pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE VILLAGES OF HARMON HOUSE, LLC**
LEGAL ENTITY

To operate **THE VILLAGES OF HARMON HOUSE**
NAME OF FACILITY OR AGENCY

Located at **601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666**
(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 **Assisted Living**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **67**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 10, 2024** until **December 10, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454540**

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 10, 2024

[redacted]
The Villages of Harmon House LLC
[redacted]

RE: The Villages of Harmon House
601 South Church Street
Mt. Pleasant, PA 15666
License #: 454540

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspection on June 14, 2024 and October 18, 2024, and the corrections you have made after our inspection, 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

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

Facility Information

Name: *THE VILLAGES OF HARMON HOUSE* **License #:** *45454* **License Expiration:** *08/23/2024*

Address: *601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *THE VILLAGES OF HARMON HOUSE, LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/06/1988* **Issued By:** *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *55* **Waking Staff:** *41*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *06/14/2024*

Inspection Dates and Department Representative

06/14/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served:** *51*

Special Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *50*

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

Have Mobility Need: *4* **Have Physical Disability:** *0*

Inspections / Reviews

06/14/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/19/2024*

Inspections / Reviews *(continued)*

07/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/03/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/07/2024*

08/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/03/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/03/2024*

11/18/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/03/2024*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

17 Record confidentiality

1. Requirements

2800.
17. Confidentiality of Records - 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

At 10:50a.m., the resident privacy coding document with the names of resident #1, resident #2 and resident #3 was attached to the licensing inspection summary (LIS) dated 9/20/23 et al, and was posted in a publicly accessible binder near the main entrance of the residence.

Plan of Correction ***Accept[redacted] - 07/31/2024)***

The Executive Director removed the privacy coding document from the survey binder and posted the Public License Inspection Summary on June 14, 2024.
The Executive Director will audit monthly that the License Inspection Summary binder has the public version posted. This audit will continue monthly to ensure compliance with the regulation. Audits to begin 8/1/2024.
Audit results will be reviewed at the facility's Quality Management Meeting for any additional required action.

Licensee's Proposed Overall Completion Date: *07/19/2024*

Implemented[redacted] - 11/18/2024)

25a Resident - residence contract

2. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #3 was admitted on [redacted]/23. The residence had a change of legal entity on [redacted]/23; however, a new resident-residence contract or resident-residence contract addendum was not completed for the resident.

Resident #4 was admitted on [redacted]/17. The residence had a change of legal entity on [redacted]/23; however, a new resident-residence contract or resident-residence contract addendum was not completed for the resident.

Resident #5 was admitted on [redacted]19. The residence had a change of legal entity on [redacted]23; however, a new resident-residence contract or resident-residence contract addendum was not completed for the resident.

Repeat Violation: 9/20/23 et al

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

The Executive Director is currently working with resident families to complete a new resident-residence contract for Resident #3, Resident #4 and Resident #5. This will be completed by 7/26/2024.
The Executive Director has performed a baseline audit of other resident contracts. Those requiring a new resident-residence contract will have those signed by August 16, 2024.

25a Resident - residence contract (continued)

The facility has developed and will utilize a record review for new admissions that will include the review and signing of a resident-residence contract prior to or within 24 hours of admission.
The Executive Director will audit new admissions within 24 hours going forward to ensure that a contract is signed within the established timeframes of this regulation. Audit results will be reviewed at the facility's Quality Management Meeting for any additional required action.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 11/18/2024)

60a Staffing/support plan needs

3. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

The residence consists of 4 floors of resident bedrooms. On 6/8/24, there were 51 residents in the residence, including 4 residents with mobility needs requiring assistance of 1 staff person to evacuate in an emergency. On this date, there were only 2 direct care staff persons working in the residence to assist residents to evacuate in the event of an emergency from 10:00 p.m. to 6:00 a.m. on 6/9/24.

The residence consists of 4 floors of resident bedrooms. On 6/9/24, there were 51 residents in the residence, including 4 residents with mobility needs requiring assistance of 1 staff person to evacuate in an emergency. On this date, there were only 2 direct care staff persons working in the residence to assist residents to evacuate in the event of an emergency from 10:00 p.m. to 6:00 a.m. on 6/10/24.

The residence consists of 4 floors of resident bedrooms. On 6/10/24, there were 51 residents in the residence, including 4 residents with mobility needs requiring assistance of 1 staff person to evacuate in an emergency. On this date, there were only 2 direct care staff persons working in the residence to assist residents to evacuate in the event of an emergency from 10:00 p.m. to 6:00 a.m. on 6/11/24.

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

Effective immediately, the ED / designee is in the process of recruiting additional staff members to fill the staffing needs of the facility. Additionally, as a best practice, the facility will review where the residents with mobility needs reside in the facility and see if it is feasible to cohort residents with mobility needs on a floor with a horizontal egress.
On July 9th Johnstown safety services arrived at the facility to conduct a fire safety inspection and complete an additional supervised drill. It was determined at this time that the fire safe areas of this facility are each stairwell and each individual floor of the facility.

In addition to the fire safe areas, the facility's determined evacuation time is now 15 minutes. This time allows for staff to safely evacuate residents into the fire safe hallway timely thus allowing the direct care staff at the assisted living to evacuate the residents. Additionally, in the event of a fire drill, responding staff from the attached SNF will provide supervision on the floors for residents who have been evacuated by AL staff.

60a Staffing/support plan needs (continued)

In a true emergency situation where SNF employees are not available for supervision, direct care staff have enough time based on the fire inspection to appropriately evacuate residents into a fire safe area within 15 minutes. Once evacuation to fire safe areas is completed, staff will monitor two floors by use of stairwell to ensure residents remain safe until emergency services arrives and utilize cell phones to keep in communication as needed.

ED / designee will continue recruitment efforts in an attempt to avoid these types of staffing situations from occurring.

Proposed Overall Completion Date: 08/16/2024

Directed:

By 8/31/24, the administrator or designee will conduct a fire drill during the overnight shift, with only 2 staff participating, to ensure 2 staff are able to safely evacuate and supervise all residents within 15 minutes. Documentation of the drill will be kept.

[redacted] ***8/16/24***

Directed Completion Date: *08/31/2024*

Implemented [redacted] ***- 11/18/2024)***

65a Fire Safety-1st day

4. Requirements

2800.

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

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

Description of Violation

Staff person A, hired on [redacted] */23, did not receive orientation in any required topics in accordance with 2800.65(a)(1-7).*

Staff person B, hired on [redacted] */24, did not receive orientation in any required topics in accordance with 2800.65(a)(1-7).*

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

The Executive Director will review required orientation topics with Staff person A and Staff person B. This will be completed by 7/24/24.

The facility has developed a new employee orientation checklist, implemented 7/1/24, to ensure that new hires have received their orientation topics as required in accordance with 2800.65a (1-7). This checklist will be completed by the executive director / designee.

The Executive Director will audit that new hires have completed all required training monthly, beginning 8/1/24.

65a Fire Safety-1st day (continued)

Audit results will be reviewed at the facility Quality Management Meeting for any additional required action.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] 11/18/2024)

65e Rights/Abuse 40 Hours

5. Requirements

2800.

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

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

Staff person A, hired on [redacted]3, did not receive orientation in any required topics in accordance with 2800.65(e)(1-6).

Staff person B, hired on [redacted]/24, did not receive orientation in any required topics in accordance with 2800.65(e)(1-6).

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

The Executive Director will review required orientation topics with Staff person A and Staff person B. This will be completed by 7/24/24.

The facility has developed a new employee orientation checklist, implemented 7/1/24, to ensure that new hires have the required topics in accordance with 2800.65e (1-6). This checklist will be completed by the executive director / designee.

The Executive Director will audit that new hires have completed all required orientations within 40 scheduled work hours. Audits began on 8/1/24, and audit results will be reviewed at the facility Quality Management Meeting for any additional required action.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 11/18/2024)

69 Dementia training

6. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person A, hired on [redacted]23, did not complete dementia-specific training within 30 days of hire.

69 Dementia training (continued)

Staff person B, hired on [redacted]/24, did not complete dementia-specific training within 30 days of hire.

Repeat Violation: 9/20/23 et al

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

The Executive Director will review required orientation topics/processes with Staff person A and Staff person B. This will be completed by 7/24/24.
The facility has developed a new employee orientation checklist, implemented 7/1/24, to ensure that new hires have at least 4 hours of dementia-specific training within 30 days of hire. Additional 2 hours of dementia-specific training annually is scheduled in their assigned annual trainings. This checklist will be completed by the executive director / designee.
The Executive Director will audit that new hires have completed all required orientations and monitors monthly thereafter that assigned annual trainings are completed. Audits began 8/1/24, and audit results will be reviewed at the facility Quality Management Meeting for any additional required action.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 11/18/2024)

83a Indoor temperature

7. Requirements

2800.
83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

At 11:41a.m., the temperature on the 5th floor, which contains a lounge and kitchen used by residents, was 57 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] 07/31/2024)***

The facility's HVAC vendor made repairs to the air conditioning system on 6/14/2024. The room temperatures have been maintained at least at 70 degree F since the day of inspection.
The maintenance department/designee will audit monthly that the temperature on 5th floor is being maintained per the regulation. Audits to begin 8/1/2024.
Audit results will be reviewed at the facility Quality Management Meeting for any additional required actions.

Licensee's Proposed Overall Completion Date: *07/19/2024*

Implemented ([redacted] - 11/18/2024)

100b Removal snow/obstructions

8. Requirements

2800.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

100b Removal snow/obstructions *(continued)*

Description of Violation

At 11:31a.m. there was an approximate 1/2" accumulation of leaves and small sticks covering the exterior emergency exit ramp off the 2nd floor of the residence.

Plan of Correction ***Accept [redacted] - 07/31/2024)***

The maintenance department removed the leaves and small sticks observed on the exterior emergency exit ramp off the 2nd floor of the residence on June 14th, 2024.
The Executive Director will include the exit ramp observation on her weekly facility environmental rounds. The maintenance department will additionally ensure walkways are free from debris when outside lawn care is performed. Audits to begin the week of 7/22/24.
Audit results will be reviewed at the facility Quality Management Meeting for any additional required action.

Licensee's Proposed Overall Completion Date: *07/19/2024*

Implemented [redacted] - 11/18/2024)

103a Kitchen

9. Requirements

2800.
103.a. A residence shall have access on the grounds to an operable kitchen with a refrigerator, sink, stove, oven, cooking equipment and cabinets or shelves for storage. If the kitchen is not in the home, the home shall have a kitchen area with a refrigerator, cooking equipment, a sink and food storage space.

Description of Violation

The residence has an operable kitchen for resident use with a refrigerator, sink, stove, oven, cooking equipment and cabinets or shelves for storage on the 5th floor; however, residents were unable to use the kitchen for approximately 2 weeks because the temperature on this floor was 57 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 07/31/2024)***

At the time of inspection the fifth floor of the facility was abnormally cold. The A/C unit had been serviced earlier in the week due to it being down for roughly 2 weeks prior to the inspection and was continuously running incorrectly. Residents still had access and were able to utilize the kitchen area.
The facility's HVAC vendor made repairs to the air conditioning system on 6/14/2024. The room temperatures have been maintained at least at 70 degree F since the day of inspection.
The maintenance department/designee will audit monthly that the temperature on 5th floor is being maintained per the regulation. Audits to begin 8/1/2024.
Audit results will be reviewed at the facility Quality Management Meeting for any additional required actions.

Licensee's Proposed Overall Completion Date: *07/19/2024*

Implemented [redacted] 11/18/2024)

132d Evacuation

10. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

132d Evacuation *(continued)*

Description of Violation

The residence has 4 floors with resident living units and 1 fire-safe area designated in writing within the past year by a fire safety expert, located on the 2nd floor. During all fire drills from July, 2023 - May, 2024, residents on floors #1, #3 and #4 were not evacuated to the fire-safe area on the 2nd floor as designated by the fire safety expert. Instead, residents on floors #1, #3 and #4 were evacuated to the stairwells on each floor, which are not designated fire-safe areas.

Repeat Violation: 9/20/23 et al

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

Due to discrepancies with the interpretation of the facility fire letter and past citations, the facility opted to have a fire safety inspection conducted along with a supervised drill by an experienced fire safety expert as their plan of correction.

On July 9th Johnstown safety services arrived at the facility to conduct a fire safety inspection and complete an additional supervised drill. It was determined at this time that the fire safe areas of this facility are each stairwell and each individual floor of the facility.

Based upon this information in this letter the facility is in compliance with 2800.132d. Moving forward the facility will continue to practice fire drills based on the instructions given in the fire safety letter by utilizing fire safe areas of the building. As a monitoring step, the ED will audit fire drill records monthly within, 24 hours of the drill, to ensure residents were appropriately evacuated into fire safe areas.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 11/18/2024)

132g Fire drills – days/times

11. Requirements

2800.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The residence routinely schedules 2 staff on the overnight shift from 10:00p.m. to 6:00a.m., as evidenced on 6/8/24, 6/9/24 and 6/10/24. However, the residence's fire drill records from July 2023 to May 2024 indicate the minimum amount of staff present for a fire drill was 5.

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

As an immediate fix, on July 9th Johnstown safety services arrived at the facility to conduct a fire safety inspection and complete an additional supervised drill. It was determined at this time that the fire safe areas of this facility are each stairwell and each individual floor of the facility.

In addition to the fire safe areas, the facility's determined evacuation time is now 15 minutes. This time allows for staff to safely evacuate residents into the fire safe hallway timely thus allowing the direct care staff at the assisted

132g Fire drills – days/times (continued)

living to evacuate the residents. Additionally, in the event of a fire drill, responding staff from the attached SNF will provide supervision on the floors for residents who have been evacuated by AL staff.

The fire drill referenced in the citation was held in March of 2024. Five fire trained staff members were present at the time of the drill including direct care workers, the resident care coordinator, and a house keeper.

Moving forward the ED / designee will work in conjunction with the facility maintenance department to ensure fire drills are held at random times throughout the year. This discussion will take place the first week of the month beginning 9/1/24.

Proposed Overall Completion Date: 08/16/2024

Directed:
By 8/31/24, the administrator or designee will conduct a fire drill during the overnight shift, with only 2 staff participating, to ensure 2 staff are able to safely evacuate and supervise all residents within 15 minutes. Documentation of the drill will be kept.

[redacted] ***8/16/24***

Directed Completion Date: *08/31/2024*

Implemented [redacted] ***- 11/18/2024)***

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE VILLAGES OF HARMON HOUSE* **License #**: *45454* **License Expiration**: *08/23/2024*

Address: *601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *THE VILLAGES OF HARMON HOUSE, LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/06/1988* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *53* **Waking Staff**: *40*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *11/01/2024*

Inspection Dates and Department Representative

10/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *49*

Special Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *49*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

10/18/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *Exception*

NO DEFICIENCIES FOUND