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

January 12, 2026

[redacted]
HARMONY HAUS OPCO LLC
[redacted]

RE: HARMONY HAUS SENIOR LIVING
1399 MERCHANT STREET
AMBRIDGE, PA, 15003
LICENSE/COC#: 45639

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/04/2025 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 HAUS SENIOR LIVING* **License #**: *45639* **License Expiration**: *03/17/2026*

Address: *1399 MERCHANT STREET, AMBRIDGE, PA 15003*

County: *BEAVER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *HARMONY HAUS OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *02/25/1999* **Issued By**: *Borough of Ambridge*

Type: *C 2 LP* **Date**: *02/20/1991* **Issued By**: *Department of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *58* **Waking Staff**: *44*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *11/04/2025*

Inspection Dates and Department Representative

11/04/2025 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *43* **Residents Served**: *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older**: *28*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

11/04/2025 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *12/12/2025*

Inspections / Reviews *(continued)*

12/15/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *12/23/2025*

12/30/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/15/2026*

01/12/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

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] at approximately 5:30 p.m., Staff Member A began yelling at Resident [redacted] while in the home's dining hall. The resident asked Staff Member A to administer [redacted] prescribed [redacted] of [redacted]. Staff Member A responded to Resident [redacted] in a raised voice, "I will get to it when I get to it."

Resident [redacted] again asked Staff Member A to administer [redacted] of [redacted] prescribed [redacted]. Staff Member A responded, "If you know so much, then maybe you should be the med tech, and when your sugar drops to zero, then what are you going to do?" Staff Member A then yelled in a raised voice at Resident [redacted] "are you a doctor? Are you some kind of diabetes specialist?"

Resident [redacted] who at this point had possession of the [redacted] rolled the medication across a dining room table towards Staff Member A. Staff Member A became highly agitated and threw a metal fork and butter knife at Resident [redacted], with the butter knife striking the resident in the lower sternum area. Staff member/s were present during the incident, however, the home failed to notify Adult Protective Services.

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

10/28 Administrator terminated Staff A as a result of abuse allegation.

12/9 Administrator conducted training for staff on Mandatory Abuse Reporting per Older Adults Protective Services Act.

12/21 Administrator shall require staff to complete semi-annual abuse training. Administrator will schedule Ombudsman to conduct one of the trainiing sessions.

12/21 Administrator will be responsile for continued compliance with 2600.15a.

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented [redacted] - 01/12/2026)

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] at approximately 5:30 p.m., Staff Member A began yelling at Resident [redacted] while in the home's dining hall. The resident asked Staff Member A to administer [redacted] prescribed [redacted] of [redacted]. Staff Member A responded to Resident [redacted] in a raised voice, "I will get to it when I get to it."
Resident [redacted] again asked Staff Member A to administer [redacted] of [redacted] prescribed [redacted]. Staff Member A

16c - Written Incident Report (continued)

responded, "If you know so much, then maybe you should be the med tech, and when your sugar drops to zero, then what are you going to do?" Staff Member A then yelled in a raised voice at Resident [redacted] "are you a doctor? Are you some kind of diabetes specialist?"
Resident [redacted], who at this point had possession of the [redacted] rolled the medication across a dining room table towards Staff Member A. Staff Member A became highly agitated and threw a metal fork and butter knife at Resident [redacted], with the butter knife striking the resident in the lower sternum area. Staff member/s were present during the incident, however, the home failed to notify The Department.

Resident [redacted] was prescribed [redacted] one vial via nebulizer every two hours as needed for wheezing or shortness of breath. The resident was administered this medication orally on multiple occasions, to include [redacted] Multiple staff members were aware of this medication error, however, the home failed to notify the department.

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

12/2 Administrator acknowledged responsibility for reporting and late submission.

12/9 Administrator conducted staff training on reporting responsibilities for abuse allegations and incidents.

12/21 Administrator shall post a reminder guideline for the reporting process for abuse reporting in the staff conference room.

12/21 Administrator/designee shall be responsible for holding staff accountable for timely reporting. Staff discipline will be handed out for non-adherence.

12/21 Administrator will be responsible for continued compliance with 2600.16c.

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented ([redacted] - 01/12/2026)

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] at approximately 5:30 p.m., resident [redacted] asked staff member A multiple times to administer [redacted] medication while in the home's dining hall. Staff member A, began yelling at resident [redacted], responding I will get to it when I get to it, if you know so much, then maybe you should be the med tech, when your sugar drops to zero, then what are you going to do? Are you a doctor? Are you some kind of [redacted] specialist? Staff member A then became highly agitated and threw a metal fork and butter knife at resident [redacted], with the butter knife striking the resident in the lower sternum area.
Resident #[redacted] reported that this altercation between [redacted] and staff member A was not an isolated incident. [redacted] stated that there have been multiple verbal altercations between [redacted] and staff member A, that these interactions frequently caused [redacted] stress and to cry.

42b - Abuse *(continued)*

Plan of Correction ***Accept [redacted] - 12/30/2025)***

10/28 Administrator terminated Staff A as a result of abuse allegation.

12/9 Administrator conducted training for staff on Mandatory Abuse Reporting per Older Adults Protective Services Act.

12/21 Administrator shall require staff to complete semi-annual abuse training. Administrator will schedule Ombudsman to conduct one of the trainiing sessions.

12/21 Administrator will be responsile for continued compliance with 2600.42b..

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented ([redacted] - 01/12/2026)

181c - Self-administration Assessment

4. 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

On [redacted] at approximately 5:30 p.m., Resident [redacted] self-administered [redacted] of [redacted] 100-unit check blood sugar and give [redacted] 3 times a day. However, Resident [redacted] 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 this medication.

Plan of Correction ***Accept [redacted] - 12/30/2025)***

11/7 Administrator obtained an order for Resident [redacted] from PCP for self administration of insulin.

11/7 Administrator conducted training for Med Tech's on residents who self administer medications. Administrator educated Resident #1 on the guidelines for self administering medications.

12/21 Administrator shall conduct annual staff training for self administering medications and educate any new resident who wishes to self administer medications for continued compliance with 2600.181c.

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented ([redacted] - 01/12/2026)

187a - Medication Record

5. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

187a - Medication Record *(continued)*

Description of Violation

Resident [redacted] was prescribed [redacted] to be injected subcutaneously at 2 mg weekly on Sundays for [redacted] management. The resident self-administered the medication on [redacted], and [redacted], however, the self-administrations were not documented on the resident's October 2025 Medication Administration Record (MAR). The corresponding fields were blank.

Resident [redacted] was prescribed [redacted]: 10 units three times a day with meals, plus a sliding scale as follows for blood glucose levels: [redacted] and greater than [redacted] The resident was administered the medication as ordered throughout October 2025; however, the administrations were not documented on the MAR for multiple dates, to include [redacted]. The corresponding fields were blank.

Resident [redacted] was prescribed [redacted] via [redacted] every two hours as needed for wheezing or shortness of breath. Resident [redacted] was administered this medication on [redacted] however, the administration was not documented on the resident's MAR for the corresponding date and time. The field was blank.

Plan of Correction ***Accept ([redacted] 12/30/2025)***

10/24 & 11/5 Administrator conducted training & education for med tech's on documenting insulin and albuterol on the MAR.

12/5 Administrator/designee conducted a complete audit of all MARS to identify incorrect documentation.

12/21 Administrator/ designee shall conduct weekly MAR audits to ensure compliance with 2600.187a

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented [redacted] - 01/12/2026)

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident #[redacted] was prescribed [redacted] one vial via [redacted]er every two hours as needed for wheezing or shortness of breath. However, the resident was administered this medication orally on multiple occasions, to include [redacted].

Plan of Correction ***Accept [redacted] 12/30/2025)***

10/24 Administrator conducted training with med techs on albuterol and nebulizer usage.

10/28 Administrator terminated employee who failed to report medication error.

121/21 Administrator shall require all outside support personnel to report in with Administrator/Designee during their visits enusre proper comunication for all physiican orders.

12/21 Administrator shall be responsible for continued compiance with 2600.187d.

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

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented [redacted] - 01/12/2026)

188b - Medication Error Reporting

7. 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

Resident [redacted] was prescribed [redacted], one vial via [redacted] every two hours as needed for wheezing or shortness of breath. The resident was administered this medication orally on multiple occasions, to include [redacted]. However, the prescribing physician was not notified.

Plan of Correction ***Accept [redacted] - 12/30/2025)***

12/11 Administrator verified with hospice that the physician was notified of medication error.

12/21 Administrator shall follow up daily with med techs to enusre any new medication orders are understood and documented correctly.

12/21 Administrator/designee shall be responsible for reporting all medication errors according to 2600.188b.

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented [redacted] - 01/12/2026)

227c - Support Plan Revision

8. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident [redacted] most recent Resident Assessment and Support Plan, completed on [redacted], indicates that the resident has been assessed as unable to self-administer medications. However, the resident is prescribed [redacted], to be injected subcutaneously at [redacted] weekly on Sundays for diabetes, "Patient to self-inject."

Plan of Correction ***Accept [redacted] 12/30/2025)***

11/7 Administrator updated the suppoort plan for Resident [redacted] to reflect self administraton.

11/7 Administrator educated med techs on reporting resident requests for self administration of medications.

12/21 Administrator conducted a review of all support plans to ensure accuracy in documenting changes in resident needs.

12/21 Administrator will be responsible for continued compliance of 2600.227c.

Licensee's Proposed Overall Completion Date: *12/21/2025*

Implemented [redacted] - 01/12/2026)

227c - Support Plan Revision *(continued)*