

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

September 23, 2026

[REDACTED], ASSOCIATE
HARRISBURG AL OPERATIONS LLC
[REDACTED]
[REDACTED]

RE: VIVA SENIOR LIVING AT
HARRISBURG
150 KEMPTON AVENUE
HARRISBURG, PA, 17111
LICENSE/COC#: 33805

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/10/2026, 02/11/2026 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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: VIVA SENIOR LIVING AT HARRISBURG

License #: 33805

License Expiration: 07/01/2026

Address: 150 KEMPTON AVENUE, HARRISBURG, PA 17111

County: DAUPHIN

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: HARRISBURG AL OPERATIONS LLC

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 10/31/1997

Issued By: Labor and Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 99

Waking Staff: 74

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Complaint

Exit Conference Date: 02/11/2026

Inspection Dates and Department Representative

02/10/2026 - On-Site: [REDACTED]

02/11/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 96

Residents Served: 68

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 24

Residents Served: 13

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 68

Diagnosed with Mental Illness: 1

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 31

Have Physical Disability: 0

Inspections / Reviews

02/10/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 03/13/2026

04/30/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/11/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 05/11/2026

Inspections / Reviews *(continued)*

09/23/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/11/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 2/10/26, at 2:30pm, resident specific information to include residents' names, room numbers, dietary needs and allergies was unlocked, unattended and accessible in the 2nd floor kitchenette area.

Plan of Correction

Accept () - 04/30/2026)

1. The ED will retrain all Staff on 2600.17 and HIPPA as is related to resident confidentiality on or before 3/27/26.
2. On 2/23/26 the ED trained all managers on regulation 2600.17. The FSD and RCD will be responsible to complete a weekly audit for 4 weeks beginning the week of 3/9/26 to ensure ongoing compliance of resident confidentiality. The ED will review completed audits weekly beginning the week of 3/9/26. Documentation of the weekly audits will be maintained for department review.
3. FSD and RCD will complete random meal rounds for 4 weeks to ensure doors are kept locked when staff are not working in kitchenettes.
4. All staff will be educated by the ED on or before 3/27/26 on the requirements of 2600.17.
5. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

42s - Privacy

2. Requirements

2600.

- 42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 2/10/26 several cameras were observed in use recording the following areas of the home:

- *resident hallways*
- *common areas of the secure dementia unit*
- *dining area on the second floor where residents eat meals and receive medications*

The home did not have signage posted by the cameras indicating the capabilities of the camera and did not have approval for camera usage in the residents' areas.

Plan of Correction

Accept () - 04/07/2026)

1. On 2/12/26 the Maintenance Director had entrances to residents' rooms block out from all camera views used for monitoring to ensure privacy of residents during bathing, dressing, changing and medical procedures.

42s Privacy (continued)

2. Maintenance Director posted required signage at cameras on 3/12/26.
3. ED/Designee will train all staff by 3/27/26 that care and/or medications will not be performed in any common areas.
4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QAQI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

51 - Criminal Background Check**3. 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 Member A, who was hired by the home on (), did not have a Pennsylvania State Police Criminal Background check completed until ().

Plan of Correction

Accept () - 04/30/2026)

1. BOM/HR from that time frame is no longer in that position
2. ED/BOM/Designee will audit all employee files to ensure all CBCs are complete by 3/31/26
3. ED/Designee will ensure new BOM, upon hire, has training in 2600.51 during orientation.
4. BOM will provide CBC to ED for verification prior to scheduling new hire orientation.
5. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QAQI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

65d - Initial Direct Care Training**4. Requirements**

2600.

- 65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff Member A, hired on (), began providing unsupervised ADL services. However, the staff member did not complete and pass the Department approved direct care training course and pass the competency test until ().

Plan of Correction

Accept () - 04/30/2026)

1. BOM/HR from that time frame is no longer in that position.
2. ED/Designee will complete an audit by 3/31/26 of all direct care staff files to ensure all direct care staff have

65d - Initial Direct Care Training (continued)

completed the DHS Department 6 hour Direct Care Staff Certification training by 3/31/26. Any direct care staff who does not have a current DHS DCS Certification will be removed from the schedule until compliant with 65.d.

3. ED/Designee will ensure new direct care staff provide proof of DHS 6 Hour Direct Care Staff Certification prior to orientation.

4. ED will ensure new BOM, upon hire, is trained on hiring requirements of all staff.

5. ED/BOM/Designee will audit 10% of new employee files monthly for 3 months beginning in April 2026 to ensure compliance.

6. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026

65e - 12 Hours Annual Training**5. Requirements**

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff Member C hired () received only 1 hour of annual training in the 2025 calendar training year.

Staff Member D, hired () received only 8.5 hours of annual training in the 2025 calendar training year.

Plan of Correction

Accept () - 04/30/2026

1. BOM at the time is no longer in that position.

2. ED will ensure new BOM, upon hire, is trained on training requirements 65.e

2. ED will train all staff on 65.e training requirements for personal care. To be completed by 3/27/26

3. ED/Designee will audit training files monthly to ensure compliance.

4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026

65f - Training Topics**6. Requirements**

2600.

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

Description of Violation

Staff Member C hired () did not receive training in the following topics during calendar training year 2025:

(1) Medication self-administration training.

(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment

65f - Training Topics (continued)

tool, medical evaluation and support plan.

(3) Care for residents with dementia and cognitive impairments.

(5) Personal care service needs of the resident.

(6) Safe management techniques

(7) Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Staff Member D, [REDACTED] did not receive training in the following topics during calendar training year 2025:

(1) Medication self-administration training.

(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

(3) Care for residents with dementia and cognitive impairments.

(6) Safe management techniques

(7) Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Plan of Correction

Accept [REDACTED] - 04/30/2026)

1. BOM at the time is no longer in that position.

2. ED will ensure new BOM, upon hire, is trained on training requirements 65.e

3. ED will train all staff on 65.e training requirements for personal care. To be completed by 3/27/26

4. Beginning in April 2026 the ED will review staff training for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented [REDACTED] - 09/23/2026)

65g - Annual Training Content**7. Requirements**

2600.

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

Description of Violation

Staff Member C, hired [REDACTED] did not receive training in the following topics during training calendar year 2025:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.

(3) Resident rights.

(4) The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

(5) Falls and accident prevention.

(6) New population groups that are being served at the home that were not previously served, if applicable.

Staff Member D did not receive training in the following topics during calendar training year 2025:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

65g - Annual Training Content (continued)

- (5) Falls and accident prevention.
- (6) New population groups that are being served at the home that were not previously served, if applicable.

Plan of Correction

Accept () - 04/30/2026)

1. BOM at the time is no longer in that position.
2. ED will ensure new BOM, upon hire, is trained on training requirements 65.e
3. ED will train all staff on 65.e training requirements for personal care. To be completed by 3/27/26
4. ED/Designee will audit 10% of training files monthly beginning April 2026 to ensure compliance.
5. Beginning in April 2026, the ED/Designee will review staff trainings at for 3 months at the monthly QA/QI held the 3rd Thursday of the month to ensure compliance.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

81b - Resident Personal Equipment**8. Requirements**

2600.

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

Description of Violation

Resident #2 has a bed rail affixed to the left, top half of () hospital bed that locks in place. On 2/10/26 Resident #2, reported that the bedrail was not affixed properly a few weeks ago and fell, injuring () finger and reports () finger is broken. Resident #2 was observed wearing a splint on () finger.

On 2/10/26 at 3:30pm, Resident #3's bedside enabler device was not properly affixed to () bed, allowing the entire top part of the device to spin a full 360 degrees when pressure was applied to it. The device is unsteady when grabbed creating a pinch point between the device and the mattress.

Plan of Correction

Accept () - 04/30/2026)

1. Maintenance Director removed enabler device from Resident 3's bed on 2/11/26.
2. ED/Designee will audit enablers monthly to ensure proper installation and compliance with 81b.
3. ED/Designee will send families a letter informing them of the regulation and asking them to consult with ED prior to affixing any equipment in residents rooms.
4. ED/Designee will provide training to all staff on 81b by 3/27/26
5. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

81b - Resident Personal Equipment (continued)

82a - Poisonous Materials

9. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 2/10/26 at 9:25am and 2:23pm, a cleaning solution to eliminate urine odors was observed stored in a generic Ecolution Odor Remover spray bottle.

Plan of Correction

Accept () - 04/30/2026)

1. Maintenance Director immediate removed and discarded the unlabeled container from cart
2. ED/Designee will educate all staff on proper storage, labeling and safe use of chemicals by 3/27/26.
3. ED/Designee will audit cleaning carts 2X weekly for 2 weeks, 1 X weekly for 2 weeks, 1 X month for 2 months.
4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

85a - Sanitary Conditions

10. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/10/26 Resident #3 had a dark brown stain on the floor immediately next to the bedside. The stain was approximately 1 foot in diameter.

On 2/10/26, the smell of urine was emanating from Resident #4's bedroom. Upon entering the resident's room, a strong smell of urine was present. Once entering the resident's bathroom, there was an extremely pungent odor of urine and feces present. In addition, feces were present on () toilet seat, the front of the toilet bowl and inside the toilet bowl. The resident reports () had diarrhea yesterday and () toilet has been like this since then.

On 2/10/26 there were two large stains next to Resident #4's refrigerator that the resident reports are from soda spills. One stain is approximately 1 foot in diameter while the other is approximately 6 inches in diameter.

On 2/10/26, at 4:00pm, Resident #5's toilet bowl contained brown and black stains and left over feces residue.

Plan of Correction

Accept () - 04/30/2026)

1. Maintenance Director will have flooring replaced for Resident #3 and Resident #4 rooms by 4/1/26 with laminate tile to promote sanitary conditions.
2. ED/Designee will educate all staff by 3/27/26 on reporting any spills or stains found on carpeting or flooring immediately to housekeeping/maintenance.

85a - Sanitary Conditions (continued)

3. Beginning in April 2026 the Maintenance Director will walk through audit of all rooms on a monthly basis for 3 months to ensure cleanliness of carpets and floors.
4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026

85e - Trash Outside Home**11. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 2/10/26, at 1:46pm, two dumpsters containing many bags of trash did not have lids covering the dumpsters.

Plan of Correction

Accept () - 04/30/2026

1. The lid to the dumpster was closed immediately at the time of inspection. The Maintenance Director posted signs on exit door leading to dumpster reiterating the dumpster lids must be closed at all times.
2. ED/Designee will train all staff on 85e and emphasize lids on dumpster by 3/27/26.
3. Beginning in April the Maintenance Director/Designee will audit the dumpsters 2X weekly for 2 weeks, 1 X weekly for 2 weeks, 1 X month for 2 months to ensure the dumpsters are covered.
4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026

100b - Removal Snow/Obstructions**13. Requirements**

2600.

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 2/10/26, at 10:18am, a spot of ice measuring approximately 2 foot by 3 foot was observed directly in front of the outside gate of the secured dementia care unit, creating a slipping hazard as there was no way to step around or avoid the ice if attempting to open the gate.

Plan of Correction

Accept () - 04/30/2026

1. On the day of inspection 2/9/26 the Maintenance Director immediately removed ice directly in front of the outside gate of secured dementia care unit and placed salt on the area.
2. Maintenance Director will ensure the area in front of the secured dementia care unit gate is kept salted any time there is precipitation and freezing temperature.
3. ED educated Maintenance Director on 2600.100b on 2/23/26.

100b - Removal Snow/Obstructions (continued)

4.ED/Maintenance Director/Designee will monitor entrances during any inclement weather to ensure safety on outside walkways, and steps during winter months to ensure resident safety.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

103c - Food Protected**14. Requirements**

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 2/10/26 at 9:39am, there was an uncovered bowl of dry cheerios, a cup of milk, a cup of orange juice and a cup of water sitting on the dining room table on the 2nd floor. The uncovered food sat at the table until after 10:00am, breakfast ended at 9:00am.

On 2/10/26, at 4:05pm, there were 4 trays of fish sticks that were uncovered stored in the kitchen's walk-in refrigerator.

Plan of Correction

Accept () - 04/30/2026)

- 1.Dining staff immediately removed the items from the dining table and disposed of them when addressed
- 2.ED/Designee will train all staff on proper food safety and handling by 3/27/26.
- 3.FSD/Designee will audit dining rooms and kitchenettes after meals 2 times weekly for 4 weeks; 1 time weekly for 2 months to ensure compliance.
4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QA/QI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

103g - Storing Food**15. Requirements**

2600.

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

Description of Violation

On 2/10/26 at 3:41pm, a plastic container of shredded cheese was sitting on the kitchen prep counter of the 1st floor kitchenette and not stored in the refrigerator. The container of cheese was warm to the touch.

Plan of Correction

Accept () - 04/30/2026)

- 1.FSD immediately removed the item from counter and disposed of on 2/10/25.
- 2.ED/Designee will train all staff on proper food handling and storage by 3/27/26.
3. 3.FSD/Designee will audit dining rooms and kitchenettes after meals 2 times weekly for 4 weeks; 1 time weekly

103g Storing Food (continued)

for 2 month to ensure compliance.

4. Beginning in April 2026 the ED will review results of the audit for 3 months at monthly QAQI meetings held the 3rd Thursday of the month to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

105g - Lint Removal and Duct Cleaning**16. 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 2/10/26, at 3:33pm, lint approximately the size of a tennis ball was in the dryer in the first floor resident laundry room. Clothes were in the dryer; however, they were the same clothes that were observed in the dryer at 10:00am.

On 2/10/26, at 3:50pm, the industrial dryer in the main laundry area did not have clothes or items in the dryer but the entire lint trap was completely covered in lint. The lint trap is approximately 2 foot x 2 foot square.

Plan of Correction

Accept () - 04/30/2026)

1.Maintenance Director immediately removed lint from dryer at the time of inspection.

2.ED/Designee will train all staff on 105g on lint removal and duct cleaning and the safety implications by 3/27/26

3.Maintenance Director will vacuum lint areas on dryers weekly.

4.ED/Designee will review compliance with plan at QAQI meeting beginning with the April 2026 QAQI meeting held the 3rd Thursday of the month to ensure compliance.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

107b - Emergency Procedures**17. Requirements**

2600.

107.b. The home shall have written emergency procedures that include the following:

Description of Violation

The home's written emergency procedures dated 1/30/26 do not include the means of transportation to the emergency relocation site.

Plan of Correction

Accept () - 04/30/2026)

1.Emergency Plan transportation sources is currently being updated to be completed by 4/1/26.

2.ED/Designee will train all staff by 3/27/26 on emergency procedures and additional staffing needed to assist with

107b - Emergency Procedures (continued)

- the safe transport of residents, if needed, to an alternate site during emergency evacuation for resident safety.*
- 3.ED/Designee submitted plan on 5/22/24 with no response from Dauphin County Agency.*
- 4. ED/Designee will ensure all resident transports are documented and accountability will be initiated at the receiving site.*
- 5. ED/Designee will review transportation sources yearly to ensure availability of transportation services.*

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented ([REDACTED] - 09/23/2026)

107d - Procedure Emergency Management Agency Submission**18. Requirements**

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were updated 1/30/26 but were last sent to the local municipality on 11/28/22.

Plan of Correction

Accept ([REDACTED] - 04/30/2026)

- 1.ED/Designee submitted Emergency Operations Plan to local emergency management agency on 3/9/26.*
- 2.ED/Designee received approval letter for Emergency Operations Plan from local emergency management agency on 3/13/2026*
- 3.ED/Designee will train all staff on 107d and the emergency plan by 3/27.*
- 4.ED/Designee will ensure compliance with review and submission of Emergency Operations Plan to local emergency management agency yearly*
- 5.ED/Designee will utilize a calendar tickler to ensure timely annual submission.*

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented ([REDACTED] - 09/23/2026)

124 - Notice to Fire Department**19. 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

As of 2/11/26, the home has 31 residents with mobility needs. The home does not have current 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. The home has not submitted notification to the local fire department since 2023 detailing this information.

124 - Notice to Fire Department (*continued*)**Plan of Correction**

Accept () - 04/30/2026)

1. On 3/2/26 the ED submitted notice to local fire department in writing of the address of the community, locations of the bedrooms, and need for assistance to evacuate the building.
2. ED/Designee will ensure a monthly letter is submitted to local fire department starting with the letter on 3/2/26.
3. ED/Designee will review monthly letter at QA/QI monthly meeting for 3 months beginning in April 2026 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

126a - Furnace Inspection

20. Requirements

2600.

- 126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home is equipped with 6 furnaces. There is no documentation detailing current or previous furnace inspections and cleanings have been conducted.

Plan of Correction

Accept () - 04/30/2026)

1. Maintenance Director has scheduled furnace cleaning/inspection for 3/18/26 and 3/19/26
2. ED/Maintenance Director/Designee will ensure HVAC is cleaned/inspected bi-annually per contract with the HVAC vendor.
3. ED/Maintenance Director/Designee will use a calendar tickler system to track bi-annual dates for HVAC cleaning/inspection.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

141a 1-10 Medical Evaluation Information

21. Requirements

2600.

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
 1. A general physical examination by a physician, physician's assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information (continued)

Description of Violation

The medical professional information section is not completed on Resident #2's status change medical evaluation dated [REDACTED] and Resident #8's initial medical evaluation dated [REDACTED]

Resident #9's annual medical evaluation dated [REDACTED], does not include the resident's weight.

Plan of Correction

Accept [REDACTED] - 04/30/2026)

1. On 2/23/26 the ED had Primary Care Physician correct the DME medical professional information for resident #2's DME with appropriate information.
2. On 2/24/26 the ED had Primary Care Physician correct the DME medical professional information for resident #8's DME with appropriate information.
3. Resident #9 was on hospice at the time and has since passed on [REDACTED]
4. ED/Designee will train all staff on 141a during staff training by 3/27/26.
5. ED/Designee will review recent DMEs in QAQI monthly meeting for 3 months beginning with the April 2026 QAQI meeting held the 3rd Thursday of the month to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented [REDACTED] - 09/23/2026)

182c - Medication Administration

22. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

On 2/11/26 at approximately 4:00pm, Staff Member D entered Resident #10's room to administer the resident's medications. Staff member D was observed, handing the resident a small cup of pills and a cup of water and proceeded to walk out of the room before the medication had been taken by the resident.

Resident #11 reports that around dinner time on 2/6/26, Staff Member E sat a cup of medications belonging to another resident beside Resident #11 at the dinner table and walked away. Resident #11 self-administers medications and knew the medications were not theirs. Resident #11 states [REDACTED] located Staff Member E to tell them this so the medications could be provided to the correct resident.

Plan of Correction

Accept [REDACTED] - 04/30/2026)

1. The ED/Medication Train the Trainer will re-educate staff Members D and E on the 5 Rights of Medication Administration, including watching the resident consume the medication by 3/27/26.
2. The Medication Administration Train the Trainer will complete 2 additional observations for Staff Members D and E by 3/27/26 per the DHS Medication Administration Course.
3. The ED/Medication Train the Trainer will re-educate all med techs by 3/27/26 on the 5 Rights of Medication Administration including observing the correct resident and watching the resident consume the medication.
4. The ED/Medication Train the Trainer will perform annual practicum Observations and MAR Reviews per the

182c Medication Administration (continued)

specified time frames for each Med Tech.

5. The ED will review Med Tech training/annual practicums at the monthly QA/QI meetings starting in April 2026 for 3 months to ensure compliance is being maintained

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

185a - Implement Storage Procedures**24. 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

On 2/6/26, a reading of 224 at 9:09am was recorded on the Medication Administration Record but was not found in Resident #2's glucometer.

On 2/8/26, a reading of 227 at 5:59pm was found in Resident #2's glucometer; however, the reading of 277 at 5:50pm was recorded on the Medication Administration Record.

Resident #2 is prescribed Bumetanide 1mg take 1 tablet by mouth daily but was not found in the medication cart or elsewhere in the home.

Resident #2 is prescribed Ready Lance 28G Safety Lancets use to test blood sugar four times a day. However, these lancets are no longer being used by the resident but were not discontinued.

Resident #2 is prescribed Iodoform 1/2" Strip change [REDACTED] wound care. [REDACTED] as needed for wound care. However, the Iodoform 1/2" strips were not found in the medication cart or elsewhere in the home.

Resident #3 is prescribed Band Aid 1 inch, apply to [REDACTED] daily after applying the triple antibiotic ointment. However, the Triple Anti biotic ointment also required to apply to great toe daily was discontinued on 2/5/26.

Resident #3 is prescribed Band Aid Ex LRG Flex 10's use to cover [REDACTED] daily after triple antibiotic applied until healed. On 2/4/26 at 11:31am, the last time the Medication Administration Record was recorded for the band aid's states exception reason "order completed." In addition, these band aids were not found in the med cart.

Resident #3 is prescribed Calmoseptine Ointment apply to affected areas [REDACTED] daily as needed. However, the medication was not in the med cart or otherwise in the home.

Resident #4's Blood Sugar is prescribed to be measured twice daily; however, the readings documented on the Medication Administration Record could not be located on the resident's Glucometer.

185a - Implement Storage Procedures (continued)

Resident #4 was prescribed Ready Lance Safety 30G with instructions to test the blood sugar 3 times daily for [REDACTED]. The resident is no longer using these lancets; however, they were not discontinued and remains in the medication cart.

On 9/18/25, Resident #6 was prescribed Trazadone 50mg tablet take 1 tablet by mouth at bedtime x 30 days as needed for insomnia, then stop. The medication was found in the medication cart in the SDCU.

Resident #6's MAR was cross-referenced with the glucometer and following the errors were noted:

- On 2/7/26, the MAR shows the reading of 96 was recorded at 7:51am; however, the glucometer shows a reading of 96 measured at 8:58am.
- On 2/8/26, the MAR shows the reading of 117 was recorded at 7:28am; however, the glucometer shows a reading of 117 measured at 8:31am.
- On 2/09/26, the MAR shows the reading of 274 was recorded at 9:28am; however, the glucometer shows a reading of 274 measured at 10:08am.
- On 2/10/26, the MAR shows the reading of 193 was recorded at 8:03am; however, the glucometer shows a reading of 193 measured at 9:09am.

Resident #8 is prescribed Haloperidol LAC 2mg/ml Con. Take 0.5ML/MG sublingually every 6 hours as needed for agitation. However, the medication was not in the cart, or otherwise in the home.

Resident 12#'s un-opened bottle of Lorazepam 2ML/MG bottle 1 of 2 quantity of 60 is not logged onto a controlled drug or other sheet to log receipt of and to track the medication.

Resident #13 is prescribed Morphine Sulf 20mg/ml take 0.25ml by mouth/under the tongue every 1 hour as needed for pain/shortness of breath. On 1/28/25 at 5:26 the resident was administered 0.25 ml and 19.75ml is recorded as remaining. The morphine bottle shows the medication remaining is approximately 16ml.

Plan of Correction**Accept [REDACTED] - 04/30/2026)**

1. RDO of Clinical Programming calibrated all resident glucometers with the correct date and time on 3/10/26 including residents #2 and #4 to ensure compliance with 185a
2. Beginning the week of 3/9/26 the RCD/designee will complete a weekly controlled substance audit and MAR to med cart audit for 4 weeks and monthly audit for 2 months thereafter, to ensure all medications are present in the med cart, discontinued medications have been removed from the med cart and count down sheets are accurate compared to medications on hand.
3. The ED will re-educate all med tech on 185a to ensure glucometer readings are accurately recorded on the MAR, countdown sheets are completed correctly at the time of administration and all medications are available in the med cart.
4. The RCD/designee will complete a weekly audit for 4 weeks and monthly for 2 months to ensure all glucometer/MAR documentation complies with 185a.
5. ED will review results of audits in the monthly QA/QI meetings starting in April 2026 for 3 months to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

185a - Implement Storage Procedures (*continued*)

Implemented () - 09/23/2026)

187a - Medication Record

25. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed Anti-Itch S/A Benadryl Cream 2% (9604646) apply topically to affected area twice daily as needed for itching was not listed on the Medication Administration Record.

Resident #2 is prescribed Bisacodyl 10mg Suppository S/A Dulcolax, [REDACTED] as needed for constipation. However, the order was not listed on the January 2026 or February 2026 Medication Administration Record.

Resident #3 is prescribed Triple Antibiotic ointment apply [REDACTED] open area as directed was in the cart but was not listed on the Medication Administration Record.

Plan of Correction

Accept () - 04/30/2026)

- 1. RDO of Clinical Programming audited Resident #2 and Resident #3 medication orders and completed a MAR to Cart Audit on 3/10/26 to ensure all medications prescribed are on the MAR and available in the med cart.*
- 2. Beginning the week of 3/9/26 the RCD/designee will complete a weekly controlled substance audit and MAR to Med Cart audit for 4 weeks, and monthly thereafter for 2 months, to ensure all current medications ordered are present in the med cart, discontinued medications have been removed from the med cart.*
- 3. The ED will re-educate all med tech by 3/27/26 on 187a to ensure compliance.*
- 4. The RCD/designee will complete a weekly MAR to audit for 4 weeks and monthly for 2 months to ensure all glucometer/MAR documentation complies with 187a.*
- 5. ED will review results of audits in the monthly QA/QI meetings starting in April 2026 for 3 months to ensure compliance is being maintained.*

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

187b - Date/Time of Medication Admin.

26. 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

Resident #14 is prescribed Clonazepam 0.5MG take ½ tablet by mouth every morning for anxiety. On 2/11/26 at 11:26am 7 pills were counted in the blister pack; however, the controlled drug record shows a total of 8 pills remaining showing the medication was last administered on 2/10/26 at 8:00am. The staff member who administered the medication stated they forgot to include their initials as well as document that the medication was administered.

187b Date/Time of Medication Admin. (continued)**Plan of Correction****Accept () - 04/30/2026)**

1. Resident #14's controlled drug record for Clonazepam 0.5MG was corrected at the time of inspection to ensure the record matched the number of tablets on hand.
2. Beginning the week of 3/9/26 the RCD/designee will complete a weekly controlled substance audit and MAR to Med Cart audit for 4 weeks, and monthly thereafter for 2 months, to ensure all controlled drug records match the accurate count for all controlled drugs for each resident as prescribed.
3. The ED will re educate all med tech by 3/27/26 on 187b to ensure compliance.
4. ED will review results of audits in the monthly QAQI meetings starting in April 2026 for 3 months to ensure compliance is being maintained

Licensee's Proposed Overall Completion Date: 04/01/2026**Implemented () - 09/23/2026)****187d - Follow Prescriber's Orders****27. Requirements**

2600.

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

Description of Violation

Resident #6 is prescribed Lisinopril 10mg, take 1 tablet by mouth once daily, hold for BP < 110, DX: HTN. On 2/1/26, the resident's BP measured 83/49 the Medication Administration Record shows that the medication was administered by a med tech at 8:05am on 2/1/26.

Resident #6 is prescribed Metoprolol Tart 25mg take 1 tablet by mouth twice daily. Hold for SBP < 100 or Pulse < 65 DX: HTN. On 2/1/25 BP read 83/49 and pulse read 65 BPM, the Medication Administration Record shows that the medication was administered by a med tech at 8:05 am on 2/1/25.

Plan of Correction**Accept () - 04/30/2026)**

1. The ED will re educate all med techs by 3/27/26 on 187d to ensure prescriber orders are followed and MAR documentation is completed accurately, including medication hold order perimeters.
2. Beginning the week of 3/9/26 the RCD/designee will complete a weekly audit of MAR to Med Cart audit for 4 weeks, and monthly thereafter for 2 months, to ensure correct MAR documentation on all current medications per prescriber orders.
3. ED will review results of audits in the monthly QAQI meetings starting in April 2026 for 3 months to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026**Implemented () - 09/23/2026)**

190a - Completion Medication Course

28. 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 Member C, who has not successfully completed the Department-approved medications administration course, administered medications to Resident #10 to include the following:

- *On 2/10/26 at 5:00pm and 8:00pm, Buspirone 15mg Tablet*
- *On 2/10/26 at 4:00pm, Carbidopa-Levo 25-100 Tab*
- *On 2/10/26 at 8:00pm, Divalproex SOD 250mg Dr Tab*

Staff Member D, who has not successfully completed the Department-approved medications administration course, administered medications to Resident #10 to include the following:

- *On 2/11/26 at 5:00pm and 8:00pm, Buspirone 15mg Tablet*
- *On 2/11/26 at 4:00pm, Carbidopa-Levo 25-100 Tab*
- *On 2/11/26 at 8:00pm, Divalproex SOD 250mg Dr Tab*

Staff Member E, who has not successfully completed the Department-approved medications administration course, administered medications to Resident #10 to include the following:

- *On 2/9/26 at 4:00pm, Carbidopa-Levo 25-100 Tab*
- *On 2/9/26 at 5:00pm and 8:00pm, Buspirone 15mg Tablet*
- *On 2/9/26 at 8:00pm, Divalproex SOD 250mg Dr Tab*

Staff Member F, who has not successfully completed the Department-approved medications administration course, administered medications to Resident #10 to include the following:

- *On 2/6/26 at 4:00pm, Carbidopa-Levo 25-100 Tab*
- *On 2/6/26 at 5:00pm and 8:00pm, Buspirone 15mg Tablet*
- *On 2/6/26 at 8:00pm, Divalproex SOD 250mg Dr Tab*

Plan of Correction

Accept () - 04/30/2026)

1. *Staff members C, D, and E had successfully completed the Department-approved medications administration course through the DHS online course through ODP that includes the passing of the Department's performance-based competency test within the past 2 years. Their Medication Administration Training Certificates were available at the time of inspection. A Certification would not be available if the staff person had not pass the course. However, the licensing inspector requested the results of the testing scores. Regulation 190a does not require a copy of the testing scores. These are recorded in the online course. The Trainer completes the attestation as well as the student, then an OFFICIAL CERTIFICATE is available to print which was available to the surveyor at the time of inspection.*
2. *On or before 3/27/26 The Medication Administrator Trainer will log into the online course and printed the test scores for Staff members C and D.*
3. *Staff Member E had successfully completed the Modified Medication Administration Course however had not*

190a Completion Medication Course (continued)

completed the full Medication Administration after the cutoff date as of 6.30.2023 as set by DHS. Staff Member E was removed from administering medications immediately on the day of inspection. Staff Member E is currently enrolled in the full Medication Administration Course.

4. The BOM/Medication Administration Trainer will complete an audit of all certified medication tech credentials by 3/27/26 to ensure compliance with 190a including annual practicums.

5. The BOM/Medication Administration Trainer will be re educated by 3/27/26 of the requirements of 190a.

6. The ED will review trainings in the monthly QA/QI meetings starting in April 2026 for 3 months to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

190b - Insulin Injections**29. Requirements**

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 2/2/26, 2/4/26 and 2/5/26 at 8:00pm, Staff Member C, who has not completed the Department approved medications administration course and the department approved diabetes patient education program, administered insulin to Resident #2.

On 2/8/26 and 2/9/26 at 8:00pm, Staff Member E, who has not completed the Department approved medications administration course and the department approved diabetes patient education program, administered insulin to Resident #2.

Plan of Correction

Accept () - 04/30/2026)

1. Staff members C and E did successfully completion of a Department approved diabetes patient education program within the past 12 months. Training was current at the time of inspection.

2. The inspector did not accept the "Commonwealth of Pennsylvania| Department of Human Services| Acknowledgement of Qualification" from the online Department approved Medication Administration Course, as the inspector wanted the test results. The official certificate states, "This certificate indicates that all medication administration course requirements have been met." With a DHS Authentication Code number specific to each student. Regulation 190b does not specify that test results are required when licensing is measuring compliance. The Trainer completes the attestation as well as the student, then an OFFICIAL CERTIFICATE is available to print which was available to the surveyor at the time of inspection.

3. Staff Member E had successfully completed the Modified Medication Administration Course however had not completed the full Medication Administration after the cutoff date as of 6.30.2023 as set by DHS. Staff Member E was removed from administering medications immediately on the day of inspection. Staff Member E is currently

190b - Insulin Injections (continued)

enrolled in the full Medication Administration Course.

4. On or before 3/27/26 The Medication Administrator Trainer will log into the online course and printed the test scores for Staff members C and D.

5. The BOM/Medication Administration Trainer will complete an audit of all certified medication tech credentials by 3/27/26 to ensure compliance with 190a including annual practicums.

6. The BOM/Medication Administration Trainer will be re-educated by 3/27/26 of the requirements of 190a.

7. The ED will review med tech trainings in the monthly QAQI meetings starting in April 2026 for 3 months to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

225a - Assessment 15 Days**31. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for Resident #8, who was admitted to the home on [REDACTED]

Plan of Correction

Accept () - 04/30/2026)

1.ED completed RASP for resident #8 on 2/24/26

2.ED/Designee will audit 25% of files for 3 months to ensure all residents have a completed RASP on file.

3.ED will train all staff on Departmental required documentation of 225a by 3/27/26.

4. 5. ED will review results of audits in the monthly QAQI meetings starting in April 2026 for 3 months to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

231c - Preadmission Screening**35. 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 #5 was admitted to the Secure Dementia Care Unit on [REDACTED] However, the resident's written cognitive preadmission screening was not completed.

Plan of Correction

Accept () - 04/30/2026)

1.RCD employed at the time is longer in the position.

231c - Preadmission Screening (continued)

2. ED completed cognitive prescreening on 3/26/26.
3. ED/RCD/Designee will train all staff on proper completion of department required forms by 3/27/26
4. ED/RCD/Designee will audit 25% of resident files monthly for 3 months to ensure compliance.
5. .ED/Designee will review compliance at QAQI for 3 months beginning in April 2026 to ensure proper procedures.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)

236 - Staff Training**38. Requirements**

- 2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct Staff Member's C and Staff Member D, who works in the Secure Dementia Care Unit (SDCU) did not complete the 6 hours of training required training in dementia care during the training year 2025.

Plan of Correction

Accept () - 04/30/2026)

1. ED/Memory Care Coordinator/RCD will ensure staff members C and D who work in the secured dementia care unit received the additional 6 hours of dementia training for the training year 2025 by 3/27/26.
2. ED/Memory Care Coordinator/RCD will ensure all staff working in secured dementia care unit have received 6 hours of annual dementia training in addition to the 12 hours of annual training upon hire and yearly thereafter.
3. ED/BOM/Designee will audit care staff files by 4/1/26 to ensure all direct care staff have the required training per 236 and 65 upon orientation and annually thereafter.
4. ED/Designee will review training records at QAQI monthly meeting for 3 months beginning April 2026 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 04/01/2026

Implemented () - 09/23/2026)