

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

April 18, 2025

[REDACTED]  
STATE COLLEGE OPERATIONS LLC  
[REDACTED]

RE: HARMONY AT STATE COLLEGE  
121 HAVERSHIRE BOULEVARD  
STATE COLLEGE, PA, 16803  
LICENSE/COC#: 22803

[REDACTED] [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/27/2025, 03/03/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *HARMONY AT STATE COLLEGE* License #: *22803* License Expiration: *08/11/2025*  
 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: *06/18/2019* Issued By: *Centre Region Code Enforcement*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *123* Waking Staff: *92*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
 Reason: *Complaint, Incident, Fine* Exit Conference Date: *03/14/2025*

**Inspection Dates and Department Representative**

02/27/2025 - On-Site: [REDACTED]  
 03/03/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: *125* Residents Served: *88*  
 Secured Dementia Care Unit  
 In Home: *Yes* Area: *Connections* Capacity: *38* Residents Served: *26*  
 Hospice  
 Current Residents: *10*  
 Number of Residents Who:  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *88*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *35* Have Physical Disability: *0*

**Inspections / Reviews**

02/27/2025 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/05/2025*

Inspections / Reviews *(continued)*

04/10/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/17/2025

04/18/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c Post Current License

1. Requirements

2600.

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

Description of Violation

On [redacted] at 10:05a.m., the book of posted license inspection reports that was in the common area did not include reports dated [redacted] and [redacted].

Plan of Correction

Accept [redacted] - 04/07/2025)

On 2/27/25 the Executive Director placed the inspection reports for [redacted] and [redacted] in the Licensing Inspection Summary Book located in the facility lobby. The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 3/24/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)

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

Resident [redacted] is prescribed [redacted] one tablet a day. The medication was not administered on [redacted] due to the medication not being available.

Resident [redacted] is prescribed [redacted] at bedtime. On [redacted] the medication was not administered due to the medication was not being available.

Resident [redacted] is prescribed [redacted] at 8:00am. On [redacted], Resident [redacted] was not administered this medication. On [redacted], Resident [redacted] was prescribed [redacted] tab 1 time a day. Resident [redacted] did not receive the first dose of the medication until [redacted].

Resident [redacted] is prescribed [redacted] once a day. On [redacted] through [redacted], the medication was not administered because the medication was not available.

The home was made aware of the medication errors on [redacted]. An incident report was not received by the department within 24 hours.

Repeat Violation: [redacted] et al, [redacted]

Plan of Correction

Accept [redacted] - 04/07/2025)

The facility is unable to retroactively correct the medication errors for Residents [redacted] and [redacted]

On 4/1/25, the Executive Director/Designee educated the Management Team on the reporting requirements according to the abuse reporting guidelines. In addition, the ED will educate direct care staff 4/17/25 at the staff meeting on abuse reporting and regulatory compliance.

16c - Written Incident Report (continued)

Starting 4/1/25 the Executive Director or designee will complete audits of timely reporting for once a week for 4 weeks then once a month for 2 months.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)

60a - Staff/Support Plan

3. 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

The census of the home on [redacted] was 98 residents with 35 immobile residents and on [redacted] the census was 100 residents with 35 immobile residents. 26 of the immobile residents are in Memory Care, 4 Memory Care hospice residents that are totally immobile and need assistance and supervision to evacuate, and 1 personal care resident that is hospice and is totally immobile and needs assist of 2 to evacuate. There are an addition 5 residents that are assist of 2 for evacuation. On [redacted], there were 2 direct care staff working in personal care and 2 direct care staff working in Memory care from 11:00pm to 7:00am. On [redacted] there were 2 direct care staff working in Memory care from 3pm - 7:00am, and 2 direct care staff in personal care from 11:00pm to 7:00am. In the event of an emergency, there was not enough staff to safely evacuate all residents.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] - 04/07/2025)

The facility cannot retroactively change the direct care staffing schedule.

On 4/1/25 the Executive Director educated the HCD and AHCD on the proper staffing requirements to safely evacuate all residents. Beginning 4/1/25 the ED/designee will monitor the schedule daily to ensure proper staffing levels are maintained.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 3/24/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)

65a - FS Orientation 1st Day

4. Requirements

2600.

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:

65a - FS Orientation 1st Day (continued)

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 C's first day of work in the home was on [REDACTED]. Staff person C did not have any of the required first day orientation.

**Plan of Correction**

Accept [REDACTED] - 04/07/2025)

Staff person C was educated on the proper fire safety and emergency preparedness procedures.

On 4/1/25 the Executive Director/designee educated the Management staff on the requirement of fire safety and emergency preparedness training on day one of orientation. Beginning 3/24/25 the ED/designee will audit the completion and education of the day one orientation.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [REDACTED] - 04/18/2025)

132c - Fire Drill Records

**5. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**Description of Violation**

The fire drill record indicates for the fire drills conducted on [REDACTED] and [REDACTED], that 85 residents were in the home at the time of the fire drill and 85 residents were evacuated. Resident [REDACTED] and Resident [REDACTED] indicated that they refused to evacuate to fire safe areas for these fire drills and stayed in their bedrooms.

**Plan of Correction**

Accept [REDACTED] - 04/07/2025)

The facility cannot retroactively correct the deficiency.

132c Fire Drill Records (continued)

On 4/1/25 the Executive Director educated the Management staff, including the Maintenance Director and Maintenance Assistant on the proper documentation needed to properly record a fire drill. In addition, the fire drills will be reported and reviewed at the monthly safety meetings. The ED/designee will begin audits of the fire drills on 4/7/25.

The Executive Director/designee will complete monthly audits to coincide with the required monthly fire drills for 4 months.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented ( ) - 04/18/2025)

132h - Designated Meeting Place

6. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Staff person C indicated that Residents ( ) and ( ) did not evacuate for fire drills completed on ( ) & ( ). Resident ( ) and Resident ( ) confirmed that they refused to evacuate for fire drills and remained in their bedrooms.

Plan of Correction

Accept ( ) - 04/07/2025)

The Executive Director spoke to Residents ( ) and ( ) concerning their refusal to evacuate during fire drills completed 1/30/25 and 2/18/25. Resident #3 continues to refuse to evacuate so the facility issued a 30 discharge notice for non compliance. Resident #4 agreed to evacuate.

The Executive Director educated the Management staff on 4/1/25 on the regulation of evacuation during a fire drill. The ED/designee will audit the fire drills for compliance of evacuation by all residents.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 3/24/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented ( ) - 04/18/2025)

187d - Follow Prescriber's Orders

7. Requirements

2600.

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

Description of Violation

Resident ( ) is prescribed ( ), one tablet a day. On ( ) and 2/25/25, the medication was not administered due to the medication not being available.

187d Follow Prescriber's Orders (continued)

Resident [redacted] is prescribed [redacted] at 8:00am. On 2/17/25, Resident [redacted] was not administered this medication. On [redacted] Resident [redacted] was prescribed [redacted] tab 1 time a day. Resident did not receive the first dose of the medication until [redacted]. Resident [redacted] is prescribed [redacted] once a day. On [redacted] through [redacted], the medication was not administered because the medication was not available.

Repeat Violation: [redacted] et al, [redacted] et al

Plan of Correction

Accept [redacted] 04/07/2025)

The facility cannot retroactively rectify the medication administration errors for Residents [redacted] and [redacted]

The Executive Director will provide education given to the Management Team the week of 4/1/25 in regards to following prescriber's orders. The HCD and AHCD will educate the Med Tech staff on 4/17/25 at the nursing staff meeting. Beginning 3/24/25 the HCD or designee will audit residents MAR/TAR to ensure orders from prescriber are being followed properly according to the regulations.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 3/24/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)

188b - Medication Error Reporting

8. 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

Notifications were not made to the resident's primary care physicians or their responsible parties on the following medication errors:

Resident [redacted] is prescribed [redacted] one tablet a day. The medication was not administered on [redacted] due to the medication not being available.

Resident [redacted] is prescribed [redacted] spray at bedtime. On [redacted], the medication was not administered due to the medication was not being available.

Resident [redacted] is prescribed [redacted] at 8:00am. On [redacted], Resident [redacted] was not administered this medication. On [redacted], Resident [redacted] was prescribed [redacted] tab 1 time a day. Resident did not receive the first dose of the medication until [redacted].

Resident [redacted] is prescribed [redacted] once a day. On [redacted] through [redacted], the medication was not administered because the medication was not available.

Repeat Violation: [redacted] et al

188b Medication Error Reporting (continued)

Plan of Correction

Accept [redacted] - 04/07/2025)

The HCD and AHCD contacted the primary care physicians of Resident's [redacted] and [redacted] to notify them of the medication errors.

The HCD and AHCD were educated by the Executive Director on 4/1/25 of the importance and requirement of notifying the primary care physician when a medication error occurs. The Med Tech staff will be educated on 4/17/25, at the nursing staff meeting, as to the proper process of communicating a medication error to the resident, resident's designated person and the prescriber. The ED/designee will begin audits of the process of communicating to the prescriber beginning 3/24/25.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 3/24/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)

227g -Support Plan Signatures

9. Requirements

2600.

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

Description of Violation

The Resident Assessment Support Plan for Resident [redacted] dated [redacted] was not signed by the resident and there was no notation that the resident was unable or refused to participate. The assessor signed but did not date the Resident Assessment and Support Plan.

Plan of Correction

Accept [redacted] - 04/07/2025)

Resident #11 signed the Resident Assessment Support Plan dated 1/30/25.

On 4/1/25 the Executive Director educated the Management Team on the proper procedure of completing a RASP signature and date for compliance purposes. Direct Care staff will be educated on 4/17/25 at the nursing staff meeting of the requirement of dates and signatures of participating individuals.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 4/1/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented ([redacted] 04/18/2025)

227i - Support Plan Accessible

10. Requirements

2600.

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

227i - Support Plan Accessible (continued)

Description of Violation

On [redacted] and [redacted], Staff person C, D, and E indicated they did not know where the resident assessment and support plans were kept. All staff that were interviewed indicated that they do not have access to the assessment and support plans and must rely on co-workers to pass on any new information on residents.

Plan of Correction

Accept [redacted] - 04/07/2025)

Staff members C, D and E were educated on the where the location of the support plans.

The Executive Director educated the Management Team on 4/1/25 of the new location for accessibility of the support plans. The direct care staff will be formally educated on 4/17/25 at the nursing staff meeting on the new accessibility procedure.

On 4/3/25 the Maintenance team installed combination locks on the cabinets behind the nursing station as the new location for the support plans. The individual staff members will be educated at the staff meeting of 4/17/25.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 4/7/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] 04/18/2025)

231c - Preadmission Screening

11. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] moved into Secured Dementia Care Unit on [redacted]. The cognitive prescreen was completed on [redacted]

Plan of Correction

Accept [redacted] - 04/07/2025)

The facility cannot retroactively correct the cognitive prescreen for Resident [redacted]

On 4/1/25 the Executive Director educated the Management Team on the requirement of a preadmission screening being completed 72 hours prior to admission to a secured dementia care unit. Beginning 4/1/25 the ED/designee will complete an audit of the 72-hour requirement for all new admissions to a secured dementia unit.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 3/31/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)

231c Preadmission Screening (continued)

234a - Admission Support Plan

12. 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 [redacted] moved into Secured Dementia Care Unit on [redacted]. An initial support plan for resident [redacted] had not been completed as of [redacted].

Repeat Violation: [redacted] et al.

Plan of Correction

Accept [redacted] - 04/07/2025)

Resident [redacted] support plan has been updated.

The Executive Director educated the HCD, AHCD and Management Team on 4/1/25 on the 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. Beginning 4/1/25 the HCD/designee will conduct an initial audit of all new admissions to SDCU over the past 3 months to ensure all residents have a support plan in place. In addition, the HCD/designee will complete an audit of all new admission for regulatory compliance of the 72 hour requirement.

The Executive Director/designee will complete weekly audits for 4 weeks, then once a month for 2 months. Audits will begin 4/1/25.

Licensee's Proposed Overall Completion Date: 05/27/2025

Implemented [redacted] - 04/18/2025)