pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

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

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

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

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

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

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

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

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

and shall remain in effect from **September 19, 2024** until **September 19, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **453220**

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: September 19, 2024

[redacted]
Fox Chapel Operations LLC
[redacted]

RE: Harmony at Harts Run
3450 Harts Run Road
Glenshaw, Pennsylvania 15116
License #: 453220

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on April 29th, 2024, April 30th, 2024, July 22nd, 2024, and July 23rd, 2024 and the corrections you have made after our inspections, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Facility Information

Name: *HARMONY AT HARTS RUN* **License #:** *45322* **License Expiration:** *08/15/2024*

Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name [redacted]

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*

Addr [redacted]

Phon

Certificate(s) of Occupancy

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

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *04/30/2024*

Inspection Dates and Department Representative

04/29/2024 - On-Site: [redacted]

04/30/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* **Residents Served:** *82*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st floor Memory Care* **Capacity:** *40* **Residents Served:** *17*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *82*

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

Have Mobility Need: *35* **Have Physical Disability:** *2*

Inspections / Reviews

04/29/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/07/2024*

06/10/2024 - POC Submission

Submitte [redacted] **Date Submitted:** *06/26/2024*

Reviewer **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/17/2024*

Inspections / Reviews *(continued)*

06/13/2024 - POC Submission

Submitted [redacted] **Date Submitted**: *06/26/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/26/2024*

09/11/2024 - Document Submission

Submitte [redacted] **Date Submitted**: *06/26/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The Licensing Inspection Summaries (LIS) posted on the bulletin board on the first floor near the elevators did not include the most recent full renewal LIS completed 9/27/23.

Plan of Correction ***Accept [redacted] 06/10/2024)***

LIS was immediately posted on 4/30/24 by ED. ED and Leadership Team will review 2600.3.c regulation by 6/4/24. Signatures will be obtained, and documentation will be kept. ED purchased a glass enclosed locked display board and all regulatory items that need posted will be placed in this board behind locked doors. ED will conduct a weekly audit to ensure compliance for 6 months. This will begin on 6/3/24, signature will be obtained, and documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/04/2024*

Implemented [redacted] 09/11/2024)

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 4/27/24 at approximately 8:10 a.m., staff person A, a cook, came into the dining room and shouted across the dining room to resident #1 and asked if [redacted] was going to eat [redacted] egg whites to which resident #1 replied "Well, yes." Staff person A then shouted, "Are you sure?" to which resident #1 replied "Yes, I always eat my breakfast." Staff person A replied "Well, you didn't two days ago, and I don't appreciate it. So, from now on, you're going to be asked every day."
Resident #1 expressed that [redacted] felt embarrassed, humiliated, attacked, and berated by this incident and reported it to staff person B, the manager on duty for the weekend, on 4/27/24 at approximately 8:30 a.m. Then on 4/28/24, resident #1 reported to staff person B that she was the second person to order breakfast and approximately 12 other residents' breakfasts came out which made her feel like she was being sabotaged/singled out. The home did not report the 4/27/24 incident to the local Area Agency on Aging/Protective Services until 4/29/24 at 2:00 p.m.

Plan of Correction ***Accept ([redacted] 06/10/2024)***

ED was not notified of the incident until 4/29/24. Staff person A was suspended on [redacted] 24, by ED and Dining Services Director. DHS and Area Agency on Aging was notified on 4/29/24, by ED. Abuse Mandatory Reporting Form was completed and sent to Area Agency on Aging on 4/30/24, by ED. On 5/22/24, ED sent final report to DHS stating that ED heard from Area Agency on Aging and that they did not find the Allegation of Abuse founded. All documentation has been kept. On 5/15/24, The Leadership Team received training on 2600.15.a thru d, 2600.15.a thru d, 2600.41.a thru e, and 2600.42.a thru q. Signatures were obtained, and documentation was kept. All staff received Abuse training on 5/23/24. Signatures were obtained, and documentation has been kept. The Ombudsman is giving an In-service by 6/20/24 on Abuse and Resident Rights. Signatures will be obtained, and documentation

15a - Resident Abuse Report (continued)

will be kept. ED will add possible alleged abuse incidents/reporting requirements on weekend MOD reports and also review at morning meeting Monday thru Friday. This will begin on 6/1/24 and continue for 6 months. Signatures will be obtained, and documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.15.a and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *06/25/2024*

Implemented [redacted] 09/11/2024)

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 4/27/24 at approximately 8:10 a.m., staff person A, a cook, came into the dining room and shouted across the dining room to resident #1 and asked if [redacted] was going to eat [redacted] egg whites to which resident #1 replied "Well, yes." Staff person A then shouted, "Are you sure?" to which resident #1 replied "Yes, I always eat my breakfast." Staff person A replied "Well, you didn't two days ago, and I don't appreciate it. So, from now on, you're going to be asked every day."
Resident #1 expressed that [redacted] felt embarrassed, humiliated, attacked, and berated by this incident and reported it to staff person B, the manager on duty for the weekend, on 4/27/24 at approximately 8:30 a.m. Then on 4/28/24, resident #1 reported to staff person B that [redacted] was the second person to order breakfast and approximately 12 other residents' breakfasts came out which made [redacted] feel like [redacted] was being sabotaged/singled out. Staff person A continued working [redacted] shift on 4/27/24 and returned to work [redacted] shift on 4/28/24. Staff person A was not suspended until 4/29/24. A plan of supervision of staff person A was not submitted to the Department.

Plan of Correction ***Accept [redacted] 06/10/2024)***

ED was not notified of the incident until 4/29/24. Staff person A was then immediately suspended on 4/29/24, by ED and Dining Services Director. DHS and Area Agency on Aging was notified on 4/29/24, by ED. Abuse Mandatory Reporting Form was completed and sent to Area Agency on Aging on 4/30/24, by ED. On 5/22/24, ED sent final report to DHS stating that ED heard from Area Agency on Aging and that they did not find the Allegation of Abuse founded. All documentation has been kept. On 5/15/24, The Leadership Team received training on 2600.15.a thru d, 2600.15.a thru d, 2600.41.a thru e, and 2600.42.a thru q. Signatures were obtained, and documentation was kept. All staff received Abuse training on 5/23/24. Signatures were obtained, and documentation has been kept. The Ombudsman is giving an In-service to all Staff by 6/20/24 on Abuse and Resident Rights. Signatures will be obtained, and documentation will be kept. Staff person A returned to work on 5/28/24, after the allegation was unfounded by Area Agency on Aging on 5/22/24. Before being allowed to return to [redacted] duties, Staff person A received education on Resident Rights, Basic Principles of Communication, and Preventing, Recognizing and Reporting Abuse. Signature was obtained and documentation was kept. ED will add possible alleged abuse incidents/reporting requirements on weekend MOD reports and also review at morning meeting Monday thru Friday. This will begin on 6/1/24 and continue for 6 months. Signatures will be obtained, and documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.15.b and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *06/25/2024*

Implemented [redacted] 09/11/2024)

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 4/27/24 at approximately 8:10 a.m., staff person A, a cook, came into the dining room and shouted across the dining room to resident #1 and asked if she was going to eat [redacted]gg whites to which resident #1 replied "Well, yes." Staff person A then shouted, "Are you sure?" to which resident #1 replied "Yes, I always eat my breakfast." Staff person A replied "Well, you didn't two days ago, and I don't appreciate it. So, from now on, you're going to be asked every day." Resident #1 expressed tha[redacted]felt embarrassed, humiliated, attacked, and berated by this incident and reported it to staff person B, the manager on duty for the weekend, on 4/27/24 at approximately 8:30 a.m. Then on 4/28/24, resident #1 reported to staff person B that [redacted]was the second person to order breakfast and approximately 12 other residents' breakfasts came out which made [redacted]el like [redacted]was being sabotaged/singled out. The home did not report the 4/27/24 incident to the Department until 4/29/24 at 3:07 p.m.

Repeat Violation 9/27/23 et al.

Plan of Correction ***Accept [redacted] 06/10/2024)***

ED was not notified of the incident until 4/29/24. Staff person A was then immediately suspended on [redacted]24, by ED and Dining Services Director. DHS and Area Agency on Aging was notified on 4/29/24, by ED. Abuse Mandatory Reporting Form was completed and sent to Area Agency on Aging on 4/30/24, by ED. On 5/22/24, ED sent final report to DHS stating that ED heard from Area Agency on Aging and that they did not find the Allegation of Abuse founded. All documentation has been kept. On 5/15/24, The Leadership Team received training on 2600.15.a thru d, 2600.15.a thru d, 2600.41.a thru e, and 2600.42.a thru q. Signatures were obtained, and documentation was kept. All staff received Abuse training on 5/23/24. Signatures were obtained, and documentation has been kept. The Ombudsman is giving an In-service to all Staff by 6/20/24 on Abuse and Resident Rights. Signatures will be obtained, and documentation will be kept. Staff person A returned to work on 5/28/24, after the allegation was unfounded by Area Agency on Aging on 5/22/24. Before being allowed to return to [redacted]duties, Staff person A received education on Resident Rights, Basic Principles of Communication, and Preventing, Recognizing and Reporting Abuse. Signature was obtained and documentation was kept. ED will add possible alleged abuse incidents/reporting requirements on weekend MOD reports and also review at morning meeting Monday thru Friday. This will begin on 6/1/24 and continue for 6 months. Signatures will be obtained, and documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.16.c for 6 months and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *06/25/2024*

Implemented [redacted]- 09/11/2024)

17 - Record Confidentiality

5. 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.

17 - Record Confidentiality *(continued)*

Description of Violation

On 4/29/24 at 11:49 a.m., there was a blue binder labeled "Shift Reports/Care Cards" setting on the unattended, accessible desk in the home's Memory Care nurse's station that contained personal information about residents to include:
4/23/24 – resident #2 - "has a broken tail bone, in lots of pain, stitches removed"
4/28/24 – resident #3 - "fell in bathroom ; no injuries reported"
4/29/24 - Resident #2 – [redacted] little confused but doing okay"; resident #11 - "hospice showered [redacted] aundry done"; resident #12 - "[staff name] helped [redacted] get cleaned this morning."

On 4/29/24 at 12:20 p.m., the unattended Health Care Director's office door was wide open at the second-floor nurse's station. There was an incident report setting on top of the director's desk for resident #4 regarding the resident being found on bedroom floor yelling for help with hematoma on left side of head and complaining of left hip pain. There were also numerous medications setting on a two-drawer lateral filing cabinet with pharmacy labels for resident #5 to include Atorvastatin 20mg, Diltiazem HCL ER 120 mg; Pantoprazole Sod DR 40mg; and Olanzapine 10mg.

Plan of Correction ***Accept [redacted] 06/13/2024)***

On 4/29/24, blue binder was immediately locked in the Medication Room, by Harmony Square Director. Beginning on 5/1/24, The Blue Binder containing Shift Reports/Care Cards will be kept in the Medication Room behind a locked door.
Health Care Director's door was immediately closed and locked on 4/29/24. ED educated the Health Care Director and Harmony Square Director (who are both responsible for maintaining compliance with regulation 2600.17) on HIPPA and 2600.183b regulation on 4/29/24. Signatures were obtained and documentation was kept. On 6/26/24, all Med Tech's will be educated on 2600.183b, by Gateway Hospice. Signatures will be obtained, and documentation will be kept. All staff will be educated on Resident Rights, Abuse and HIPPA by the Ombudsman on 6/26/24. Signatures will be obtained, and documentation will be kept. All of the above signatures and documentation will be kept in accordance with Regulation 2600.65(i). ED will conduct an audit of HCD and HSD's office doors to ensure compliance. Documentation will be kept. This will begin on 6/3/24 and continue for 6 months. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.17 and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] - 09/11/2024)

42c - Treatment of Residents

6. Requirements

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

Description of Violation

On 4/27/24 at approximately 8:10 a.m., staff person A, a cook, came into the dining room and shouted across the dining room to resident #1 and asked if [redacted] was going to eat [redacted] egg whites to which resident #1 replied "Well, yes." Staff person A then shouted, "Are you sure?" to which resident #1 replied "Yes, I always eat my breakfast." Staff person A replied "Well, you didn't two days ago, and I don't appreciate it. So, from now on, you're going to be asked every day." Resident #1 expressed that [redacted] elt embarrassed, humiliated, attacked, and berated by this incident and reported it to staff person B, the manager on duty for the weekend, on 4/27/24 at approximately 8:30 a.m. Then on 4/28/24,

42c - Treatment of Residents (continued)

resident #1 reported to staff person B that [redacted] was the second person to order breakfast and approximately 12 other residents' breakfasts came out while she waited approximately 50 minutes for her breakfast. Resident #1 stated that this made [redacted] feel like [redacted] was being sabotaged/singled out [retaliated against] for reporting the prior day's incident to management.

Plan of Correction ***Accept [redacted] 06/10/2024)***

ED was not notified of the incident until 4/29/24. Staff person A was then immediately suspended on 4/29/24, by ED and Dining Services Director. DHS and Area Agency on Aging was notified on 4/29/24, by ED. Abuse Mandatory Reporting Form was completed and sent to Area Agency on Aging on 4/30/24, by ED. On 5/22/24, ED sent final report to DHS stating that ED heard from Area Agency on Aging and that they did not find the Allegation of Abuse founded. All documentation has been kept. On 5/15/24, The Leadership Team received training on 2600.15.a thru d, 2600.15.a thru d, 2600.41.a thru e, and 2600.42.a thru q. Signatures were obtained, and documentation was kept. All staff received Abuse training on 5/23/24. Signatures were obtained, and documentation has been kept. The Ombudsman is giving an In-service to all Staff by 6/20/24 on Abuse and Resident Rights. Signatures will be obtained, and documentation will be kept. Staff person A returned to work on 5/28/24, after the allegation was unfounded by Area Agency on Aging on 5/22/24. Before being allowed to return to his duties, Staff person A received education on Resident Rights, Basic Principles of Communication, and Preventing, Recognizing and Reporting Abuse. Signature was obtained and documentation was kept. ED will add possible alleged abuse incidents/reporting requirements on weekend MOD reports and also review at morning meeting Monday thru Friday. This will begin on 6/1/24 and continue for 6 months. Signatures will be obtained, and documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.42.c and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *06/25/2024*

Implemented [redacted] 09/11/2024)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Staff person C, medication technician, hired 1/3/22, did not receive training during the 1/1/23 – 12/31/23 staff training year in the following:
(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
(5) Personal care service needs of the resident.
(6) Safe management techniques.

Staff person D, LPN, hired [redacted]/21, did not receive training during the 1/1/23 – 12/31/23 staff training year in the following:
(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

65f - Training Topics (continued)

(5) Personal care service needs of the resident.
(6) Safe management techniques.

Plan of Correction ***Accept [redacted] 06/10/2024)***

Staff person C is no longer employed by facility, as of [redacted]24. Staff person D received training for (2), (5) and (6) on 6/3/24. Signature was obtained, and documentation was kept. An in-service will be held by 6/27/24 for all staff on all required annual training. Signatures will be obtained, and documentation will be kept. An audit of all personnel files will be completed by 6/20/24 to ensure compliance with 2600.65.f and documentation will be kept. If any staff member is found to be out of compliance, they will immediately be educated and if they are not immediately available, they will be taken off the schedule until educated. Signatures will be obtained, and documentation will be kept. Beginning 6/1/24, all new hires will be given all required training before they are permitted to work on the floor. Signatures will be obtained, and documentation will be kept. Beginning on 6/1/24, ED or designee, will conduct an audit of all new employee Files to ensure compliance. This will continue for 6 months. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.65.f for 6 months and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] 09/11/2024)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff person C, medication technician, hired [redacted]22, did not receive training during the 1/1/23 – 12/31/23 staff training year in the following: Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and The Older Adult Protective Services Act.

Staff person D, LPN, hired [redacted]21, did not receive training during the 1/1/23 – 12/31/23 staff training year in the following: Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and The Older Adult Protective Services Act.

Plan of Correction ***Accept [redacted]06/10/2024)***

Staff person C is no longer employed by facility, as of [redacted]24. Staff person D will receive the required fire training by 6/27/24. An in-service will be held by 6/27/24 for all staff on all required annual training. Signatures will be obtained, and documentation will be kept. An audit of all personnel files will be completed by 6/20/24 to ensure compliance with 2600.65.f and documentation will be kept. If any staff member is found to be out of compliance, they will immediately be educated and if they are not immediately available, they will be taken off the schedule until educated. Signatures will be obtained, and documentation will be kept. Beginning 6/1/24, all new hires will be given all required training before they are permitted to work on the floor. Signatures will be obtained, and

65g - Annual Training Content (continued)

documentation will be kept. Beginning on 6/1/24, ED or designee, will conduct an audit of all new employee Files to ensure compliance. This will continue for 6 months. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.65.g for 6 months and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] 09/11/2024)

183b - Meds and Syringes Locked

9. 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 4/29/24 at 12:20 p.m., the unattended Health Care Director's office door was wide open at the second-floor nurse's station. There were numerous medications setting on a two-drawer lateral filing cabinet to include:
**A clear plastic bag of medication for resident #3 including Bisacodyl/Dulcolax 10mg suppository – unwrap and insert 1 suppository rectally every day as needed for constipation.*
** A clear plastic bag with medication for resident #3 including Bisacodyl/Dulcolax 10mg suppository – insert 1 unwrapped suppository rectally every 96 hours as needed for constipation.*
** Two Blister booklets of medication for resident #5 to include Atorvastatin 20mg, Diltiazem HCL ER 120 mg; Pantoprazole Sod DR 40mg; and Olanzapine 10mg.*
** A medication bottle with handwritten label for resident #6 that indicates "Advil generic"*
** A 30 tablet box of Top Care Allergy Relief loratadine tablets, 10mg with resident #7's name written on it.*

Plan of Correction ***Accept ([redacted] 06/10/2024)***

Health Care Director's door was immediately closed and locked on 4/29/24. On 6/6/24, ED ordered 2 sets of self-closing door hinges to be installed on the Health Care Director's door and the Harmony Square Director's door, so that both doors will automatically close. Health Care Director and Harmony Square Director were educated on HIPPA and 2600.183b regulation on 4/29/24. Signatures were obtained and documentation was kept. By 6/25/24, all Med Tech's will be educated on 2600.183b. Signatures will be obtained, and documentation will be kept. All staff will be educated on HIPPA by 6/25/24. Signatures will be obtained, and documentation will be kept. ED will conduct an audit of HCD and HSD's office doors to ensure compliance. Documentation will be kept. This will begin on 6/3/24 and continue for 6 months. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.183.b for 6 months and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] 09/11/2024)

183e - Storing Medications

10. Requirements

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

183e - Storing Medications *(continued)*

Description of Violation

On 4/29/24 at approximately 12:45 p.m., there were more than 12 packets of Pain Zapper relief 2 tablet packets with "Exp 2023-05" on them in the first aid kit at the personal care concierge desk.

Repeat Violation 9/27/23 et al.

Plan of Correction ***Accept [redacted] 06/10/2024)***

On 4/29/24, expired medications were immediately disposed of by Maintenance Director. An in-service on First Aid Kits/Storing Medications will be held for all staff by 6/25/24. Signatures will be obtained, and documentation will be kept. Health Services Director, or designee, will conduct a weekly audit of all First Aid Kits to ensure compliance. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.183.e for 6 months and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] 09/11/2024)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is ordered Bisacodyl 10mg suppository – Insert 1 unwrapped suppository rectally every 96 hours as needed for constipation. Give if MOM ineffective and no bowel movement by the morning of 4th day. However, on 4/30/24 at approximately 10:15 a.m., there were two clear ziptop bags containing the medication with pharmacy labels. One of the labels was correct and the other label indicated Bisacodyl 10mg suppository – unwrap and insert 1 suppository rectally every day as needed for constipation. There was no "directions changed" sticker on the label.

Resident #8 is ordered Levemir Flexpen 100 unit/ML – Inject 23 units subcutaneously every morning and every evening. However, on 4/30/24 at 11:00 a.m., there was a Levemir Flexpen with pharmacy label that indicated – Inject 30 units subcutaneously 2 times a day. There was no "directions changed" sticker on the label.

Repeat Violation 9/27/23 et al., 12/19/23

Plan of Correction ***Accept [redacted] 06/10/2024)***

On4/30/24, Health Care Director, immediately placed a change of direction sticker on suppository and insulin bag. All Med Tech's will be educated on proper MAR review to medication order and medication administration procedures by June 25, 2024. Signatures will be obtained, and documentation will be kept. LPN will conduct a weekly audit on all suppository and insulin medications to ensure compliance with regulation. This audit will begin on June 7th and be completed by June 15th, and then be ongoing weekly for 6 months. Documentation will be kept. Health Care Director will conduct a weekly audit on all suppository and insulin medications to ensure compliance. This audit will begin on June 15th and be completed by June 30th and be ongoing for 6 months. Documentation will be kept. ED will conduct a quality management review of all items specified in 2600.184.a. This will begin by June 20th and be ongoing for 6 months. Documentation of the Quality Management Review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

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

Implemented [redacted] 09/11/2024)

185a - Implement Storage Procedures

12. 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

On 4/25/24 at 3:50 p.m. the glucose reading in resident #8's glucometer measured 130. However, 120 was entered on the resident's April 2024 medication administration record on 4/25/24 at 4:30 p.m.

Repeat Violation 5/25/23, 12/19/23

Plan of Correction ***Accept [redacted] 06/10/2024)***

No residents suffered as a result of violation 2600.185.a. All Med Tech's will be re-educated on recording proper documentation of glucometer reading to the MAR/TAR and on medication administration procedures. This education will be completed by 6/25/24. Signatures will be obtained, and documentation will be kept. On 6/10/24, Health Care Director will begin a weekly audit of all glucometer readings for 6 months to ensure accuracy of all readings. Documentation will be kept. After 6 months and thereafter, Health Care Director. or designee, will continue this audit on a monthly basis. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.185.a and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] 09/11/2024)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

On 2/7/24, resident # 9 was ordered Eliquis 10mg by mouth twice a day for 7 days then, Eliquis 5mg by mouth twice a day for 3 months. On 4/4/24, it was discovered by the pharmacy during a cart audit that the order for Eliquis 5mg by mouth twice a day for 3 months which should have begun approximately 2/16/24, had never been filled or administered.

Repeat Violation 9/27/23 et al.

Plan of Correction ***Accept [redacted] 06/13/2024)***

On 4/4/24, Immediately at discovery of this item, the CRNP was notified, and [redacted] ordered resident to start Eliquis 5mg PO BID for 3 months to begin on 4/6/24. CRNP was notified and ordered Eliquis 5mg PO BID for 3 months to start 4/6/24. The order was faxed to the Pharmacy and arrived that night, on 4/5/24. Family was also notified on 4/4/24. All resident's vitals were stable, and resident had no complaint of pain or discomfort. All privileges to approve/discontinue orders were revoked from all Med Tech's. This incident was reported to DHS by HCD on 4/5/24 at 4:30pm. The Med Error was documented by HCD and has been kept as part of resident's permanent record. All Med Tech's will be re-educated on the home's medication administration procedures by 6/26/24, by Gateway

187d - Follow Prescriber's Orders (continued)

Hospice. Signatures will be obtained, and documentation will be kept. By 6/10/24, Health Care Director and Harmony Square Director will conduct weekly med cart audits to medication orders. This will continue weekly for 6 months and then monthly thereafter. All documentation will be kept. By 6/27/24, Pharmacy will conduct monthly cart audits. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.187.d and the documentation of the quality management review will be kept.

Proposed Overall Completion Date: 07/05/2024

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented ([redacted] 09/11/2024)

225c - Additional Assessment

14. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #10's most recent medical evaluation, dated [redacted]23, indicates diagnoses of neurocognitive disorder with Lewy Body Dementia, anemia, and restlessness and agitation. However, these diagnoses are not included on resident #10's most recent assessment dated [redacted]23.

Plan of Correction ***Accept[redacted] 06/10/2024)***

On 5/1/24, Health Care Director ensured all diagnosis from the DME were on Resident #10's Rasp. By 6/30/24, Health Care Director, or designee, will complete a chart audit of all Residents to ensure all diagnosis match DME to RASP. Documentation will be kept. The Health Care Director and Harmony Square Director will be re-educated on requirements of 2600.225.c. Signatures will be obtained, and documentation will be kept. The Health Care Director and Harmony Square Director will audit all new admissions to ensure compliance. This documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.225.c and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] 09/11/2024)

226a - Mobility Assessment

15. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #8's medical evaluations (DMEs) from[redacted] & [redacted]24 indicate the use of a cane and a wheelchair. Staff person E states that the resident currently uses a wheelchair for ambulation. The resident's most recent assessment completed 1/25/24 indicates the resident is "Minimal (Mobile)" and requires limited physical or oral assistance to evacuate in an emergency.

Plan of Correction ***Accept[redacted] 06/10/2024)***

Resident #8's DME for mobility needs was corrected by the Health Care Director on 4/30/24. The Health Care Director and Harmony Square Director will be re-educated on all requirements for 2600.226.a. Signatures will be

226a - Mobility Assessment (continued)

obtained, and documentation will be kept. The Health Care Director will begin an audit of all resident's charts for mobility needs by June 7, 2024, and it will be completed by 6/30/24. Signatures will be obtained, and documentation will be kept. HCD will also complete an audit of all new admissions and this documentation will be kept. ED will complete a weekly audit of all new admits ensuring compliance. This will begin 6/5/24 and will be ongoing. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.226.a and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] 09/11/2024)

233c - Key-Locking Devices

16. 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

On 4/29/24 at 11:35 a.m., the code to override the magnetic locking system at the gate to exit the secure dementia care unit (SDCU) courtyard was not posted.

Plan of Correction ***Accept [redacted] 06/10/2024)***

On 4/29/24, the code was posted to the SDCU courtyard. An in-service will be given to all staff regarding 2600.233.c by 6/25/24. Signatures will be obtained, and documentation will be kept. Harmony Square Director will conduct a weekly audit beginning 6/3/24 to ensure compliance. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] 09/11/2024)

236 - Staff Training

17. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Staff person C, hired [redacted]/22, works in the home's secure dementia care unit (SDCU). However, staff person C only had 1 hour of the 6 required hours of annual training related to dementia during the 1/1/23 - 12/31/23 staff training year.

Staff person D, hired [redacted]/21, works in the home's SDCU. However, staff person D only had 2.5 hours of the 6 required hours of annual training related to dementia during the 1/1/23 - 12/31/23 staff training year.

Plan of Correction ***Accept [redacted] 06/10/2024)***

Staff person C is no longer employed by facility, as of [redacted]24. Staff person D will receive the required dementia training by 6/27/24. An in-service will be held by 6/27/24 for all staff on all required annual training. Signatures

236 - Staff Training (continued)

will be obtained, and documentation will be kept. An audit of all personnel files will be completed by 6/20/24 to ensure compliance with 2600.236 and documentation will be kept. If any staff member is found to be out of compliance, they will immediately be educated and if they are not immediately available, they will be taken off the schedule until educated. Beginning 6/1/24, all new hires will be given all required 6 hours of Dementia training before they are permitted to work on the floor. Signatures will be obtained, and documentation will be kept. Beginning on 6/1/24, ED or designee, will conduct an audit of all new employee Files to ensure compliance. This will continue for 6 months. Documentation will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.236 and the documentation of the quality management review will be kept. By 6/20/24, ED will conduct a quality management review of all items specified in 2600.236 and the documentation of the quality management review will be kept.

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented [redacted] 09/11/2024)

Facility Information

Name: *HARMONY AT HARTS RUN* **License #:** *45322* **License Expiration:** *08/15/2024*

Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name [redacted]

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*

Addre [redacted]

Phone [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *115* **Waking Staff:** *86*

Inspection Information

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

Reason: *Complaint, Provisional, Incident, Interim* **Exit Conference Date:** *07/23/2024*

Inspection Dates and Department Representative

07/22/2024 - On-Site [redacted]

07/23/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* **Residents Served:** *83*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care - 1st floor* **Capacity:** *40* **Residents Served:** *20*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *82*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *32*

Have Physical Disability: *1*

Inspections / Reviews

07/22/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/05/2024*

08/28/2024 - POC Submission

Submitte [redacted] *s* **Date Submitted:** *09/04/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/04/2024*

Inspections / Reviews *(continued)*

09/06/2024 - Document Submission

Submitte [redacted] **Date Submitted**: *09/04/2024*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1, admitted [redacted]24, had previously eloped from the SDCU three times on [redacted]24, [redacted]24 and [redacted]4. The resident's assessment indicates that the resident's supervision need is "Moderate - Resident requires some supervision in the home and needs attendance when outside the home, and/or tends to wander". On 6/17/24 at approximately 6:30 p.m., during a power outage, resident #1 eloped from the home's secure dementia care unit (SDCU) and was found across Saxonburg Boulevard, where resident #1 was observed unattended.

Plan of Correction ***Accept [redacted] 08/28/2024)***

On 7/26/24, Health Care Director updated Resident #1's RASP to include "Extensive" Supervision, a significant change, 3 elopements and 1-hour checks on resident. Health Care Director and LPN will be re-educated on regulation 2600.23.a. by 8/31/24. Signatures will be obtained, and documentation will be kept. Health Care Director will complete an audit on all residents with a significant change to ensure compliance with regulation 2600.23a. This audit will begin on 8/29/24 and will be completed by 9/19/24. All documentation will be kept. An additional audit will be completed for all residents with a new significant change. This will be completed by the Health Care Director and begin on 8/29/24 and be completed by 9/19/24. Documentation will be kept. Resident discharged from this community on 8/16/24.

Licensee's Proposed Overall Completion Date: *09/19/2024*

Evidence of Completion ***Implemented [redacted] 09/06/2024)***

See attached.

225a - Assessment 15 Days

2. 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.

[redacted]

225c - Additional Assessment

3. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

225c - Additional Assessment *(continued)*

Description of Violation

Resident #2's medical evaluation, completed 7/21/23. indicates that resident is on "Regular Diet (cut food into bite size pieces)." However, the assessment completed 8/4/23 for resident #2 indicates "cut food into bite sized pieces as per request."

Plan of Correction ***Accept[redacted] 08/28/2024)***

On 7/18/14, Resident #2's RASP was updated by Health Care Director to include "Regular diet - cut food into small pieces". Health Care Director and LPN will be re-educated on regulation 2600.225.c. Signatures will be obtained, and documentation will be kept. Health Care Director will complete an audit on all residents who are not on a regular diet to ensure compliance with regulation 2600.225.c. This audit will begin on 8/29/24 and will be completed by 9/19/24. All documentation will be kept. An additional audit will be completed for all new admissions without a regular diet order. This will be completed by the Health Care Director and begin on 8/29/24 and be completed by 9/19/24. Documentation will be kept. Resident discharged from Personal Care to Independent Living on 7/18/24.

Licensee's Proposed Overall Completion Date: *09/19/2024*

Evidence of Completion ***Implemented [redacted]09/06/2024)***

See attached.