



Pennsylvania Department of Human Services

Sent via email to: [REDACTED]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 21, 2025

[REDACTED]
[REDACTED]
State College Operations LLC
[REDACTED]

RE: Harmony at State College
121 Havershire Boulevard
State College, Pennsylvania 16803
License #228032

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 8, 2025, July 9, 2025, October 1, 2025 and October 7, 2025 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. 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 SECOND PROVISIONAL license is enclosed and is valid from NOVEMBER 21, 2025 to MAY 21, 2026.

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 X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
132h	III	93	\$3	\$279	15 calendar days from mailing date of this letter
185a	III	93	\$3	\$279	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:


 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Forum Place, 6th Floor
 PO Box 2675
 Harrisburg, Pennsylvania 17105-2675
 PH: 717-265-8942

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.

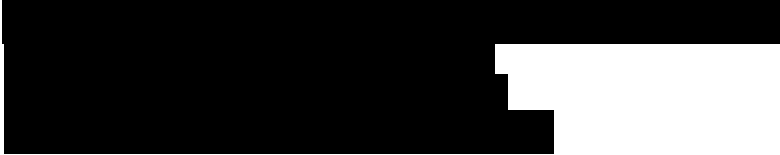
Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *HARMONY AT STATE COLLEGE* License #: *22803* License Expiration: *08/11/2025*
Address: *121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803*
County: *CENTRE* Region: *NORTHEAST*

Administrator

Name: [REDACTED]

Legal Entity

Name: *STATE COLLEGE OPERATIONS LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *06/19/2019* Issued By: *Centre Region Code Enforcement*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *122* Waking Staff: *92*

Inspection Information

Type: *Full Provisional* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *07/09/2025*

Inspection Dates and Department Representative

07/08/2025 - On-Site: [REDACTED]
07/09/2025 - 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: *n/a* Capacity: *38* Residents Served: *25*

Hospice

Current Residents: *8*

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: *34* Have Physical Disability: *0*

Inspections / Reviews

07/08/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/08/2025*

08/18/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/19/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/25/2025*

09/02/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/19/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *09/17/2025*

11/17/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *09/19/2025*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

28e - Death of a Resident

2. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #15 passed away on [redacted]/25. Resident #15 's personal belongings were removed from [redacted] r room on 3/3/25; however, the resident's estate received a refund on 4/4/25.

Plan of Correction

Directed [redacted] - 09/02/2025)

On 8/7/25 the Business Office Manager initiated the process the additional 2 days of reimbursement for the resident's family.

On 7/9/25 the Business Office Manager was educated by the Executive Director on the correct process of reimbursing a family within 30 days of death.

On 7/22/25 the Executive Director educated the management staff on the requirement of refunding the remainder of previously paid charges to the resident's estate within 30 days.

Beginning 8/1/25 the Executive Director/designee will complete a weekly audit of reimbursement due to resident's estates to ensure compliance within the 30-day requirement.

The audits will be completed for 4 weeks, then 2 months thereafter.

The Business Office Manager initiated the proper reimbursement to the deceased resident's family on 8/7/25. On that same date the Business Office Manager created a tracking method in the business file to ensure the reimbursement payments are received within the allowable timeframe according to the Elder Care Payment Restitution Act.

Beginning 8/1/25 the ED will review all such future cases for compliance purposes.

(Directed)

In addition to the above noted plan: Effectively immediately in the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P.S. §§ 10226.101 – 10226.107). The home shall keep documentation of the refund in the resident's record.

Directed Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

29a SOPb1- Hospice Care: Doctor Certification

3. Requirements

2600.

29a SOPb1- Hospice Care: Doctor Certification (continued)

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

Resident # 1, who was not evacuated during the fire drill conducted on 6/13/25 at 5:25 a.m., does not have a written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/9/25 the facility obtained a physician order using the proper verbiage of "The resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill".

On 7/9/25 the Executive Director educated the Management team on the proper terminology needed to meet the regulation for non-participation in a fire drill by hospice resident. In addition, on 8/14/25 the Executive Director will educate direct care staff on the proper protocol and procedures for hospice residents not participating in facility fire drills.

Beginning 8/1/25, the ED/designee will complete monthly audits of any orders for hospice residents not participating in the monthly fire drills to ensure compliance. Audits will be completed for 4 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

29a SOPb2 - Hospice Care: Informed Consent

4. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 2. The resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative has provided written informed consent that the person is not to evacuate in a fire drill.

Description of Violation

There is no statement of informed consent from Resident #1, the resident's [redacted] for health care, the resident's [redacted], or the resident's [redacted] regarding the resident not evacuating during fire drills. The resident was not evacuated during the fire drill conducted on 6/13/25 at 5:25 a.m.

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/9/25 a letter of informed consent for Resident #1 was obtained by the facility.

On 7/9/25 the Executive Director educated the Management team on the proper documentation of informed consent from the resident on non-participation in monthly facility fire drills. In addition, on 8/14/25 the Executive Director will educate direct care staff on the proper protocol and procedures for hospice residents not participating in facility fire drills.

29a SOPb2 - Hospice Care: Informed Consent (continued)

Beginning 8/1/25, the ED/designee will complete monthly audits of any orders for hospice residents not participating in the monthly fire drills to ensure compliance. Audits will be completed for 4 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented [redacted] - 10/06/2025)

29a SOPb3 - Hospice Care: Relocating Residents

5. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 3. If practicable, the home is to locate the bedroom of a resident receiving hospice care and services on the ground level of the building and near to an exit or fire-safe area as defined in § 2600.132(d) (relating to fire drills).

Description of Violation

According to the administrator, the home has not given consideration to the practicality of relocating Resident # 1 who was not evacuated during the fire drill conducted on 6/13/25 at 5:25 a.m. to a room closer to an exit.

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/9/25 the facility researched the practicality of relocating Resident #1 to a room closer to an exit. It was determined the options for relocating the resident closer to an emergency exit was not practical.

On 7/9/25 the Executive Director educated the Management team on the requirement and importance of reviewing the possibility of relocating the hospice resident who is non-participation in monthly facility fire drills to a location closer to an emergency exit. In addition, on 8/14/25 the Executive Director will educate direct care staff on the proper protocol and procedures for hospice residents not participating in facility fire drills.

Beginning 8/1/25, the ED/designee will complete monthly audits of any orders for hospice residents not participating in the monthly fire drills to ensure compliance. Audits will be completed for 4 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

29a SOPb4 - Hospice Care: Inform Non-Participating

6. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 4. During a fire drill, the one designated person at the home who has knowledge in advance of the fire drill is to immediately upon setting off the fire alarm to begin the fire drill, go to the room of the resident who meets the conditions of paragraphs (1)—(3), and notify the affected resident and any staff person who attempts to evacuate the resident, that this is a fire drill and the resident is not to be evacuated.

Description of Violation

Staff person D, who conducted the fire drill on 6/13/25 at 5:25 a.m. did not inform Resident #1 or the staff person

29a SOPb4 - Hospice Care: Inform Non-Participating (continued)

responsible for evacuating the resident, that the alarm indicated a fire drill rather than an actual fire. Resident #1 meets the conditions for not participating in fire drills.

Plan of Correction

Accept [redacted] - 08/18/2025)

The facility cannot retroactively inform resident #1 of a fire drill instead of an actual fire.

On 7/9/25 the Executive Director educated the Management team on the proper procedure of communicating with the Hospice Resident indicating it is a fire drill not an actual fire. In addition, on 8/14/25 the ED will educate on direct care staff on the proper protocol and procedures for hospice residents not participating in facility fire drills.

Beginning 8/1/25, the ED/designee will complete monthly audits of any orders for hospice residents not participating in the monthly fire drills to ensure compliance. Audits will be completed for 4 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 11/06/2025)

29a SOPb6 - Hospice Care: Resident Evacuation

7. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

6. If the provisions of paragraph (4) are not initiated, staff persons will proceed to evacuate the resident. All staff persons are to be trained to follow this evacuation procedure.

Description of Violation

On 6/13/25, at 5: 25a.m. the fire alarm of the home sounded. The staff responsible for evacuating Resident #1 was not informed that the alarm was a drill, but did not evacuate the resident.

Plan of Correction

Accept [redacted] - 08/18/2025)

The facility cannot retroactively inform Resident #1 of a fire drill instead of an actual fire.

On 7/9/25 the Management team was educated on the proper procedure of communicating with the Hospice Resident indicating it is a fire drill not an actual fire. In addition, on 8/14/25 direct care staff will be educated on the proper protocol and procedures for hospice residents not participating in facility fire drills.

Beginning 8/1/25, the ED/designee will complete monthly audits of any orders for hospice residents not participating in the monthly fire drills to ensure compliance. Audits will be completed for 4 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

29a SOPb11 - Hospice Care: Records

8. Requirements

2600.

29a SOPb11 - Hospice Care: Records (continued)

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 11. Documentation of compliance with this section is to be kept in the fire drill record, as well as in the resident's record. The documentation is to include the following:
 - i. A copy of the Department of Health license for the hospice agency.
 - ii. Written certification by the physician as specified in paragraph (1).
 - iii. Written informed consent as specified in paragraph (2).
 - iv. Written documentation of the home's consideration of relocation of the resident's bedroom as specified in paragraph (3)

Description of Violation

Resident # 1 's record does not contain a copy of the Department of Health license for the hospice agency, written certification by the physician as specified in §2600.29a(b)(1), there was not written consent as specified in §2600.29a(b) (2), or written documentation of the home's consideration of relocation of the resident's bedroom as specified in §2600.29a(b)(3).

Plan of Correction

Accept () - 08/18/2025)

On 7/9/25 the facility included in the Fire Drill records 1) a copy of the Hospice agency license, 2) Written certification by the physician, 3) Written informed consent and 4) written documentation of the home's consideration of relocation of the resident's bedroom.

On 7/9/25 the Management team was educated on the proper procedure of communicating with the Hospice Resident indicating it is a fire drill not an actual fire. In addition, on 8/14/25 direct care staff will be educated on the proper protocol and procedures for hospice residents not participating in facility fire drills.

Beginning 8/1/25, the ED/designee will complete monthly audits of any orders for hospice residents not participating in the monthly fire drills to ensure compliance. Audits will be completed for 4 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented () 10/06/2025)

51 - Criminal Background Check

9. Requirements

2600.

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

Description of Violation

Staff Person A began working in the home on [redacted]/25. The staff person's Pennsylvania State Police Criminal Background Check was not completed by the home.

Plan of Correction

Accept () - 08/18/2025)

The facility initiated a background check for Staff person A on 7/12/25 and the result was found to be appropriate.

On 7/12/25 the Executive Director educated the BOM on proper background check procedure and protocol.

51 - Criminal Background Check (continued)

On 7/22/25 the Executive Director educated the Management team on the requirement and importance of securing a criminal background check on all new employees before beginning their employment.

Beginning 7/21/25 the Executive Director/designee will complete weekly audits of new hire background checks for 4 weeks, then monthly audits for 2 months.

Audit all new employees for background checks.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented [redacted] - 10/06/2025)

65b - Rights/Abuse 40 Hours

10. Requirements

2600.

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

Description of Violation

Staff person B completed [redacted] 40th scheduled work hour on or before 5/30/25 However, this staff person did not complete training in the following topics: Emergency Medical Plan.

Plan of Correction

Accept [redacted] - 08/18/2025)

On July 22, 2025, Staff member B was educated by the HCD on the Emergency Medical Plan.

On 7/22/25 the Executive Director educated the Management staff on the requirement of training new employees on the Emergency Medical Plan. In addition, on 8/14/25 direct care staff will be educated on the requirement of new employees being trained on the facility Emergency Medical Plan.

Beginning 8/1/25 the Business office Manager will complete an audit of new employee orientation files to verify the Emergency Medical Plan was reviewed with each new employee. Audits will be conducted weekly for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] 10/06/2025)

65i - Training Record

11. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of annual fire safety training conducted on 10/4/24 does not include the length of the course.

Plan of Correction

Directed [redacted] - 09/02/2025)

The facility cannot retroactively record the training time conducted during annual fire safety training.

65i - Training Record (continued)

On 7/22/25 the Executive Director educated the management staff on the requirement of recording the training time of fire safety educational sessions.

Beginning 8/1/25, the Executive Director/designee will complete monthly audits of all fire safety training will be completed to verify documents have been time stamped appropriately.

The monthly audits will be completed for 4 months.

Beginning 8/1/25 the Maintenance Director will be responsible for recording the length of the courses for all annual and monthly fire safety trainings. All fire safety trainings will be reviewed by the ED for compliance and accuracy purposes. The fire safety trainings will be monitored and reviewed by the QA committee as well.

(Directed)

In addition to the above noted plan: An audit of the completed 2025 training will be reviewed to include the staff person trained, date, source, content, length of each course and copies of any certificates received. Documentation of the audit shall be maintained.

Directed Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

103i - Outdated Food

12. Requirements

2600.

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

Description of Violation

On 7/9/25 there was a dented can of Ketchup and a dented can of Chunky Applesauce on the can rack in the dry storage area.

Repeat violation: 11/20/24 et al

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/8/25 all dented cans were removed and disposed of in the proper manner.

On 7/22/25 the Executive Director educated the Management and Dining team of the importance of identifying dented cans in the dry storage unit.

Beginning 7/22/25 the Executive Director/Designee will complete a weekly audit of the dry storage of food cans to ensure prevention of spoiled food. Any dented cans will be immediately disposed of in the proper manner.

The weekly audits will be completed for 4 weeks, then two months thereafter.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

105g - Lint Removal and Duct Cleaning

13. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 7/8/25 at approximately 9:30 a.m., there was an accumulation of lint the size of a golf ball in each of the lint traps in the third floor laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept [redacted] - 08/18/2025)

A sweep of the lint traps and drum of clothes was completed immediately.

On 7/22/25 the Executive Director provided education to the housekeeping staff and direct care staff on proper procedure of cleaning lint traps. In addition, the ED will educate the direct care staff of the proper procedure of cleaning the lint traps and drum.

Beginning 7 /21/25 weekly audits of the lint traps will be completed by the Maintenance Director/designee to ensure compliance and cleaning.

The weekly audits will be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

124 - Notice to Fire Department

14. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/9/25 the Executive Director sent formal written notice to the local fire department outlining the address of the home, location of bedrooms and assistance needed to evacuate in an emergency.

On 7/22/25 the Executive Director educated the management team on the need for documentation outlined in 2600.124, between the facility and the local fire department in case of evacuation.

On 8/14/25 direct care staff will be educated on the facility information the facility is required to be communicated to the local Fire Department, including the address of the home, location of the bedrooms and assistance needed to evacuate in an emergency.

The information will be kept on file and will be updated annually.

124 - Notice to Fire Department (continued)

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [REDACTED] - 10/06/2025)

132h - Designated Meeting Place

15. 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

During the fire drill on 6/13/25 at 5:25 a.m., Resident #3 and Resident #4 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drills conducted on 3/11/25 at 3:08 a.m., 4/7/25 at 1:37 p.m. and 5/23/25 at 2:15p.m., Resident #4 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Repeat violation: 2/27/25 et al

Plan of Correction

Accept [REDACTED] - 09/02/2025)

The facility cannot retroactively evacuate residents to a designated meeting place.

On 7/9/25 the Executive Director educated the management team on the designated meeting place away from the building or within a fire-safe area. In addition, on 8/14/25 direct care staff will be educated on the designated meeting pace away from the building and within a fire-safe area.

Beginning 8/1/25 the Executive Director/designee will complete monthly audits of each fire drill conducted to determine compliance in evacuating residents to an approved designated meeting place.

The monthly audits will be conducted for 4 months.

The Executive Director spoke to Resident #3 on 7/9/25 about the requirement of evacuating and [REDACTED] refusal to evacuate during a fire drill. This is the first refusal by this resident and resident has agreed to evacuate to a safe area during all future fire drills. On 7/9/25 the ED also spoke with resident #4 concerning [REDACTED] refusal to evacuate during a fire drill. The resident has been put on notice that if the resident refuses evacuation during the next drill [REDACTED] will be issued a 30-day notice for failure to comply with the regulation.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented ([REDACTED] - 10/06/2025)

141b1 - Annual Medical Evaluation

16. Requirements

2600.

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

141b1 - Annual Medical Evaluation (continued)

Description of Violation

Resident # 2's most recent medical evaluation was completed on [redacted]/25. The resident's previous medical evaluation was completed on [redacted]/23.

Plan of Correction

Accept [redacted] - 08/18/2025)

Resident #2's annual evaluation for 2024 cannot be retroactively produced.

On 7/9/25 the Executive Director educated the HCD on the requirement of a resident's medical evaluation being updated and revised annually.

Beginning 8/1/25 the HCD/designee will complete an audit of resident's annual evaluation to determine compliance of at least annual updates. A weekly audit will also be completed to ensure change of status revisions are completed within the regulatory guidelines.

The audits will be completed for 4 weeks, then 2 months thereafter.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented [redacted] - 10/06/2025)

181c - Self-administration Assessment

17. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #11 self-administers medications to include Miralax; however, resident #11 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction

Accept [redacted] - 08/18/2025)

Resident #11 has been evaluated for [redacted] ability to self-administer medications. The HCD updated the self-medication orders for Resident #11.

On 7/2/25 the Executive Director educated the HCD on the self-medication process and assessment compliance. In addition, on 8/14/25 the direct care staff will be education on the self-medication regulations and processes by the HCD.

Beginning 8/1/25 the HCD/designee will audit the self-medicating residents to confirm compliance.

The audits will be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

181d -Storing Medication

18. Requirements

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident’s room for self-administration. Medications stored in the resident’s room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #8 self-administers medication and stores medication in their room. On 7/9/25 at approximately 1:15 p.m. there was unlocked, unattended Metamucil in Resident #8’s bedroom.

Plan of Correction

Accept [redacted] - 08/18/2025)

Resident #8’s medication was securely locked for safe storage.

On 7/2/25 the direct care staff/med techs were educated on the need for proper security of medication for self-administrators, including the method of locking the medication bins, by the Executive Director.

Beginning 8/1/25 the HCD/designee will initiate audits that will be completed for compliance and safety of medications being secured for Self-administering residents.

The weekly audits will be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

181f - Record of Medication

19. Requirements

2600.

181.f. The resident’s record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 7/9/25, Resident #10's medication record did not include a current list of treatments to be stored at bedside. The list in the resident's medication administration record did not specify that the residents Trelegy Ellipta inhaler and Refresh Tears .5% eye drops may be stored at bedside as per the physicians orders.

On 7/9/25 Resident # 8's record did not include a current list of medications. The list in the resident's record did not contain Metamucil.

Plan of Correction

Accept [redacted] - 08/18/2025)

Residents #8 & #10's medication was added to their medication list.

On 7/22/25 the HCD trained the direct care staff on the need to keep resident’s medication up-to-date and accurate. On 8/14/25 direct care staff will be receiving additional training on what the self-medicating resident’s record should contain including, a current list of prescription, CAM and OTC medications.

Beginning 8/1/25 a weekly audit of resident that self-administer will be completed to determine the list of medications are up-to-date and accurate.

181f - Record of Medication (continued)

The weekly audits will continue for 4 weeks then, monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

183b - Meds and Syringes Locked

21. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/9/25 at approximately 2:30 p.m. Bacitracin 500 Unit/gm ointment was unlocked, unattended, and accessible in Room [redacted].

Plan of Correction

Accept [redacted] - 09/02/2025)

Residents in rooms [redacted] had their Bacitracin and Metamucil safely secured in their lock boxes inside their rooms.

On 7/22/25 the HCD educated the direct care staff on the need for proper security of medication for residents who self-administer medications. On the 8/14/25 the direct care staff will be re-educated on the proper storage and security of medications.

Weekly audits will be completed by the HCD/designee starting 8/1/25 for compliance and safety of medications being secured for Self-administering residents.

Weekly audits will be completed for 4 weeks, then monthly for 2 months.

A self-medication review was complete on the resident in room [redacted] and they have a physician's order to self-administer Bacitracin and Metamucil, respectively.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [redacted] - 10/06/2025)

183d - Prescription Current

22. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 7/9/25, Donepezil 10 mg tablets prescribed for Resident #13, were in the home's medication cart; however, the

183d - Prescription Current (continued)

medication was discontinued on 7/7/25.

On 7/9/25 Rosuvastatin Calcium 10mg tablets prescribed for Resident #13 were in the home's medication cart; however the medication was discontinued on 7/6/25.

Repeat violation: 3/26/25

Plan of Correction

Accept (█ - 08/18/2025)

Outdated medication for Resident #13 were removed from the cart and disposed of properly. A review of the med carts was completed to check for any additional out of date medication.

The HCD educated the med tech staff 7/22/25 on the procedure for checking resident medications to ensure the carts have only current medications available. At the staff meeting on 8/14/25 additional training will be provided by the HCD/designee.

Weekly audits of the medication carts will be completed to determine accuracy and availability of current medications.

The audits will begin 8/1/25 and be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented (█ - 10/06/2025)

185a - Implement Storage Procedures**23. 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 #11 has an order for PRN Biscopalax 10mg suppositories and Senna 8.6mg tablets. On 7/9/25 the medication was not available in the medication cart.

Resident #12 has an order for blood glucose checks to be completed daily at 8:00 a.m. On 7/5/25 a blood glucose reading of 140 as recorded on the residents medication administration record, however no blood glucose reading was observed in the resident's glucometer for this date.

Resident #12 has an order for PRN Naproxen 500mg tablets. On 7/9/25 the medication was not available in the medication cart.

Repeat Violation 3/26/25, 9/10/24 et al

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept [redacted] - 08/18/2025)

Resident #11 & #12's PRN medications was reordered and delivered to the facility. Resident #12 blood glucose check was not able to be completed retroactively.

The direct care/med tech staff were educated on 7/22/25 by the HCD, on the proper procedure of safe storage, access and distribution of medications as well as proper glucose blood pressure check procedures. Additional training will be provided by the HCD at the 8/14/25 staff meeting.

Weekly audits of the medication carts will be completed by the HCD/designee to determine accuracy and availability of current medications. The facility will secure an outside service to conduct monthly medication cart audits. In addition, weekly audits of Glucose Blood pressure checks will be completed for timeliness and accuracy.

The audits will begin 8/1/25 and be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented ([redacted] - 11/05/2025)

187b - Date/Time of Medication Admin.

24. Requirements

2600.

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

Description of Violation

On 7/9/25 at 8:00 a.m., Resident #14 was administered Bromidine eye drops. Staff Person B did not initial the medication administration record until 10:40 a.m. when a reminder that the medication record was not initialed was received during the home's medication cart audit.

Repeat violation: 9/10/24 et al

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/9/25 Staff member B was educated by the HCD on the proper practice of recording the medication administration time immediately upon providing the medication.

The HCD educated direct care staff on 7/22/25 on the timely recording of medication administration. Additional training will be provided on 8/14/25 at the monthly staff meeting.

Beginning weekly audits of the medication carts will be completed by the HCD/designee to determine accuracy and availability of current medications.

The audits will begin 8/1/25 and be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented ([redacted] - 10/06/2025)

187d - Follow Prescriber's Orders

25. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed Olopatadine GNP 0.1% eye drops, instill 1 drop into affected eye twice a day for allergies. However, this medication was not administered to Resident #1 on 6/18/25 because the medication was not available in the home.

Resident #7 is prescribed Quetiapine Fumarate 25 mg tablet, take one tablet by mouth every day for BPH. However, this medication was not administered to Resident # 9 on 6/6/25 because the medication was not available in the home.

Resident #10 is prescribed to receive blood pressure checks twice daily at 8:00 a.m. and 8:00 p.m. However, Staff Person B reported at approximately 10:45 a.m. on 7/9/25 that Resident #10's blood pressure was not checked on 7/9/25 at 8:00 a.m.

Resident #12 is prescribed to have blood glucose checks completed daily at 8:00 a.m. On 7/5/25, the resident's blood glucose check was not completed.

Repeat Violation 2/27/25 et al., 11/20/24 et al, 9/10/24 et al

Plan of Correction

Accept [REDACTED] - 08/18/2025)

On 7/9/25 Residents # 1 & #7 medications were ordered and delivered to the facility. Residents #10 & #12 blood glucose checks could not be retroactively completed. Staff member B was educated on the importance of timely blood pressure checks.

On 7/22/25 the HCD direct care staff were educated on the importance of following a Prescriber's Orders. In addition, education was provided on timely blood glucose and blood pressure checks. Additional training will be provided on 8/14/25 by the HCD at the monthly staff meeting.

Beginning 8/1/25 the HCD/designee will initiate weekly audits of the medication carts will be completed to determine accuracy and availability of current medications. Audits of blood glucose and blood pressure checks will be completed.

The audits will begin 8/1/25 and be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Implemented [REDACTED] - 10/06/2025)

190c - Record of Training

26. Requirements

2600.

190c - Record of Training (continued)

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff Person C dated [redacted]/25 does not include the staff person's signature and both dates the staff member's medication administration observations were completed.

Plan of Correction

Accept [redacted] - 08/18/2025)

On 7/9/25 Staff person C medication administration training record was updated with all pertinent information.

On 7/22/25 the Executive Director educated the Healthcare Director on the training record requirements including the staff person trained, the date, source, name of trainer and documentation of course begin successfully completed. In addition, on 8/14/25 direct care staff will be educated on the requirements of the training record to show a successful completion of the program.

Beginning 8/1/25 the ED/designee will complete a weekly audit of the facility's medication administration training records to ensure compliance. Any new staff member participating in the medication training will have their record audited for compliance purposes.

The weekly audits will be completed for 4 weeks, then monthly for 2 months.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented [redacted] - 10/06/2025)

225c - Additional Assessment

27. Requirements

2600.

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

- 1. Annually.
- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #3's current assessment was completed on [redacted]/25. However, the resident's previous assessment was completed on [redacted]/23.

Resident #3 utilizes an enabler bar. The assessment dated [redacted]/25 does not include the residents use of the enabler bar and the specific need for it.

Resident #5 utilizes an enabler bar. The assessment dated [redacted]/25, does not include the residents use of the enabler bar and the specific need for it.

Repeat violation 9/10/24 et al.

225c - Additional Assessment (continued)

Plan of Correction

Accept [redacted] - 09/02/2025)

Resident #3 2024 assessment cannot be retroactively produced. Resident #3 was assessed for the need, safety and use of a halo device.

The Executive Director educated the HCD on 7/22/25 on the requirement of completing an assessment due to a resident's change of condition or annual assessment coming due. Education for the direct care staff will be provided by the HCD on 8/14/25 at the monthly staff meeting.

On 8/1/25 an audit of resident's having Halo devices will be completed by the HCD/designee to determine compliance for the use of Halo devices. Weekly audits be the HCD/designee will be completed to ensure continued compliance.

Audits will be completed weekly for 4 weeks and then monthly for 2 months.

Resident #5 was assessed for the need, safety and use of a halo device and an order was obtained.

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented [redacted] - 10/06/2025)

231c - Preadmission Screening

28. 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 # 6 was admitted to the Secure Dementia Care Unit on [redacted]/25. However, the Resident 's written cognitive preadmission screening was completed on [redacted]/25.

Plan of Correction

Accept [redacted] - 08/18/2025)

The facility cannot retroactively complete the preadmission screening.

On 7/9/25 the Executive Director educate the HCD on the timeliness of the preadmission screening process of within 72 hours prior to an admission to a secure dementia unit. Additional training will be provided to the Management Team and Direct Care Staff at the 8/14/25 staff meeting.

Beginning 8/1/25 a weekly audit of all new preadmission screens will be completed by the ED/designee to ensure compliance with the regulation.

Audits will be completed for 4 weeks, then monthly for 2 months.

231c - Preadmission Screening (*continued*)

Licensee's Proposed Overall Completion Date: 09/16/2025

Not Implemented [REDACTED] 10/06/2025)