

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

January 14, 2026

[REDACTED]  
STATE COLLEGE OPERATIONS LLC  
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/01/2025, 10/07/2025 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: 06/19/2019 Issued By: Center Region Code Enforcement

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 133 Waking Staff: 100

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Interim Exit Conference Date: 10/07/2025

**Inspection Dates and Department Representative**

10/01/2025 - On-Site: [Redacted]  
 10/07/2025 - Off-Site: [Redacted]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: 125 Residents Served: 93  
 Secured [Redacted] Care Unit  
 In Home: Yes Area: n/a 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: 93  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 40 Have Physical Disability: 1

**Inspections / Reviews**

10/01/2025 Partial

Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 11/23/2025

Inspections / Reviews (*continued*)

## 12/29/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/02/2026

## 01/06/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/11/2026

## 01/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

29a SOPb2 - Hospice Care: Informed Consent

1. 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 [REDACTED], the resident’s power of attorney for health care, the resident’s legal guardian, or the resident’s health care representative regarding the resident not evacuating during fire drills. The resident was not evacuated during the fire drill conducted on [REDACTED] at 10:32 a.m., [REDACTED] at 3:10 p.m. or [REDACTED] at 4:50 a.m.

Plan of Correction

Accept [REDACTED] 12/29/2025)

On 11/11/25 resident [REDACTED] signed a statement of informed consent regarding the resident not evacuating during fire drills.

On 11/24/25 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.

Beginning 11/11/25, 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 3 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [REDACTED] 01/14/2026)

51 - Criminal Background Check

2. 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 who began working in the home on [REDACTED], did not have a Pennsylvania State Police Background Check completed.

Plan of Correction

Accept [REDACTED] - 12/29/2025)

On 10/15/25 Staff Person A’s Criminal Background Check was completed.

The facility initiated a background check for Staff person A on 10/12/25 and the result was found to be appropriate.

On 10/15/25/25 the Executive Director educated the Business Office Manager on the requirement and importance of securing a criminal background check on all new employees before beginning their employment.

Beginning 10/15/25 the Executive Director/designee will complete weekly audits of new hire background checks for

51 - Criminal Background Check (continued)

4 weeks, then monthly audits for 2 months. Audit all new employees for background checks.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/14/2026)

103g - Storing Food

3. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 9:35a.m. there were 4 ice cream containers in the ice cream freezer that did not have lids on them.

Plan of Correction

Accept [redacted] - 12/29/2025)

On 10/8/25 the Dining Service Director secured the lids of the ice cream containers according to regulatory compliance.

On 10/12/25 the ED educated the Dining Service Director (DSD) on the need for ice cream containers to have lids secured attached to the containers in the freezer.

In addition, the DSD educated the kitchen staff on the need for securing lids on the ice cream containers at all times.

Beginning 10/15/25 the ED/designee will conduct weekly audits of the ice containers for proper securing of the container lids. The weekly audits will be conducted for 4 weeks then monthly for 3 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/06/2026)

132c - Fire Drill Records

4. 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 for the drill conducted on [redacted] at 3:10 p.m. and [redacted] at 4:50 a.m. does not include the correct number of residents evacuated. On [redacted] residents did not evacuate, 1 due to provisions of regulation 29 and 2 due to refusal to evacuate. On [redacted] 2 residents were not evacuated, one due to provisions of regulation 29 and the other due to refusal to evacuate. The fire drill log for [redacted] notes that there were 98 residents in the home and 98 evacuated. The fire drill log for [redacted] noted that there were 91 residents in the home and 91 evacuated.

Repeat violation [redacted] et al.

132c - Fire Drill Records (continued)

Plan of Correction

Accept [redacted] - 12/29/2025)

The facility cannot retroactively change or alter fire drill records.

On 10/15/25 the Executive Director educated the Maintenance Staff on the proper method of counting the number of residents in the home at the time.

Beginning 10/15/25 the Executive Director/designee will complete monthly audits of each fire drill conducted to determine compliance in evacuating residents. The audits will be performed monthly for 4 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] 01/14/2026)

132h - Designated Meeting Place

5. 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 [redacted] at 3:10pm, Residents [redacted] and [redacted] did not evacuate to a designated meeting place away from the building or within the fire-safe area. During the fire drill on [redacted] Resident [redacted] did not evacuate to a designated meeting place away from the building or within the fire safe area.

Repeat violation [redacted] et al.

Plan of Correction

Accept ([redacted] 12/29/2025)

The facility cannot retroactively evacuate residents to a designated meeting place. The ED educated both Resident [redacted] and Resident [redacted] to the requirement of evacuating during a fire drill. Additionally, Resident #1 was educated to the fact a 30-day discharge notice for non-compliance.

On 10/12/25 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 10/15/25 direct care staff was educated on the designated meeting place away from the building and within a fire-safe area.

Beginning 10/15/25 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.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/14/2026)

141a 1-10 Medical Evaluation Information

6. Requirements

141a 1-10 Medical Evaluation Information (continued)

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 [redacted]’s medical evaluation dated [redacted] does not include height, weight, temperature, or if the resident’s needs can be met at a personal care home.

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

**Plan of Correction**

Accept ([redacted] - 12/29/2025)

On 10/10/25 Resident [redacted]’s medical evaluation was updated to include height, weight, temperature and if the resident’s need can be met by the facility.

On 10/15/25 the ED/designee educated the HCD on the requirement of completing the Medical Evaluation Information in its entirety.

Beginning 10/15/25 the ED/designee will complete a weekly audit of all new Medical Evaluations being completed in the facility for regulatory compliance. The weekly audits will be completed for 4 weeks then monthly for 3 months.

Licensee’s Proposed Overall Completion Date: 12/31/2025

Implemented ([redacted] - 01/14/2026)

141b1 - Annual Medical Evaluation

**7. Requirements**

2600.

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

**Description of Violation**

Resident [redacted]’s most recent medical evaluation was completed on [redacted]

**Plan of Correction**

Accept ([redacted] - 12/29/2025)

The facility cannot retroactively complete Resident [redacted]’s 2024 medical evaluation. The 2025 Annual Medical Evaluation is compliant.

On 10/15/25 the Executive Director educated the HCD on the requirement of a resident’s medical evaluation being

141b1 Annual Medical Evaluation (continued)

updated and revised annually. In addition, the Management staff was also educated on the purpose of the annual medical evaluation and its importance to the health and wellbeing of the resident.

The ED/Designee will complete a weekly audit of annual evaluations that are due. The audits will also be completed to ensure change of status revisions are completed within the regulatory guidelines.

The audits will be completed weekly for 4 weeks, then 3 months thereafter

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/14/2026)

185a - Implement Storage Procedures

8. 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 [redacted] has a PRN order for [redacted], apply to affected area as needed. This medication was not available on site.

Resident [redacted] has a PRN order for [redacted] tablet, [redacted] tablet, take 1 tablet by mouth every 4 hours as needed for severe pain, and a PRN order for [redacted] tablet, take 1 tablet by mouth 2 times daily as needed for pain. These medications were not available at the time of the inspection.

Repeat violation [redacted] et al

Plan of Correction

Accept [redacted] - 12/29/2025)

On 10/9/25 Resident [redacted] medication was reordered and obtained from the pharmacy. Also, Resident [redacted] Medication was updated through the pharmacy and is available when needed.

The direct care/med tech staff were educated on 10/15/25 by the HCD, on the proper procedure of safe storage, access and distribution of medications. Additional training will be provided by the HCD at all future staff meetings.

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.

The audits will begin 10/15/25 and be completed for 4 weeks, then monthly for 3 months

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/14/2026)

190a - Completion Medication Course

9. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department’s performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B completed the modified medication administration course on [redacted] but did not complete the standard medication administration course as required has administered medications to residents to include the following: On [redacted] at 8:00a.m. [redacted] injections.

Plan of Correction

Accepted [redacted] - 12/29/2025)

On 10/29/25 Staff Person B completed the standard medication administration course as required to administer medications.

On 10/22/25, a Certified Medication Administration Trainer conducted multiple training and education classes for all Med Tech’s in the facility to ensure compliance of the Medication Administration program. In addition, the Certified Trainer educated the HCD and resident care staff on the proper method of training, administration and recording of medication administration transactions.

An audit of all Med Tech’s was completed by the ED/designee 11/1/25 to ensure compliance. A monthly audit will also be completed by the ED/designee to monitor ongoing compliance with the Medication Administration program. The monthly audits will be conducted for 4 months, then semi-annually.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/14/2026)

224a - Preadmission Screen Form

10. 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 [redacted] was admitted to the home on [redacted]; however, the resident’s preadmission screening form was not completed by the home.

Repeat Violation: [redacted] et al

Plan of Correction

Accepted [redacted] - 12/29/2025)

Resident [redacted] preadmission screening can not be retroactively completed.

The ED educated to the HCD on the requirement of completing the preadmission screening outlining the facility services can meet the needs of the resident. In addition, the ED will review the preadmission screen prior to the resident admission to the facility.

224a - Preadmission Screen Form (continued)

The ED/designee will initiate weekly audits of all admissions to ensure the regulatory compliance of Preadmission screening. The weekly audits will be completed for 4 weeks, then monthly for 3 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/06/2026)

225c - Additional Assessment

11. Requirements

2600.

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

- 1. Annually.

Description of Violation

The assessment dated [redacted] for Resident [redacted] does not address that the resident is a fall risk. The resident's record contained documentation of a fall sustained by the resident on [redacted] and noted the resident is a fall risk and would need constant supervision in the home.

Repeat Violation: [redacted] et al

Plan of Correction

Accept [redacted] - 12/29/2025)

Resident [redacted] assessment was updated 10/15/25 to address the risk of falls and supervision needs while in the facility.

The HCD on 10/15/25 educated the direct care staff on the requirement of completing an assessment due to a resident's change of condition. Ongoing training will be included in each monthly training sessions going forward.

Beginning 10/15/25, weekly audit will be completed by the HCD/designee to ensure continued compliance. Audits will be completed weekly for 4 weeks and then monthly for 3 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/14/2026)

231c - Preadmission Screening

12. 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 [redacted] care unit.

Description of Violation

Resident [redacted] was admitted to the Secure [redacted] Care Unit on [redacted]. However, the resident written cognitive preadmission screening was not completed by the home.

Repeat Violation: [redacted] et al

231c - Preadmission Screening (continued)

Plan of Correction

Accept ( [redacted] 12/29/2025)

The facility cannot retroactively complete the preadmission screening.

On 10/15/25 the Executive Director educated the HCD on the timeliness of the preadmission screening process of within 72 hours prior to an admission to a secure [redacted] unit.

Beginning 10/15/25 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 3 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] 01/06/2026)

234a - Admission Support Plan

13. Requirements

2600.

234.a. [redacted] hours of the admission, or within 72 hours prior to the resident's admission to the secured care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [redacted] was admitted to the Secure [redacted] Care Unit on [redacted]. However, the resident's initial support plan was finalized on [redacted].

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

Plan of Correction

Accept [redacted] 12/29/2025)

The facility cannot retroactively complete the initial support plan for resident [redacted].

The ED educated the HCD on 10/15/25 on the requirement of completing an admission support plan will be completed either within 72 hours of the admission or within 72 hours prior to admission for a secured unit.

Beginning 10/15/25 the ED/designee will initiate weekly audit on all admission for compliance of the 72-hour requirement. The audits will be completed for 4 weeks, then monthly for 3 months.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/06/2026)