pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **STATE COLLEGE OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT STATE COLLEGE**
NAME OF FACILITY OR AGENCY

Located at **121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803**
(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 **125**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 38**

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 **February 11,** **2025** until **August 11,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **228031**

ISSUING OFFICER

ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 11, 2025

State College Operations, LLC
[redacted]

RE: Harmony at State College
121 Havenshire Blvd
State College, PA 16803
License: 228031

Dear State College Operations, LLC:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 29, 2024, September 10, 2024, September 25, 2024, November 20, 2024, and December 18, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 228030) dated August 5, 2024, to August 5, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated August 5, 2024, to August 5, 2025, is NOT reinstated upon expiration of this SECOND PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 11, 2025 to August 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
5a	III	112	$3	$336	15 calendar days from mailing date of this letter
16c	III	112	$3	$336	15 calendar days from mailing date of this letter
187d	II	112	$5	$560	5 calendar days from mailing date of this letter
188b	III	112	$3	$336	15 calendar days from mailing date of this letter
225c	III	112	$3	$336	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *HARMONY AT STATE COLLEGE* **License #:** *22803* **License Expiration:** *08/05/2025*

Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *STATE COLLEGE OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/19/2019* **Issued By:** *Centre Region Code Enforcementt*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *148* **Waking Staff:** *111*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *12/18/2024*

Inspection Dates and Department Representative

12/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *112*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *38* **Residents Served:** *30*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *97*

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

Have Mobility Need: *36* **Have Physical Disability:** *0*

Inspections / Reviews

12/18/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/20/2025*

01/22/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/16/2025*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

02/04/2025 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *01/22/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

15a - Resident Abuse Report

1. 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 [redacted] Staff Member A documents they heard Resident #1 screaming from down the hall. They witnessed the resident on the floor with their legs in the air. It was reported that Resident #2 had kicked Resident #1 when they attempted to enter their room. It was further documented that Resident #1 was very distraught, in tears, holding their back and hip. The incident was not reported to the Area Agency on Aging as required.

Plan of Correction ***Directed ([redacted] - 01/17/2025)***

12/19/24 -Area on Agency notified
Resident rights education on policy and protocols
Incident Reporting Policy and procedures to correct agencies
Poa notified at time of incident
HCD or designee will audit incident reports weekly x's 8 weeks to ensure all appropriate agencies were notified, per policies.

Proposed Overall Completion Date: 01/16/2025

Directed: The home shall immediately report suspected abuse of residents in the home in accordance with the Older Adults Protective Services Act.
All staff will be trained in reporting requirements as set forth in the Older Adults Protective Services Act.
Weekly audits completed by the HCD or designee will be documented to include date of audit, person completing the audit, and any issues identified from the audit including any corrective actions taken.

Directed Completion Date: *01/30/2025*

Not Implemented ([redacted] - 02/04/2025)

16c - Written Incident Report

2. 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] Staff Member A documents they heard Resident #1 screaming from down the hall. They witnessed the resident on the floor with their legs in the air. It was reported that Resident #2 had kicked Resident #1 when they attempted to enter their room. It was further documented that Resident #1 was very distraught, in tears, holding their back and hip. The incident was not reported to the Department as required. Repeat Violation: 11/15/23 & 4/10/24

16c - Written Incident Report *(continued)*

Plan of Correction ***Directed ([redacted] - 01/17/2025)***

12/19/24 -Area on Agency notified
12/19/24 - DHS notified
Poa was notified at time of occurrence.
HCD or designee will audit weekly x 8 weeks that any required notice for incidents was sent to appropriate agencies.

Proposed Overall Completion Date: 01/16/2025

Directed: The home shall report to the department all required incidents within the time frames outlined in § 2600.16.
All staff will be trained in reporting requirements as outlined by this regulation.
Weekly audits completed by the HCD or designee will be documented to include date of audit, person completing the audit, and any issues identified from the audit including any corrective actions taken.

Directed Completion Date: *01/30/2025*

Not Implemented ([redacted] - 02/04/2025)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] Staff Member A documents they heard Resident #1 screaming from down the hall. They witnessed the resident on the floor with their legs in the air. It was reported that Resident #2 had kicked Resident #1 when they attempted to enter their room. It was further documented that Resident #1 was very distraught, in tears, holding their back and hip. The resident was subsequently sent to the emergency room for evaluation.

Plan of Correction ***Directed ([redacted] - 01/17/2025)***

See attached.Resident rights education on policy and protocols
Incident Reporting Policy and procedures to correct agencies
Poa notified at time of incident
HCD or designee will audit incident reports weekly x's 8 weeks to ensure all appropriate agencies were notified, per policies.

Proposed Overall Completion Date: 01/16/2025

Directed: All staff will be trained in resident rights and have training in the Older Adults Protective Services Act.
The administrator or designee will assess all residents of the secured dementia unit to ensure that their behaviors and needs can be met by the home. This assessment will be documented by the home and include date of the assessment, person completing the assessment, determination of the assessment.

42b - Abuse *(continued)*

Directed Completion Date: *02/14/2025*

Implemented ([redacted] - 02/04/2025)

42k - Resident Record

4. Requirements

2600.
42.k. A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.

Description of Violation

[redacted] of Resident #1 requested the resident's chart for review on 11/19/2024, 11/20/2024, 11/22/2024, 11/25/2024, and 12/9/2024. As of 12/18/2024 [redacted] only received the resident's Medication Administration Record but was not given the complete chart as requested.

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Actions: POA paperwork requested reviewed by POA with DHS representative. Copies provided of information wanted.
12/19/24: Staff education provided on policies and procedures on releasing of medical information.
1/23/24: Policies and procedures of Residents records and access education will be reviewed at all staff meeting.
Ongoing: HCD or designee will audit weekly x 8 weeks for any written resident or POA request for medical record release and if requested ensure wanted documents were received.

Proposed Overall Completion Date: 01/16/2025

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented ([redacted] - 01/22/2025)

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

Facility Information

Name: *HARMONY AT STATE COLLEGE* **License #:** *22803* **License Expiration:** *08/05/2025*

Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *STATE COLLEGE OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/19/2019* **Issued By:** *Centre Region Code Enforcement*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *131* **Waking Staff:** *98*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date:** *11/21/2024*

Inspection Dates and Department Representative

11/20/2024 - On-Site: [redacted]

11/21/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *94*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *38* **Residents Served:** *29*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *94*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *37*

Have Physical Disability: *0*

Inspections / Reviews

11/20/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/21/2024*

12/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/03/2025*

02/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/03/2025*

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

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:

Description of Violation

On 11-20-24, Department Representatives asked for resident records at 10:10 am. Resident records were not given to the Department Representatives until 12:40pm.

Repeat Violation: 3-6-24

Plan of Correction ***Accept ([redacted] - 12/23/2024)***

Immediate: 12/20/24, RDO provided education to leadership team regarding the need to provide DHS representatives the immediate access to resident records and reports upon request.

Beginning 12/20/24, 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: *12/20/2024*

Not Implemented ([redacted] - 01/13/2025)

16c - Written Incident Report

2. 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

The home did not send a written reportable incident form to the department within 24 hours when Resident 1 and Resident 2 missed the below medications:
Resident #1:
9-1-24 Levothyroxine 75mcg 8am (Out of Facility)
9-2-24 Cephalexin 500mg 2pm (Out of Facility)
9-19-24 Buspirone HCL 5mg 8pm (Out of Facility)
9-19-24 Calcium 600mg 8pm (Out of Facility)
9-19-24 Pregabalin 100mg 8pm (Out of Facility)
9-20-24 Levothyroxine 75mcg 8am (Out of Facility)
9-20-24 Buspirone HCL 5mg 8am (Out of Facility)
9-20-24 Calcium 600mg 8am (Out of Facility)
9-20-24 Clopidogrel 75mg 8am (Out of Facility)
9-20-24 Ferrous Gluconate 240(27)mg 8am (Out of Facility)
9-20-24 Lantus Solostar 100units 8am (Out of Facility)
9-20-24 Magnesium Oxide 500mg 8am (Out of Facility)
9-24-24 Buspirone HCL 5mg 8pm (Out of Facility)

16c - Written Incident Report (continued)

9-24-24 Calcium 600mg 8pm (Out of Facility)
9-24-24 Pregabalin 100mg 8pm (Out of Facility)
9-25-24 Levothyroxine 75mcg 6am (Out of Facility)
9-28-24 Pregabalin 100mg at 8am and 8pm (Refill not available)
9-29-24 Pregabalin 100mg at 8am and 8pm (Refill not available)
9-30-24 Pregabalin 100mg at 8am and 8pm (Refill not available)

Resident #2:
11-15-24 Levothyroxine 75mcg at 6am (Missed Dose)

Repeat Violation: 4-10-24 & 11-15-23

Plan of Correction ***Accept ([redacted] - 12/23/2024)***

Immediate: 12/20/24, Executive Director educated HCD and AHCD on this regulation.
Initial: 12/24/24, Executive Director or designee will educate all Medication Technicians on these regulations and the process by which to immediately notify the Nurse-on-call for missed or refused medications and to notify the prescriber and family.
Beginning: 12/24/24, Executive Director or Designee will Educate all Medication Technicians on this regulation and the process by which to immediately notify the Nurse-on-call for missed or refused medications and to notify the prescriber and the family.
Beginning 12/24/24, Executive Director or Designee will create a reminder to be attached to all medication carts to outline what to be done when a resident either misses or refuses medication(s)
By 12/31/24, Healthcare Director or Designee will complete an initial audit of MAR from October 1, 2024 to present to identify missed medications.

Ongoing:
Beginning 1/1/24, Healthcare Director or Designee will conduct a daily MAR audit for a period of 8 weeks to identify missed or refused medications to ensure proper reporting of missed or refused medications.
Findings will be reviewed at monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented ([redacted] - 01/13/2025)

23a - Activities of Daily Living Assistance

3. 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

Upon reviewing the home's call bell report from 11-13-24 through 11-20-24, it was noted on 60 different occasions, residents call bells rang for 20 minutes or more. Of those 60 occasions, 9 times the call bell rang up to 20 minutes, 32

23a - Activities of Daily Living Assistance (continued)

times it rang up to 30 minutes, and 18 times the call bell rang up to 59 minutes, leaving the residents waiting for staff to assist them. The home is not meeting the needs of the residents as identified in the resident's assessment and support plans. Resident interviews confirmed that wait times for their call bells to be answered by staff can take 30-45 minutes.

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:
On 12/20/24, Executive Director educated all Leadership team members on this regulation.
Initial:
By 12/24/2, Executive Director or Designee will educate all Direct Team Members on the expectations regarding response time to resident call bells.
By 12/27/24, Executive Director or Designee will conduct and initial audit of Call Bell Report from 12/1/24 through present to identify trends regarding time/shift, resident, staff members, root cause. Trends will be reviewed with Leadership Team and performance improvement activities will be implemented to address the identified trends.
Ongoing:
Beginning 1/1/25, Maintenance Director or Designee will review daily call bell report with Leadership Team members at Daily Stand up, to identify and discuss trends and make recommendations to minimize response times to meet resident's needs. Recommendations will be reviewed and evaluated during monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/13/2025)

42c - Treatment of Residents

4. Requirements

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

Description of Violation

On 11-7-24, Resident 9 reported that Staff member A did not treat them with dignity and respect. When interviewed, Resident 9 reported staff member A refused to assist with toileting, stating that it was not part of their job. Resident 9 felt that this was done in a rude manner and made the resident uncomfortable for asking for assistance.
On 11-7-24, Resident 6 reported that Staff member A did not treat them with dignity and respect. When interviewed, Resident 6 reported being embarrassed in front of other residents when Staff member A yelled for them to "hurry up" while the resident was trying to walk to dinner. Staff member A is aware that resident 6 has difficulty walking. Resident interviews indicated that Staff member A will raise their voice unnecessarily to residents when addressing them.

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:

42c - Treatment of Residents (continued)

On 12/20/24, Executive Director educated all Leadership Team on the regulation and Resident Rights.
On 12/16/24, Executive Director confirmed that Staff Member A was Agency PCA who is no longer permitted to work in the community.

Initial:
By 12/27/2024, Executive Director or Designee will provide training to all associates on the Resident's Rights and empathy in the workplace.

Ongoing:
Beginning 12/23/24, Executive Director or Designee will conduct 3 random resident interviews monthly to ensure Resident's Rights are being met. Monthly interviews will be conducted for a period of 3 months.
Beginning 1/1/25, Business Office Manager or Designee will ensure a review of Resident Rights will be conducted with each new associate during onboarding.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/10/2025)

81b - Resident Personal Equipment

5. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 11-20-24, the enabler bar in room H109 was not securely fastened to the bed frame. The enabler bar was held in place only by the weight of the mattress.

Repeat Violation: 9-27-23, et al.

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:
On 12/9/24, Executive Director met with the Designated Person for H109, reviewed the regulation. subsequently removed the enabler.
Initial:
By 12/20/24, Executive Director or Designee will educate all clinical team members regarding resident personal equipment.
By 12/24/24, Healthcare Director or Designee will complete and initial audit of all residents' apartments to identify if enablers are present.
Ongoing:
Beginning 01/1/25, Healthcare Director or Designee will complete a weekly audit of all residents' apartments for a period of 8 weeks. Audit results will be reviewed during monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/13/2025)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 11-21-24, located in the walk-in freezer was a bag of what appeared to be meat patties. The bag was not labeled with what the contents were and was not dated.

Repeat Violation: 9-27-23 et al, 3-6-24

Plan of Correction ***Accept (- 12/27/2024)***

Initial:
On 11/21/24, Executive Director disposed of the meat patties identified during the inspection.
On 12/20/24, Executive Director educated all Leadership Team members on proper labeling.

Immediate:
By 12/24/24, Executive Director will conduct training of all dietary staff on proper labeling in the kitchen.
By 12/24/24, Executive Director will conduct an initial audit of all kitchen areas, including SDCU, to ensure proper labeling.

Ongoing:
Beginning 1/1/25, Dining Services Director or Designee will conduct a daily audit for period of 8 weeks, of all kitchen areas, to include SDCU, to verify proper labeling practices are being implemented. Results of the audits will be reviewed and discussed during monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/13/2025)

141a 1-10 Medical Evaluation Information

7. 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 Documentation of Medical Evaluation, dated , was incomplete due to section (7) not being

141a 1-10 Medical Evaluation Information (continued)

completed to indicate if the resident can self-administer medications.

Repeat Violation: 11-15-2023

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:
On 11/25/24, Healthcare Director requested an updated DME to reflect resident #3 was not able to administer own medications.
On 12/20/24, Executive Director educated the Healthcare Director, Associate Healthcare Director on the accuracy and completeness requirements of a Resident DME.

Initial:
By 12/31/24, Healthcare Director or Designee will conduct an initial audit of resident DME's for accuracy and completion.

Ongoing:
Beginning 1/1/25, Healthcare Director or Designee will conduct a weekly audit for a period of 8 weeks, of all new and updated resident DME's for accuracy and completion.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/13/2025)

183e - Storing Medications

8. 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 11-21-24, while conducting a medication cart audit, Resident 4's Nitroglycerin 0.4 mg was found in the medication cart. The medication label documented that the medication expired 1-14-22.

On 11-21-24 while conducting a medication audit of the memory care medication cart, Resident 1's Lantus Solostar 100 units/ml pen did not include documentation of the date of first use or the date of expiration.

Plan of Correction ***Accept (- 12/27/2024)***

On 11/21/24, Executive Director disposed of Res #4 expired medications.
Initial:
By 12/24/24, Executive Director or Designee will conduct training with Healthcare Director, Associate Healthcare Director and Medication Technicians on proper med cart procedures.
By 12/27/24, Healthcare Director or Designee will conduct and initial cart audit of all medications carts in the community.

183e - Storing Medications (continued)

By12/27/24, Healthcare Directo or Designee will provide training to all Medication Technicians on how to conduct a proper med cart audit.
Ongoing:
Beginning 1/1/25, Healthcare Directo or Designee will conduct a weekly audit on each medication cart in the community for a period of 8 weeks.
Beginning 1/1/25, Healthcare Director or Designee will schedule pharmacy to conduct monthly audits on each medications cart in the community
Results of cart audits will be reviewed and discussed during monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented ([redacted] - 01/13/2025)

184a - Resident's Meds Labeled

9. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
3. The date the prescription was issued.

Description of Violation

On 11-21-24 while doing a medication cart audit, resident 4's Degludec insulin pen 100 units did not include a label with the resident's name, the date the prescription was issued, the prescribed dosage and instructions for administration or the name of the prescriber.

On 11-21-24 while doing a medication cart audit, resident 5's Aspart insulin pen 100 units did not include a label with the resident's name, the date the prescription was issued, the prescribed dosage and instructions for administration, and the name of the prescriber.

Plan of Correction ***Accept ([redacted] - 12/27/2024)***

On 11/21/24, Healthcare Director contacted pharmacy to obtain proper pharmacy label for Res#4 and Res#5

Immediate:
By 12/24/24, Healthcare Director or Designee will provide training to all Medication Technicians on properly medication labeling. If a medication is identified or received from pharmacy without the proper labeling, MT will report the finding to the ED or Designee immediately.

Ongoing;
Beginning 01/1/25, Healthcare Director or Designee will conduct a weekly audit on each medication cart in the community for a period of 8 weeks
Beginning 1/1/25, Healthcare Director or Designee will schedule pharmacy to conduct monthly audits on each medication cart in the community,
Results of cart audits will be reviewed and discussed during monthly Quality Assurance Meeting.
Documentation of completed audits and educations will be kept by the home and available for review by the Department

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

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/10/2025)

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

The home did not administer the following resident's medications as prescribed on the below dates for the following reasons.

Resident #1:
9-1-24 Levothyroxine 75mcg 8am (Out of Facility)
9-2-24 Cephalexin 500mg 2pm (Out of Facility)
9-19-24 Buspirone HCL 5mg 8pm (Out of Facility)
9-19-24 Calcium 600mg 8pm (Out of Facility)
9-19-24 Pregabalin 100mg 8pm (Out of Facility)
9-20-24 Levothyroxine 75mcg 8am (Out of Facility)
9-20-24 Buspirone HCL 5mg 8am (Out of Facility)
9-20-24 Calcium 600mg 8am (Out of Facility)
9-20-24 Clopidogrel 75mg 8am (Out of Facility)
9-20-24 Ferrous Gluconate 240(27)mg 8am (Out of Facility)
9-20-24 Lantus Solostar 100units 8am (Out of Facility)
9-20-24 Magnesium Oxide 500mg 8am (Out of Facility)
9-24-24 Buspirone HCL 5mg 8pm (Out of Facility)
9-24-24 Calcium 600mg 8pm (Out of Facility)
9-24-24 Pregabalin 100mg 8pm (Out of Facility)
9-25-24 Levothyroxine 75mcg 6am (Out of Facility)
9-28-24 Pregabalin 100mg at 8am and 8pm (Refill not available)
9-29-24 Pregabalin 100mg at 8am and 8pm (Refill not available)
9-30-24 Pregabalin 100mg at 8am and 8pm (Refill not available)

Resident #2:
11-15-24 Levothyroxine 75mcg at 6am (Missed Dose)

Resident 6
11-15-24 Restasis 1 drop in each eye at 8pm (Medication not available)

Repeat Violation: 11/15/2023

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:
On 12/20/24, Executive Director 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 medication requires a new order, to request a new order from prescribers at least 10 days in advance.
Initial:
By 12/24/24, Executive Director or Designee will educate all HCD,AHCD, and Medication Technicians on the regulation.
By 12/27/24, Healthcare Director or Designee will conduct initial medication cart audits to ensure all required medication are on hand and compile a list of required refills.
Ongoing:
Beginning 1/1/25, Healthcare Director or Designee will complete weekly med cart audits, for a period of 8 weeks, to include compiling a list of medications requiring refills or new orders.
By 1/1/25, Executive Director will secure outside service to conduct monthly cart audits for a period of 6 months.---Express Care has been obtained to conduct monthly cart audits.
Results of the audits will be reviewed and discussed monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/13/2025)

188b - Medication Error Reporting

12. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

The home did not have documentation of contacting the resident, the resident's designated person and the prescriber when Resident 1 missed the following medications:

9-1-24 Levothyroxine 75mcg 8am (Out of Facility)
9-2-24 Cephalexin 500mg 2pm (Out of Facility)
9-19-24 Buspirone HCL 5mg 8pm (Out of Facility)
9-19-24 Calcium 600mg 8pm (Out of Facility)
9-19-24 Pregabalin 100mg 8pm (Out of Facility)
9-20-24 Levothyroxine 75mcg 8am (Out of Facility)
9-20-24 Buspirone HCL 5mg 8am (Out of Facility)
9-20-24 Calcium 600mg 8am (Out of Facility)
9-20-24 Clopidogrel 75mg 8am (Out of Facility)
9-20-24 Ferrous Gluconate 240(27)mg 8am (Out of Facility)
9-20-24 Lantus Solostar 100units 8am (Out of Facility)
9-20-24 Magnesium Oxide 500mg 8am (Out of Facility)
9-24-24 Buspirone HCL 5mg 8pm (Out of Facility)
9-24-24 Calcium 600mg 8pm (Out of Facility)
9-24-24 Pregabalin 100mg 8pm (Out of Facility)

188b - Medication Error Reporting (continued)

9-25-24 Levothyroxine 75mcg 6am (Out of Facility)
9-28-24 Pregabalin 100mg at 8am and 8pm (Refill not available)
9-29-24 Pregabalin 100mg at 8am and 8pm (Refill not available)
9-30-24 Pregabalin 100mg at 8am and 8pm (Refill not available)

Repeat Violation: 11-15-23

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:
On 12/20/24, Executive Director notified the resident, resident's designated party and prescriber of missed medications identified on this survey.

Initial:
By 12/24/24, Executive Director or Designee will educate the Healthcare Director, Associate Health Care Director and Medication Technician on the need to document and report medication errors, to include missed medications to the appropriate parties, and the process to follow.
On 12/20/24, Executive Director placed a sign on all med carts to serve as a reminder on what to do for missed/refused medications and medication errors.
By 12/31/24, Health Care Director or Designee will complete an initial audit of MAR from October 1, 2024 to present to identify missed medications.

Ongoing:
Beginning 1/1/24, Healthcare Director or Designee will conduct a daily MAR audit for a period of 8 weeks to identify medication errors to ensure proper reporting of missed or refused medications. Findings will be reviewed at monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented (- 01/13/2025)

224a - Preadmission Screen Form

13. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 5's preadmission screening form dated did not include a determination, if the home can meet the needs of the resident.

Repeat Violation: 11-15-23

Plan of Correction ***Accept (- 12/27/2024)***

Immediate:
On 10/31/24 Executive Director completed a new preadmission screening form for a resident #5 which indicates that the home can in fact meet the resident's needs.

224a - Preadmission Screen Form (continued)

Initial:
On 12/20/24, Executive Director educated Healthcare Director and Associate Healthcare Director on proper completion of the pre-admission screening to determine appropriateness for admission.
By 12/31/24, Healthcare Director or Designee will complete an initial audit for all new residents since August 1, 2024 to ensure accuracy and completion of the pre-admission screening.

Outgoing:
Beginning 1/1/25, Healthcare Director will conduct a weekly audit, for a period of 8 weeks, of all new resident preadmission screenings for accuracy and completion prior to admission.

****The resident did have the proper pre-screening in her chart. [redacted] was In Personal Care side upon coming to facility and the prescreen in chart did state the facility could meet those needs. [redacted] was later moved to memory care unit where another prescreen was completed to reflect those needs could be meant. See attached prescreen for entrance.*

Licensee's Proposed Overall Completion Date: *12/21/2024*

Not Implemented ([redacted] - 01/13/2025)

231f - Assessed Annually

14. 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 7 was last assessed for their continuing need to be in a secured dementia care unit on [redacted]

Resident 8 was last assessed for their continuing need to be in a secured dementia care unit on [redacted]

Plan of Correction ***Accept ([redacted] - 12/27/2024)***

Immediate:
ON 11/25/24, updated DME'S for Resident's #7 and #8 were obtained; both assessments confirmed the need for continued residency in the SDCU.

Initial:
On 12/20/24, Executive Director educated the Healthcare Director and Associate Director on the annual requirement that assess the continued need to reside in a SDCU.
On 12/31/24, Healthcare Director or Designee will conduct an audit of all SDCU resident files to ensure assessment has been completed for the continuing need for residency in the 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.

Ongoing:
Beginning 1/1/25 Healthcare Director or Designee will review all initials/annual/significant change evaluations to

231f - Assessed Annually (continued)

ensure residents are assessed and appropriate for residency in SDCU>

Licensee's Proposed Overall Completion Date: *12/20/2024*

Not Implemented ([redacted] - 01/13/2025)

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

Facility Information

Name: *HARMONY AT STATE COLLEGE* **License #:** *22803* **License Expiration:** *08/05/2025*

Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *STATE COLLEGE OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/19/2019* **Issued By:** *Centre Region Code Enforcement*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *118* **Waking Staff:** *89*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *09/25/2024*

Inspection Dates and Department Representative

09/25/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *86*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *N/A* **Capacity:** *38* **Residents Served:** *28*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *86*

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

Have Mobility Need: *32* **Have Physical Disability:** *1*

Inspections / Reviews

09/25/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/21/2024*

12/27/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/11/2024*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

12/27/2024 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *12/27/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

42c - Treatment of Residents

1. Requirements

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

Description of Violation

Staff member A was found to be verbally inappropriate and harsh towards memory care residents, which is not treating with dignity and respect.

Plan of Correction ***Accept (- 10/21/2024)***

Immediate action: Staff member A was an agency worker; agency was contacted in regard to above situation. Agency staff member was terminated to ever return to facility.
09/26/24 Healthcare Director/designee educated DCS in regard, that all residents shall be treated with dignity and respect.
Healthcare Director/designee will continue education, that residents shall be treated will dignity and respect. x 3 months.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented (- 12/27/2024)

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

Facility Information

Name: *HARMONY AT STATE COLLEGE* **License #:** *22803* **License Expiration:** *08/05/2025*

Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *STATE COLLEGE OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/19/2019* **Issued By:** *Centre Region Code Enforcement*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *09/11/2024*

Inspection Dates and Department Representative

09/10/2024 - On-Site: [redacted]

09/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *87*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *unit* **Capacity:** *38* **Residents Served:** *25*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *87*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *28*

Have Physical Disability: *3*

Inspections / Reviews

09/10/2024 - Full

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

10/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/11/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/23/2024*

11/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/22/2024*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

12/27/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *11/15/2024*

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

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:

Description of Violation

On 9/10/2024, Staff records were requested by the department at approximately 9:45am but were not provided until 12:30pm.

Plan of Correction ***Accept (- 10/23/2024)***

10/15/24-BOM/HCD/designee will ensure that DHS will have immediate and ongoing access to the department.
9/11/24 - Executive Director provided Leadership team education in regard to the need to provide representatives of the Department of Human Services immediate access to resident records and reports upon request.
By: 10/31/24:: Executive Director or designee will ensure immediate and ongoing access to resident record and reports will be granted immediately upon request.

Licensee's Proposed Overall Completion Date: *10/21/2024*

Not Implemented (- 11/26/2024)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident 3 fell in the home on [redacted] Resident 3 was assessed by staff member B and no injury was noted. The resident contacted a family member on [redacted] indicating that they had fallen the previous day and needed medical care. The family member contacted the staff at the home on [redacted] and was told the resident was fine and did not require additional care. On [redacted], a family member visited and noted bruises and a bump on the head of Resident 3. Resident 3 was also seen to be lethargic and not communicating. The family member then had the resident taken to the hospital. Resident 3 was admitted to the hospital with a broken hip that required surgery.

Plan of Correction ***Accept (- 10/23/2024)***

Immediate response on 09/12/24; Executive Director reviewed / educated Resident Rights with all Harmony Leadership Team members.
09/12/24: Executive Director spoke with the Director of Shift key Agency and had [redacted] remove any future shifts at our facility of said staff person so this action will not occur again in the future.
Beginning 10/15/24, Executive Director/designee will provide training on Residents Rights to all Harmony at State College associates. Training will be completed by 10/31/24
10/15/24 Healthcare Director/designee will audit incident reports 5 x's times weekly for accuracy x's 4 weeks. The weekly audits will be completed by Healthcare Director/designee for accuracy of incident reports.

Licensee's Proposed Overall Completion Date: *10/21/2024*

42b - Abuse *(continued)*

Implemented (- 11/26/2024)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

The facility was unable to provide verification of staff member A (Date of Hire:) completing the following training topics for the 2023 training year: Medication self-administration, Instruction on meeting the needs, Care for residents with dementia and cognitive impair, Infection Control, Personal care service needs of the resident, Safe management techniques, Care for Residents with MH or ID

The facility was unable to provide verification of staff member B (Date of Hire: completing the following training topics for the 2023 training year: Medication self-administration, Instruction on meeting the needs, Care for residents with dementia and cognitive impair, Personal care service needs of the resident, Safe management techniques.

The facility was unable to provide verification of staff member C (Date of Hire:) completing the following training topics for the 2023 training year: Medication self-administration, Instruction on meeting the needs, Care for residents with dementia and cognitive impair, Infection control, Personal care service needs of the residents.

Repeat violation 9/27/2023, et al.

Plan of Correction ***Accept (- 10/23/2024)***

09/12/24 immediate response. - BOM/ ED had staff person member B caught up on all required annual trainings. See attached
Staff member A & C were no longer employed at facility during the time of inspection.
9/16/24- Posting in time clock room all staff must be up to date with Relias annual training by 11/29/24.
Beginning 9/30/24 - All trainings will be monitored/audited by BOM/designee for a weekly completion of training for each employee of at least 25% to be completed 11/29/24

Licensee's Proposed Overall Completion Date: *10/22/2024*

Implemented (- 11/26/2024)

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65g - Annual Training Content *(continued)*

Description of Violation

The facility was unable to provide verification of staff member A (Date of Hire: [redacted] completing the following training for the 2023 training year: Resident Rights, Older Adult Protective Services Act, Falls and Accident Prevention, New Population Groups

The facility was unable to provide verification of staff member B (Date of Hire: [redacted]) completing the following training for the 2023 training year: Resident Rights, Older Adult Protective Services Act, Falls and Accident Prevention, New Population Groups

The facility was unable to provide verification of staff member C (Date of Hire: [redacted]) completing the following training topics for the 2023 training year: Fire safety, Emergency Preparedness Procedures, Resident Rights, Falls and Accident Prevention, New Population Groups

repeat violation 9/27/2023, et al

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

09/12/24 immediate response. Executive Director educated all Leadership Team Members on the regulation regarding annual training requirements for direct care staff.
By 11/15/24, Executive Director/designee will have available training for all direct care staff members on: Medication Self-Administration, instruction on meeting resident needs, care for residents with dementia and cognitive impairment; infection control; personal care needs of the resident, safe management techniques, care for residents with MH or ID.
By 11/29/24, Executive Director/designee will ensure all staff is up to date for all required trainings for 2024.
By: 10/15/24 Staff member B will be up to date with all required trainings. See attached.
Staff members A & C were no longer employed at facility at time of inspection.

Licensee's Proposed Overall Completion Date: *10/22/2024*

Implemented ([redacted] - 11/26/2024)

82c - Locking Poisonous Materials

5. 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 9/10/2024 at approximately 9:30am, bingo dabbers and poster paint both labeled as do not ingest were found unlocked in a storage unit in the activities room of the Secured Dementia Unit (SDU). Not all residents in the home are assessed to be around and safely use poisonous materials.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

09/12/24 immediate: Executive Director provided training to all Leadership Team regarding poisonous materials to be locked and inaccessible to residents in memory care unit. Unless residents living in the home are able to safely avoid poisonous materials. All bingo daubers and poster paint were removed from unit 9/11/24.
By 10/31/24, Executive Director / designee will purchase lock boxes to maintain all bingo daubers for the storage

82c - Locking Poisonous Materials (continued)

unit in SDCU.
By 11/1/2024, Harmony Square Director/ designee will conduct daily inspection for a period of 8 weeks to ensure all poisonous materials, relative to life enrichment, are secured for resident safety.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented ([redacted] - 11/26/2024)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

Description of Violation

Resident bedroom 104 did not have a light source that was accessible to the resident from bedside.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

9/11/24- A lamp was placed at resident's bedside table.
9/12/24-DCS was educated by Healthcare Director that an operatable lamp/light must be at residents' bedside within reach at all times.
09/12/24- An audit for a light source at all resident's bedsides was completed by Executive Director.
Beginning 11/1/24, Executive Director/designee will conduct a bi-weekly audit of all resident's apartments for a period of 8 weeks to ensure residents have an operable light source near bedside.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented ([redacted] - 11/26/2024)

103e - Left Overs

7. Requirements

2600.
103.e. Food served and returned from an individual’s plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 9-11-2024 during the physical site inspection, the kitchen walk- in freezer contained an opened 5lb. plastic bag of breaded chicken tenders that was not dated.

Repeat Violation: 9/27/2024, et al.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

Above date is incorrect:
9/11/24 immediate action: Chicken tenders were disregarded.
09/12/24- Dietary manager/ designee provided education to all kitchen staff on requirements on food that has been opened, requirements of labeling and dating.
Beginning 9/12/24- Dietary manager/designee will audit daily x's 30 days that all opened food items are labeled and dated. Daily audits ending 10/13/24.
Beginning the week of 10/14/24; Dietary Manager/designee will audit all open food items for labels and dates once weekly thru December 31, 2024.

103e - Left Overs *(continued)*

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented (- 11/26/2024)

125a - Combustible Storage

8. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 9/10/2024 in the 3rd floor laundry room, A dryer sheet was observed behind the dryer and near the dryer's exhaust vent.

Plan of Correction ***Accept (- 10/15/2024)***

09/10/24: Immediate action: Maintenace Director disregarded the dryer sheet behind dryer.
9/13/24: Maintenance Director educated all Leadership team members on the regulation; combustible and flammable materials may not be used near heat sources or water heaters.
By 10/31/24, Maintenance director or designee will train all housekeeping and direct care staff on regulation: combustible and flammable materials may not be located near a heat sources or water heaters.
Beginning 11/1/24, Maintenance Director/designee will conduct a daily audit for a period of 4 weeks to ensure areas surrounding washers and dryers are free and clear of combustible and flammable materials.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented (- 11/26/2024)

141a 1-10 Medical Evaluation Information

9. 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

The Documentation of Medical Evaluation (DME) for resident 2, dated , does not include the resident's Blood Pressure, weight, Pulse, or Temperature.

Plan of Correction ***Accept (- 10/15/2024)***

9/12/24- immediate response: Executive Director provided education to Healthcare Director/ AHCD /HSD in required information that is to be on Documented Medical Evaluations to be in compliance.

141a 1-10 Medical Evaluation Information (continued)

B/P, weight, pulse, temp was obtained 9/12/24 for resident #2 for an updated DME.
By 11/15/24, all residents' medical charts will be audited by Healthcare Director/ designee for completion/accuracy of Documented Medical Evaluations in all medical charts.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented (- 11/26/2024)

142a - Secure Medical Care

10. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

Resident 3 fell in the home on . Resident 3 was assessed by staff member B and no injury was noted. Resident contacted a family member on noting that they had fallen and needed medical care. The family then contacted the staff at the home and was told the resident was fine and did not require additional care. On a family member visited and noted bruises and a bump on the head of Resident 3. Resident 3 was lethargic and not communicating. The family then had the resident taken to the hospital. Resident 3 was admitted to the hospital with a broken hip that required surgery.

Plan of Correction ***Accept (- 10/23/2024)***

9/13/24: Education was provided by Healthcare Director to DCS on emergency response requirements and notification to POA immediately.
Reportable was sent to DHS by Harmony Square Director.
Beginning 11/1/24 weekly audits will be completed by Healthcare Director/designee providing education for DCS x's 4 weeks, in regard to incident reports, emergency response and expected notifications to POA.

Licensee's Proposed Overall Completion Date: *10/22/2024*

Implemented (- 11/26/2024)

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:
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

Resident 4 is prescribed 10mg of Memantine HCL 2 times daily. On 9/11/2024, Resident 4's bottle of Memantine HCL 10 mg was found on medication cart A on the first floor without a pharmacy label.

184a - Resident's Meds Labeled (continued)

Plan of Correction ***Accept (- 10/15/2024)***

9/12/24: In house pharmacy was notified by Executive Director that all medications sent must have a pharmacy label placed on them. Label sent for resident #4 for above listed medication.
Beginning 9/12/24: Med Techs were educated that all medications must have a pharmacy label placed on them by the sending pharmacy by Healthcare Director. All Med tech education at facility will be completed by 10/14/24.
Beginning the week of 9/16/24 a cart audit will be completed once weekly x's 4 weeks by Healthcare Director/ designee to ensure all medications have proper labels.
Beginning; 10/31/24 an initial audit of all medications in medication carts are labeled with required pharmacy label.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented (- 11/26/2024)

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

Resident 6 has an order to receive MAPAP-arthritis ER 650MG by mouth 4 times PRN. The medication was not available on 9/11/2024.

Plan of Correction ***Accept (- 10/15/2024)***

9/12/24- immediate action: Medication was ordered from in house pharmacy.
9/12/24: Education was provided to all Leadership team by Executive Director on the need to ensure safe storage, access, security, distributions of medications and medical equipment by trained staff, per regulations.
By 10/31/24, Healthcare Director/designee will conduct training of all Medication Technicians regarding the regulation and need to ensure residents have the medication/supplies on hand as prescribed.
By 10/31/24, Healthcare Director/designee will create a reminder to be attached to med cart to request refills no less than 7 days in advance, when possible, to ensure residents have required medications and supplies as prescribed.
By 11/15/24, Healthcare Director/designee will conduct an initial audit of all medication carts to ensure all medications are on hand for residents as prescribed.
Beginning 12/1/24, Healthcare Director / designee will conduct weekly medication cart audits to include ensuring refills are requested an obtained in a timely manner.
Beginning 12/1/24, Healthcare Director/designee will secure outside service to conduct monthly medication audits for a period of 6 months.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented (- 12/10/2024)

187b - Date/Time of Medication Admin.

13. Requirements

2600.

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

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

Description of Violation

Resident 4's Medication Administration Record (MAR) states that they are to receive Galantamin HBR 8mg twice daily, Calcium Antacid 500mg once daily, Alendronate Sodium 70mg once weekly Memantine HCL 10MG twice daily, and Sertraline HCL 100mg once daily. The MAR was not initialed as having been administered on the following dates and times.

Galantamin: 9/2/2024-8:00am; 9/6/2024-8:00am; 9/8/2024-5:00pm; 9/9/2024-5;00pm
Calcium Antacid: 9/2/2024; 9/4/2024; 9/6/2024; 9/8/2024; 9/10/2024
Alendronate Sodium: 9/2/2024
Memantine: 9/2/2024-8:00am; 9/6/2024-8:00am
Sertraline: 9/2/2024; 9/6/2024

It was determined through staff interviews that the medications were administered but the MAR was not initialed by staff after administering the medications.

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

9/12/24 Executive Director provided education to Healthcare Director on the regulation - home shall follow the direction of the prescriber.
By 10/31/24, ED /designee will provide training to all Med Techs regarding the regulation and responsibility to ensure residents have the medication/supplies on hand as prescribed.
On 10/14/24, Executive Director created a reminder which was placed on medication cart to serve as a reminder to request refills at least 7 days in advance, or if medication requires a new order request new order from prescriber at least 10 days in advance.
Beginning on 12/1/24, Healthcare Director/designee will conduct weekly medication cart audits to include ensuring refills are requested and obtained in a timely manner x's 4 weeks.
By 12/1/24, Healthcare Director/designee will secure an outside service to conduct monthly medication cart audits for a period of 6 months.

Proposed Overall Completion Date: 10/22/2024

Directed: Within 7 days of receipt of this plan of correction, The administrator or designee will train all staff that pass medications on the requirement and responsibility to document the Medication Administration Record (MAR) at the time of administering the medication.
The administrator or designee will complete weekly audits of the MAR's until 12/1/2024 when an outside service is secured to conduct audits for a period of 6 months.

Directed Completion Date: *11/11/2024*

Implemented ([redacted] - 11/26/2024)

187d - Follow Prescriber's Orders

14. Requirements

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

Resident 7 had an order to receive Melatonin 3mg once daily. The medication was not available on 9/2/2024 and was unable to be administered as prescribed. The medication was reordered and received on 9/3/2024.

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

9/12/24, Executive Director provided education to Healthcare Directo on the regulation- home shall follow the directions of the prescriber.
By 10/31/24, Healthcare Director/designee will provide training to all Med Techs regarding the regulation and responsibility to ensure residents have the medication / supplies on hand as prescribed.
On 10/14/24, Executive Director created a reminder which was placed on Med carts to serve as a reminder to request refills at least 7 days in advance, or if medication requires a new order, to request new order from prescriber at least 10 days in advance.

Proposed Overall Completion Date: 10/22/2024

Directed: Beginning 10/28/2024 through 11/30/2024, The administrator or designee will complete weekly audits of the MAR's until 12/1/2024 when an outside service is secured to conduct audits for a period of 6 months. Any medication errors will be reported to the department, the prescribing physician, and family within required reporting time frames. Any staff member that administered a medication in error will be re-educated in medication administration within 3 days of discovery of the medication error or not allowed to pass medications until this re-education is completed.

Directed Completion Date: *11/11/2024*

Not Implemented ([redacted] - 11/26/2024)

225c - Additional Assessment

15. Requirements

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

Description of Violation

The most current resident assessment and support plan (RASP) for Resident 2 was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

9/12/24, Executive Director provided education to all leadership team in regard to this regulation.
By 10/31/24, Healthcare Director/designee will complete an assessment on Resident #2.
By 11/15/24, Healthcare Director/designee will conduct an initial audit of all resident assessments to ensure timely and accuracy of assessments.
Beginning 12/1/24. Healthcare Director/Designee will create a RASP tickler to ensure all resident assessments are completed in a timely manner.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented ([redacted] - 12/10/2024)

231f - Assessed Annually

16. 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

The most recent RASP for resident 9 was completed on [redacted]

The most recent RASP for resident 10 was completed on [redacted]

Plan of Correction ***Directed (- 10/23/2024)***

9/12/24, Executive Director educated on Leadership team on this regulation.
By 10/31/24, Healthcare Director/designee will complete an assessment to continued need for SDCU and create an updated RASP addressing that need for Resident #9 and Resident # 10.
By 11/15/24, Healthcare Director/designee will create a RASP tickler to ensure resident assessments are completed in a timely manner and reviewed for continued need for SDCU.

Proposed Overall Completion Date: 10/22/2024

Directed: By 10/26/2024, the administrator or designee will have Resident 9 & 10 reassessed for continuing need of placement in a secured dementia unit (SDU).
By 10/30/2024, the administrator or designee will review all resident records in the secured dementia unit and ensure that they have all been assessed for placement in the SDU within the last year. Any resident that has not been assessed in the last year will be assessed by 11/2/2024.

Directed Completion Date: *11/02/2024*

Not Implemented (- 11/26/2024)

234a - Admission Support Plan

17. 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 8 was admitted to the home's Secured Dementia Unit on [redacted] *The home does not have a support plan completed for the resident as of 9/10/2024.*

repeat violation 9/27/23, et al.

Plan of Correction ***Directed (- 10/23/2024)***

9/12/24, Executive Director educated Healthcare Director on this regulation that within 72 hours of the admission, or within 72 hours prior to the resident's admission to SDCU, a support plan shall be developed, implemented and documented in the resident record.
By 10/31/24, Healthcare Director/designee will complete and assessment and support plan for resident #8.

234a - Admission Support Plan (continued)

By 11/15/24, Healthcare Director / designee will conduct an initial audit of all new admissions to SDCU over the past 6 months to ensure all residents have a support plan in resident record.
Beginning 11/1/24, Executive Director / designee will utilize a Move In checklist to ensure all new residents files contain the required documentation for admission to SDCU. Checklist will be effective immediately.

Proposed Overall Completion Date: 10/22/2024

Directed: The administrator or designee will complete a support plan for Resident #8 by 10/26/2024.

Directed Completion Date: *10/26/2024*

Implemented ([redacted] - 11/26/2024)

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

Facility Information

Name: *HARMONY AT STATE COLLEGE* **License #:** *22803* **License Expiration:** *08/05/2025*

Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *STATE COLLEGE OPERATIONS LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *116* **Waking Staff:** *87*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *08/29/2024*

Inspection Dates and Department Representative

08/29/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *90*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care* **Capacity:** *36* **Residents Served:** *26*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *90*

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

Have Mobility Need: *26* **Have Physical Disability:** *3*

Inspections / Reviews

08/29/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/27/2024*

Inspections / Reviews *(continued)*

10/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/14/2024*

11/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

02/04/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

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

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

Through interviews with staff it was determined that staff are expected to answer resident's call bells within 7 minutes. Upon reviewing the call bell log for the home from 8-12-24 through 8-20-24, it was noted that on 12 occasions during the time period sampled, the call bell response time from staff ranged between 25 minutes, and 58 minutes and 49 seconds, leaving residents to wait for staff assistance. The home is not meeting the needs of the residents as identified in their Resident Assessment and Support Plans.

Repeat Violation: 6-26-24 & 3-6-24

Plan of Correction ***Directed [redacted] - 10/18/2024)***

Immediate response Executive Director provided education to staff on the regulation and importance of response time to assist residents with ADLs per their support plan 9/21/24.
Beginning September 21, 2024, Executive Director or designee will audit the call pendant reports from 9/1/24 to date, to identify any areas where time response was in excess of 30 minutes. The audit will be used to identify root causes: commonalities regarding, regarding staff, resident, shift.
Ongoing: 9/21/24 Executive Director or designee will pull call pendant report 2x/week through December 31, 2024, to review response time. ED or designee will identify root cause/commonalities regarding staff, resident, shift, ED or designee will make adjustments to resident care plan as necessary.

Proposed Overall Completion Date: 10/09/2024

(Directed)
Effective immediately the Administrator will audit call pendant reports daily to identify days that response time is in excess of 15 minutes. Daily audits will continue until response time is under 15 minutes or less for 2 weeks. Administrator/designee will randomly pull 10 call bells a week x 3 months and wait for response time. These response times will be documented and reviewed for training purposes with staff and for the Departments review.

Directed Completion Date: *10/23/2024*

Not Implemented [redacted] 12/02/2024)

60a - Staff/Support Plan

2. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 8/11/24, there were 4 staff scheduled on the overnight shift. On that date, there were 83 residents present in the home. 26 of those residents reside on the secured dementia care unit and require assistance due to their cognitive

60a - Staff/Support Plan (continued)

functioning. 11 residents require the assistance of one person to transfer, and 5 residents require the assistance of 2 persons to transfer. The home is not able to meet the needs of the residents as identified in the Residents Assessment and Support Plans in the event of an emergency on the overnight shift.

On 8/13/24, 8/15/24, 8/18/24 and 8/21/24, there were 4 staff scheduled on the overnight shift. On that date, there were 84 residents present in the home. 27 of those residents reside on the secured dementia care unit and require assistance due to their cognitive functioning. 11 residents require the assistance of one person to transfer, and 5 residents require the assistance of 2 persons to transfer. The home is not able to meet the needs of the residents as identified in the Residents Assessment and Support Plans in the event of an emergency on the overnight shift.

On 8/23/24 there were 4 staff scheduled on the overnight shift. On that date, there were 82 residents present in the home. 27 of those residents reside on the secured dementia care unit and require assistance due to their cognitive functioning. 11 residents require the assistance of one person to transfer, and 5 residents require the assistance of 2 persons to transfer. The home is not able to meet the needs of the residents as identified in the Residents Assessment and Support Plans in the event of an emergency on the overnight shift.

Repeat Violation: 3-6-24

Plan of Correction ***Directed ([redacted] - 10/18/2024)***

Immediate: Executive Director provided education to Healthcare Director and Assistant Healthcare Director on the regulation and need for medical valuation at least annually.
By 10/31/24, Healthcare Director or designee will complete an initial audit of all medical evaluations to ensure they are up to date. By 10/15/24, Medical Evaluation will be completed for Resident #3.
Beginning 12/1/24, Healthcare Director or designee will create a tickler file for all resident charts weekly for a period of 3 months.

Proposed Overall Completion Date: 10/09/2024

(Directed)
Administrator will reassess all residents in the facility for the correct mobility and acuity needs and ensure that the home can meet the needs of those residents. The Administrator will review the direct care staffing schedule daily to ensure there are enough staff on the overnight shift to meet the needs of all residents in the home and be able to assist them with evacuation in the event of an emergency. The staff schedules shall be maintained by the home.

Directed Completion Date: *11/08/2024*

Not Implemented ([redacted] - 12/02/2024)

141b1 - Annual Medical Evaluation

3. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

The most recent medical evaluation for Resident #3 was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Repeat Violation: 9-27-23

Plan of Correction ***Accept ([redacted] - 10/18/2024)***

Education was provided to HCD/AHCD on 9/17/24 in regard to regulatory compliance / expectations of documented medical evaluations.
Charts will be audited for compliance by 10/21/24.
HCD/Designee will audit charts monthly times 3 months to ensure charts are complete per regulatory compliance for Documented Medical Evaluations.

Proposed Overall Completion Date: 10/09/2024

Licensee's Proposed Overall Completion Date: *10/09/2024*

Not Implemented ([redacted] 02/04/2025)

182c - Medication Administration

4. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

Description of Violation

Through interviews with staff and residents, it was determined that Staff Person A was leaving medications in resident rooms and not watching to ensure the residents were taking their medications.

Plan of Correction ***Directed ([redacted] - 10/18/2024)***

Immediate 10/8/24, Executive Director provided education to all staff regarding the 7 rights of medication administration. Training will be completed by 10/31/24.
By 10/31/24, Healthcare Director or designee will complete an initial audit of all resident apartments to ensure no medications are in resident apartments, and if self-medications are secured.
Beginning 10/15/24, Healthcare Director or designee will complete a weekly audit x 8 weeks, to all resident apartments to ensure resident apartments are clear of medications.
Beginning 10/15/24, Healthcare Director or designee will conduct observations of 3 Medication Technicians per week through December 31, 2024.

Proposed Overall Completion Date: 10/11/2024

(Directed)

182c - Medication Administration (continued)

The Administrator will complete a training with all medication trained staff on the 7 rights of medication administration. The Administrator will complete random audits daily of residents bedrooms for medications being left in residents rooms by staff and interview residents regarding medication administration. The Administrator will complete two medication administration observations on each shift weekly. The Administrator will monitor for ongoing compliance.

Directed Completion Date: *11/08/2024*

Implemented ([redacted] - 12/26/2024)

224a - Preadmission Screen Form

5. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted to the home on [redacted], the home did not complete a preadmission screening.

Resident #2's preadmission screening dated [redacted] does not indicate if the home can meet the residents needs.

Repeat Violation: 11-15-23

Plan of Correction ***Accept ([redacted] - 10/18/2024)***

9/21/24 Executive Director trained the Healthcare Director/ AHCD and HSD on the regulation-need for pre-admission screening prior to admission.
By 10/15/24, a preadmission screening will be completed for Resident #1 and updated pre-admission screening will be completed for Resident #2.
By 10/31/24, Healthcare Director or designee will compete an initial audit of all resident charts to ensure completion of required pre-admission screening.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented ([redacted] - 12/02/2024)

225c - Additional Assessment

6. Requirements

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

Description of Violation

Resident #3 's most recent assessment portion of the Resident Assessment Support Plan was completed on [redacted]

Repeat Violation 11-15-23

225c - Additional Assessment (continued)

Plan of Correction ***Accept ([redacted] - 10/18/2024)***

9/21/24 Executive Director trained Healthcare Director/ AHCD and Harmony Square Director on the regulation- the need for assessments at least annually.
By 10/15/24, Healthcare Director or designee will complete an assessment for resident 3#. By 10/31/24, Healthcare Director or designee will complete an initial audit of all Rasps and create a Rasp tickler to ensure ongoing compliance.
Beginning 11/1/24, Healthcare Director or designee will utilize will a Rasp tickler to ensure assessments are completed as required. Healthcare Director or designee will audit 25% of resident files monthly for a period of 3 months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented ([redacted] - 12/20/2024)