resident records including staff communication books with resident-specific information pertaining to ADL assistance and behavior and audits of various resident charts which documented medications and PRNs were unlocked, unattended, and accessible in the 4th floor nursing area.

Repeated Violation - 12/20/2023, et al

Plan of Correction ***Accept ([redacted] - 08/15/2024)***

On 7/31/24, RDO conducted training with all associates regarding confidentiality of resident information and HIPAA.

Beginning 8/5/24, Executive Director or Designee will provide a secured locking system to ensure all resident records are secured, but accessible by staff. To be implemented by 8/30/24.

By 8/30/24, Healthcare Director or Designee will conduct an initial audit to ensure confidentiality of resident information and HIPAA.

Beginning 9/1/24, Healthcare Director or Designee will conduct a weekly audit for a period of 8 weeks to ensure all records to secured to prevent unauthorized access.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented ([redacted] - 11/21/2024)

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

November 21, 2024

[redacted], REGIONAL DIRECTOR OF OPERATIONS
HAMPDEN OPERATIONS LLC
[redacted]

RE: HARMONY AT WEST SHORE
1910 TECHNOLOGY PARKWAY
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33381

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/01/2024, 10/02/2024 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 AT WEST SHORE* **License #**: *33381* **License Expiration**: *09/26/2024*

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**: *89* **Waking Staff**: *67*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date**: *10/02/2024*

Inspection Dates and Department Representative

10/01/2024 - On-Site: [redacted]

10/02/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *63*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Harmony Square* **Capacity**: *35* **Residents Served**: *18*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *26* **Have Physical Disability**: *1*

Inspections / Reviews

10/01/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/26/2024*

10/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/20/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2024*

Inspections / Reviews *(continued)*

11/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/20/2024*

11/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

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 [redacted] Resident #1 passed away expectedly in the home. However, this reportable incident was not reported to the Department until [redacted]

Repeated Violation - 12/20/23, et al.

Plan of Correction ***Directed ([redacted] - 11/04/2024)***

On 10/21/24 the Executive Director educated the Health Care Director (HCD) and new Assistant Health Care Director on the Suspected Abuse policy.

On 10/31/24 the Executive Director will educate all staff on the Suspected Abuse policy and regulation 2600.16c at the All staff Meeting. The Executive Director will be responsible for ensuring that the Suspected Abuse (Associate to Resident) policy is implemented and compliance is maintained. ED or Designee will review the policy annually for updates. In addition, the Executive Director will create a log of all reportable occurrences.

(Directed)
In addition to the above plan of corrections:

- *Beginning no later than 11/10/24, the Administrator or designee will review and discuss any incidents that have occurred the day prior to determine if a Reportable is required to be sent to the Department. The Administrator will then audit the Reportable sent to the Department or complete any necessary follow-up notifications.*
- *Documentation of reviews, audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *11/10/2024*

Implemented ([redacted] - 11/21/2024)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 10/1/2024 at 11:10AM, resident records were unlocked, unattended, and accessible via a laptop sitting on top of a medication cart by the SDCU entrance.

On 10/01/2024 at 11:13AM, the folder-style clip board was unsecured, unattended, and accessible on the 3rd floor med cart and contained various resident documents including:

17 - Record Confidentiality (continued)

- Resident #7 had a change in their sensor.
- Physician's order request note asking for medication order for Resident #5 to help with anxiety.
- Pharmacy orders for Acetaminophen for Resident #8.
- Pharmacy orders for Diclofenac for Resident #9.
Resident records including staff communication books with resident-specific information pertaining to ADL assistance and behavior and audits of various resident charts which documented medications and PRNs were also unlocked, unattended, and accessible in the 3rd floor nursing area.

On 10/01/2024 at 11:24AM, a folder-style clipboard was observed to be unsecured, unattended, and accessible at the 4th floor med cart and contained various resident documents including blood sugar readings for Resident #10. Resident records including staff communication books with resident-specific information pertaining to ADL assistance and medication administration needs were unlocked, unattended, and accessible in the 4th floor nursing area.

Plan of Correction ***Directed (- 11/04/2024)***

The Executive Director (ED) or Designee secured the clipboard on the 4th floor med cart 10/1/24. All nursing stations were reviewed to ensure resident specific information was secured as well.

The Executive Director (ED) will educate all staff members on the resident's rights to confidentiality and the potential for HIPPA violations at the all staff meeting 10/31/24.

The Health Care Director (HCD) or designee will conduct audits of the nursing stations to ensure resident records are securely locked inaccessible to anyone other than facility associates. Weekly audits will be completed for an 8-week duration.

(Directed)
In addition to the above plan of corrections:

- *Weekly audits will begin 10/28/24.*
- *Documentation of completed audits and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *11/04/2024*

Implemented (- 11/21/2024)

51 - Criminal Background Check

3. Requirements

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

51 - Criminal Background Check *(continued)*

Description of Violation

Staff Member A was hired on [redacted]; however, a Pennsylvania State Police Criminal Background Check was not obtained for Staff Member A until [redacted]

Staff Member B was hired on [redacted] however, a Pennsylvania State Police Criminal Background Check was not obtained for Staff Member B until [redacted].

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

On 10/21/24 the Executive Director (ED) educated Leadership Team members on the requirement for criminal background checks to obtained in accordance with OAPSA regulations. The Business Office Manager (BOM) will conduct an audit of all employee files to determine compliance. The audit will be completed by 11/7/24.

Beginning 10/28/24 the Executive Director or Designee will conduct weekly audits of newly hired associates to verify the completion of the criminal background check according to OAPSA. Audits will be completed for 8 weeks.

Licensee's Proposed Overall Completion Date: *11/07/2024*

Implemented ([redacted] - 11/21/2024)

101j7 - Lighting/Operable Lamp

4. 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 10/01/2024 at 11:02AM, Resident #2 did not have access to a source of light within reach that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 10/28/2024)***

On 10/1/24 the facility Maintenance Director placed a push light that is accessible to Resident #2's bed.

On 10/31/24 the Executive Director (ED) or Designee will educate all Leadership Team members on the regulation regarding the requirement for all residents to have an operable lamp or source of lighting that can be operated at bedside.

The Harmony Square Director will conduct weekly audits starting 10/28/24 of operable lamps or sources of lights and will be reported to the Executive Director for verification. Audits will be completed for 8 weeks

Licensee's Proposed Overall Completion Date: *12/30/2024*

Implemented ([redacted] - 11/21/2024)

141a 1-10 Medical Evaluation Information

5. 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 #3's initial medical evaluation, dated [redacted] did not include the resident's blood pressure, temperature, pulse rate, nor a mobility needs assessment.

Plan of Correction ***Directed ([redacted] - 11/04/2024)***

On 10/2/24 Resident #3's evaluation has been updated to include the resident's blood pressure, temperature, pulse rate and mobility needs assessment by the Health Care Director (HCD). An initial audit of resident DME's will be completed the week of 10/28/24.

On 10/31/24 the Health Care Director (HCD) or designee will educate staff on proper completion of the Medical Evaluation. New DMR's will be audited weekly for 8 weeks to ensure proper completion and accuracy of the of the DME.

(Directed)
In addition to the above plan of corrections:
- *New DME's will be audited weekly for 8 weeks by the Administrator or designee beginning 11/10/24.*
- *Documentation of completed audits and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *11/10/2024*

Implemented ([redacted] - 11/21/2024)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

As of 10/1/2024, Resident #4's most recent medical evaluation was completed [redacted]

Plan of Correction ***Accept ([redacted] - 10/28/2024)***

On 10/21/24 the Executive Director (ED) completed a review of each resident's annual medical evaluation for

141b1 - Annual Medical Evaluation (continued)

compliance and accuracy. Any out of compliance will be updated.

On 10/31/24 the Health Care Director (HCD) or designee will provide training for the leadership team and all staff on the requirement of residents having a complete and thorough medical evaluation at least annually. Resident #4's medical evaluation will be updated to meet compliance standards.

The Health Care Director (HCD) or designee will conduct an 8 week facility audit of all resident evaluations beginning 10/28/24 to determine status of most recent evaluation. A tracking sheet will be implemented to maintain proper compliance of evaluations being completed at least annually. Any evaluation found to be out of compliance will be properly updated and recorded on the tracking sheet.

Licensee's Proposed Overall Completion Date: *12/30/2024*

Implemented ([redacted] - 11/21/2024)

183e - Storing Medications

7. 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 10/2/2024 at approximately 10:55AM, a white, round pill was observed to be loose in the SDCU medication cart.

On 10/2/2024 at approximately 11:35AM, a white, oblong pill was observed to be loose in the 3rd floor medication cart.

Repeated Violation - 4/17/2024, 2/22/2024, et al., 12/20/2023, et al.

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

On 10/2/24 the pills found in the carts were properly discarded by the Health Care Director in accordance with standard operating procedures for discarding of medications.

On 10/31/24 the Health Care Director (HCD) or designee will educate the facility Med Techs on the proper storage of prescription medications, OTC's and CAM. In addition, the HCD or designee will provide quarterly education for all Med Techs on proper storage of prescription medications, OTC's and CAM. The Cart audits will be completed on a weekly basis on each cart to ensure proper storage and organization of the medications. The HCD or designee will begin auditing 10/28/24 and will be completed for 8 weeks.

Licensee's Proposed Overall Completion Date: *11/04/2024*

Implemented ([redacted] - 11/21/2024)

185a - Implement Storage Procedures

8. Requirements

185a - Implement Storage Procedures *(continued)*

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 #3 is prescribed Bisacodyl 10mg insert 1 suppository rectally PRN for constipation. On 10/2/2024 at approximately 10:50AM, this medication was not available in the home.

Resident #5 is prescribed glucose checks four times daily before meals and at bedtime. The blood glucose checks on glucometer used for the resident did not match the numbers transcribed on the medication administration record including the following:
Glucometer reading on 9/29/2024 at 9:24PM was 151 – the number documented in the MAR on 9/29/2024 at 8:00PM reads blood glucose is 192.
Glucometer reading on 9/29/2024 at 9:06AM was 274 - the number documented in the MAR on 9/28/2024 at 7:30AM reads blood glucose is 97.
Glucometer reading on 9/28/2024 at 7:50PM was 304 - the number documented in the MAR on 9/28/2024 at 8:00PM reads blood glucose is 167.

Repeated Violation - 12/20/2023, et al.

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

On 10/2/24 Health Care Director (HCD) updated Resident #3 prescription and dispensed so medication was available when needed. In addition, the HCD or designee will complete an audit of all medication in house to ensure medications are available as ordered. The audit will be completed by 11/8/24.
Facility staff will be educated by Health Care Director (HCD) on 10/31/24 on the proper procedure of ordering medication, glucometer reading and results documentation.
On 10/28/24 the Health Care Director (HCD) or designee will complete weekly audits to ensure completion, proper storage, accuracy of resident's glucometers and available medications. Audits will be completed for 8 weeks.

Licensee's Proposed Overall Completion Date: *11/08/2024*

Implemented ([redacted] - 11/21/2024)

187c - Refusal of Medication

9. 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

On 9/13/2024 and 9/29/2024 at 8:00AM, Resident #4 refused to take scheduled doses of Clonidine HCL 0.1mg tablet, Ferrous Sulfate EC 325mg tablet, Furosemide 40mg tablet, Glimepiride 2mg tablet, Guaifenesin ER 600mg tablet, Sertraline HCL 100mg tablet, and Vitamin B-12 500mcg tablet. The home did not report the refusals to the prescriber.

Repeated Violation - 2/22/2024, et al.

187c - Refusal of Medication (continued)

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

On 10/2/24 the Health Care Director (HCD) or designee notified the physician of the medication refusals of during survey.

On 10/28/24 the Health Care Director (HCD) or designee educated the facility staff to the proper procedure of documenting the refusal of medication. On 10/28/24 he Health Care Director or designee will complete education on the proper reporting of medication refusals.

Starting on the 10/28/24 the Health Care Director (HCD) or designee will complete weekly random audits of medication refusals and notification of the physician of such an occurrence. The weekly audits will be completed for 8 weeks.

Licensee's Proposed Overall Completion Date: *11/04/2024*

Implemented ([redacted] - 11/21/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident #6 has a physician's order to receive Alprazolam 0.25mg take 1 tablet by mouth three times a day. Resident #6 did not did not receive this medication as ordered 9/24/2024-9/28/2024 at 8:00PM.

Resident #3 has physician's orders to receive Eliquis 2.5mg take 1 tablet by mouth every 12 hours, Quetiapine Fumarate 25mg take ½ tablet by mouth every 12 hours, Simvastatin 20mg take 1 tablet by mouth at bedtime, and Thera Tablet take 1 tablet by mouth daily.
Resident #3 did not receive Eliquis, Quetiapine Fumarate and Simvastatin as ordered on 9/26/2024 at 8:00PM as the medication was not available in the home and was "awaiting on pharmacy".
Resident #3 did not receive Quetiapine Fumarate and Thera tablet as ordered on 9/29/2024 at 8:00AM as the medication was "not on hand awaiting pharmacy".
Resident #3 did not receive Eliquis, Quetiapine Fumarate and Simvastatin on 9/30/2024 as the medication was not available in the home and was "awaiting on pharmacy arrival".
On 10/2/2024 at approximately 10:45AM, the medications were also not available in in the home.

On 7/29/2024, Resident #4 was prescribed Cefuroxime 500mg take 1 tablet by mouth twice a day for 7 days. However, Resident #4 did not receive Cefuroxime as ordered until 8/6/2024.

Repeated Violation - 2/22/2024 et al., 12/20/2023, et al.

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Accept (- 11/04/2024)***

The Health Care Director (HCD) on 10/2/24 Residents #3 and #6 physician orders were updated and clarified by physician orders. Staff was educated on the proper procedure to following a physician order. Starting 11/4/24 new physician orders will be reviewed daily for completion and delivery of medications.

Beginning 10/28/24 the Health Care Director (HCD) or designee will complete at least 2 med administration observations of all certified med techs and weekly medication cart audits will be performed to ensure medications are available all residents in accordance with the physician orders.

Audits will be completed for 8 weeks and reviewed for future educational and training purposes.

Licensee's Proposed Overall Completion Date: *11/04/2024*

Implemented (- 11/21/2024)

231b - Medical Evaluation

11. 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 #3 was admitted to the Secure Dementia Care Unit on 9/23/2024; however, the resident's medical evaluation, completed on 9/16/2024, did not include need for the resident to be served in a secured dementia care unit.

Plan of Correction ***Directed (- 11/04/2024)***

Resident #3 and #5's written cognitive preadmission screening was completed by the Health Care Director (HCD) on 10/3/24.

On 10/31/24 Facility staff will be educated on the proper completion of the written cognitive preadmission screening by the Health Care Director (HCD).
Beginning 10/28/24 the Health Care Director (HCD) or designee will audit of all new written cognitive preadmission screening to ensure completion and accuracy. The weekly audits will be completed for 8 weeks and be reviewed for future educational and training purposes

(Directed)

- *Resident #3's medical evaluation will be properly completed by 11/10/24 by the Administrator or designee and the resident's physician.*
- *An initial audit of all current resident medical evaluations, for those residing in the SDCU, will be reviewed by the Administrator or designee by 11/15/24 to ensure the medical evaluations include a diagnosis of Alzheimer's or other dementia and the need for the resident to be served in the SDCU.*
- *By 11/15/24, education will be provided to staff member's responsible for medication evaluations on regulation 2600.231(b) by the Administrator.*

231b - Medical Evaluation (continued)

- *Beginning no later than 11/10/24, any medical evaluations completed for a new admission to the SDCU will be audited for proper completion by the Administrator or desginee.*
- *Documentation of completed initial audits, staff education and on-going audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *11/15/2024*

Implemented ([redacted] - 11/21/2024)

231c - Preadmission Screening

12. 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 #5 was admitted to the Secure Dementia Care Unit on 9/26/2024. However, as of 10/2/2024, the resident has not had a written cognitive preadmission screening completed.

Resident #3 was admitted to the Secure Dementia Care Unit on 9/23/2024 as confirmed by Staff Members C and D. However, the resident 3's written cognitive preadmission screening was completed on 9/18/2024.

Plan of Correction ***Directed ([redacted] - 11/04/2024)***

Resident #6's Admission Support Plan was updated by the Health Care Director (HCD) on 10/3/24.

On 10/31/24 the Health Care Director (HCD) will educate the facility leadership team on the importance of completing the support plan within the 72 hours prior or 72 hours post admission of a resident.

Beginning 10.28.24 the Executive Director (ED) or designee will complete weekly audits of all admission support plans to ensure completion and accuracy. The audits will be completed for 8 weeks.

(Directed)

- *Resident #5 will have a cognitive preadmission screening completed by 11/10/24 by the Administrator or designee.*
- *An audit of all resident cognitive preadmission screenings will be completed by 11/15/24 by the Administrator or designee to ensure one has been completed.*
- *Education will be provided to all staff member's responsible for completing cognitive preadmission screenings by 11/10/24 by the Administrator or designee.*
- *Beginning no later than 11/10/24, the Administrator or designee will review all new admissions to the SDCU to ensure a written cognitive preadmission screening has been completed thoroughly and timely.*

231c - Preadmission Screening (continued)

- *Documentation of initial audits, staff education and continued audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *11/15/2024*

Implemented (- 11/21/2024)

234a - Admission Support Plan

13. 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 #6 was admitted to the Secure Dementia Care Unit (SDCU) on 9/26/24. However, the resident's initial assessment and support plan was completed on 9/10/24.

Plan of Correction ***Accept (- 10/28/2024)***

Resident #6's Admission Support Plan was updated by the Health Care Director (HCD) on 10/3/24.

On 10/31/24 the Health Care Director (HCD) will educate the facility leadership team on the importance of completing the support plan within the 72 hours prior or 72 hours post admission of a resident.

Beginning 10.28.24 the Executive Director (ED) or designee will complete weekly audits of all admission support plans to ensure completion and accuracy. The audits will be completed for 8 weeks.

Licensee's Proposed Overall Completion Date: *12/30/2024*

Implemented (- 11/21/2024)

Department of Human Services
Bureau of Human Service Licensing
PRIVACY CODING

Facility Information

Name: *HARMONY AT WEST SHORE* **License #**: *33381* **License Expiration**: *09/26/2024*
Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*

Inspection Information

Start Date: *10/01/2024* **Type**: *Partial*

Staff Privacy Coding

Designation	Staff Members Name	Job Title	Date Hired
Staff Member A	*Aleanah Cruz*	*Dietary Aide*	*08/21/2024*
Staff Member B	*Ava Aquallo*	*Dietary Aide*	*08/21/2024*
Staff Member C	*Stephanie Wolfley*	*Acting Healthcare Director*	*08/19/2024*
Staff Member D	*Robert Musser*	*Executive Director*	*08/12/2024*

Resident Privacy Coding

Designation	Resident's Name	Date of Death
Resident 1	*Kennard Bowman*	*09/16/2024*
Resident 2	*Charles Schaeffer*	
Resident 3	*Gay Bomgardner*	
Resident 4	*Carol Armstrong*	
Resident 5	*Jay Magee*	
Resident 6	*James Schally*	
Resident 7	*Nancy Ford*	
Resident 8	*Linda Rodgers*	
Resident 9	*Patricia Agnew*	
Resident 10	*Walter Dubas*	