pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **STATE COLLEGE OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT STATE COLLEGE**
NAME OF FACILITY OR AGENCY

Located at **121 HAVERSHIRE BOULEVARD, STATE COLLEGE, PA 16803**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **125**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 38**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 12, 2026** until **February 12, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **228030**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: May 12, 2026

[redacted]
Chairman Manager
State College Operations LLC
[redacted]

RE: Harmony at State College
121 Havershire Boulevard
State College, Pennsylvania 16803
License #: 228030

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on February 17, 2026, February 18, 2026 and February 24, 2026, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

May 6, 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 02/17/2026, 02/18/2026, 02/24/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HARMONY AT STATE COLLEGE* **License #**: *22803* **License Expiration**: *02/12/2026*

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**: *Centre Region Code Enforcement*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *132* **Waking Staff**: *99*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *02/24/2026*

Inspection Dates and Department Representative

02/17/2026 - On-Site: [redacted]
02/18/2026 - On-Site: [redacted]
02/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *99*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *NA* **Capacity**: *38* **Residents Served**: *27*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *98*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *33* **Have Physical Disability**: *1*

Inspections / Reviews

02/17/2026 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/19/2026*

Inspections / Reviews *(continued)*

03/19/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/07/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/24/2026*

05/04/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/07/2026*

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

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted] at 3:30a.m., Resident [redacted] accused Staff person F of hitting them. This incident was reported to staff person G at approximately 3:40a.m. Staff person F continued to work on [redacted] from 3:30a.m. until 6:00a.m. under a plan of supervision to not interact with the resident that was not submitted or approved by the department.

Plan of Correction ***Accept[redacted] - 03/19/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 1/29/26 by the Executive Director. The Executive Director educated the Health Care Director on a requirement for a plan of supervision and suspending the associate pending investigation.
The Executive Director/designee will train all members of the leadership team on abuse reporting, with a completion date of 4/1/26. All newly hired staff will receive abuse training and reporting abuse upon hire, and annually.

Effective 3/16/26 the Executive Director/designee will perform personnel audits monthly for three months, to ensure training is in compliance. Healthcare Director/designee will audit all reportable incidents and subsequent investigations, weekly and ongoing, to maintain compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/16/2026*

Implemented[redacted] - 05/04/2026)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for resident [redacted] was not signed by the resident until [redacted].

The resident-home contract, dated [redacted] for resident [redacted] was not signed by the resident until [redacted].

The resident-home contract, dated [redacted], for resident [redacted] was not signed by the resident until [redacted].

The resident-home contract, dated [redacted] for resident [redacted] was not signed by the resident.

The resident-home contract, dated [redacted], for resident [redacted] was not signed by the resident.

Plan of Correction ***Accept[redacted] - 03/19/2026)***

In response to the violation on 02/17/2026 by the Pennsylvania Bureau of Human Service Licensing, a review of

25b - Contract Signatures (continued)

contracts for residents [redacted] was completed on 3/13/26 by the Executive Director. All contracts will be reviewed with the residents and/or POA for signature by 4/1/26.
A full audit of all resident contracts will be completed with a completion date of 4/19/26 by Executive Director and/or designee.
Effective 3/19/26 the Business Office Manager/designee will audit new resident files monthly, for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented [redacted] - 05/04/2026)

26a - Quality Management Plan

3. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not have documentation that that an annual quality management plan review had taken place with the past 12 months.

Plan of Correction ***Accept [redacted] - 03/19/2026)***

Immediate action was taken on 3/4/26 by the Executive Director. The QMP/QAPI regulation/policy/process was reviewed and tools provided to the leadership team.
On 3/4/2026, the Executive Director/designee in-serviced department head team regarding the regulation of the quality management plan program.
To enhance the currently compliant operations, on 3/16/26 the Executive Director scheduled quarterly QMP meetings (3/25/26, 6/24/26, 9/23/26, 12/30/26) with all leadership team members. A designated binder has been established to house all meeting notes.

Licensee's Proposed Overall Completion Date: *06/24/2026*

Implemented [redacted] - 05/04/2026)

65a - FS Orientation 1st Day

4. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person D whose first day of work was [redacted], did not receive orientation on the following topics:
1.Evacuation procedures.
2.Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3.The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

65a - FS Orientation 1st Day (continued)

4.Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5.The location and use of fire extinguishers.
6.Smoke detectors and fire alarms.
7.Telephone use and notification of emergency services.

Staff person E whose first day of work was 8/25/24, did not receive orientation on the following topics:
1.Evacuation procedures.
2.Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3.The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4.Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5.The location and use of fire extinguishers.
6.Smoke detectors and fire alarms.
7.Telephone use and notification of emergency services.

Plan of Correction ***Accept [redacted] 03/19/2026)***

Agency staff D and agency staff E are not regularly scheduled at the community. If either of these team members return to the community, the orientation will be completed prior to that shift, or prior to working the floor.
The Executive Director will review all schedules with agency staff assignment. Any agency staff will be expected to complete training prior to start of shift.
Effective 3/19/26 the Executive Director or designee will perform an audit of all agency staff orientation to ensure compliance. Any deficiencies will be corrected immediately, agency staff will be removed from the assignment until completion of training and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented [redacted] - 05/04/2026)

65b - Rights/Abuse 40 Hours

5. 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 D completed their 40th scheduled work hour. However, this staff person did not complete training in the following topics:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Staff person E whose first day of work was [redacted], did not receive orientation on the following topics:
1.Evacuation procedures.
2.Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an

65b - Rights/Abuse 40 Hours (continued)

emergency location if applicable.
3.The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4.Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5.The location and use of fire extinguishers.
6.Smoke detectors and fire alarms.
7.Telephone use and notification of emergency services.
Staff person D completed [redacted] 40th scheduled work hour. However, this staff person did not complete training in the following topics:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
Repeated violation[redacted] et al.

Plan of Correction ***Accept[redacted] - 03/19/2026)***

Agency Staff D and agency staff E are not regularly scheduled at the community. If either of these team members return to the community, the orientation will be completed prior to that shift, or before working on the floor.
The Executive Director/designee will review all schedules with agency staff assignments. Any agency staff will be expected to complete training prior to start of shift.
Effective 3/19/26 the Executive Director/designee will perform an audit of all agency staff orientation to ensure compliance. Any deficiencies will be corrected immediately, agency staff will be removed from the assignment until completion of training, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented[redacted] - 05/04/2026)

65e - 12 Hours Annual Training

6. 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

Direct care staff person A received 0 hours of annual training in training year 2025.

Direct care staff person B received 7.5 hours of annual training in training year 2025.

Plan of Correction ***Accept[redacted] - 03/19/2026)***

An audit in Relias was completed on 3/19/26 to ascertain training needs for all associates. Annual training for staff

65e - 12 Hours Annual Training (continued)

A and staff B will be completed as of 3/31/2026.
The Executive Director/designee will assign training to all newly hired staff upon hire, and annually to ensure training compliance for all staff. Adjustments will be made, if appropriate, to assigned training plans.
Effective 3/19/26 the Executive Director and/or designee will perform an audit of Relias monthly to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented [redacted] - 05/04/2026)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person A did not receive annual training in the following during 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.
4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
(5) Personal care service needs of the resident.
(6) Safe management techniques.
(7) Care for residents with mental illness or mental retardation, or both.

Direct care staff person B did not receive annual training in the following during training year 2025:
Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration and Care for residents with mental illness or mental retardation, or both.

Direct care staff person C did not receive annual training in the following during 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.
(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
(5) Personal care service needs of the resident.
(6) Safe management techniques.
(7) Care for residents with mental illness or mental retardation, or both.

65f - Training Topics *(continued)*

Plan of Correction ***Accept (- 03/19/2026)***

An audit of Relias was completed on 3/19/26 to ascertain training needs for all associates.
All training topics listed in regulation 2600.65f will be reviewed in Relias or offline during monthly staff meetings on 3/26 and 4/26. Staff B and staff C annual training will be completed by 3/31/2026.
The Executive Director/designee will assign training to all newly hired staff upon hire, and annually to ensure training compliance for all staff. Adjustments will be made, if appropriate, to assigned training plans.
Effective 3/19/26 the Executive Director and/or designee will perform an audit of Relias monthly, for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented - 05/04/2026)

65g - Annual Training Content

8. 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

Direct care staff person A did not receive annual training in the following during training year 2025:
Emergency preparedness procedures and recognition and response to crises and emergency situations. Resident rights. The Older Adult Protective Services Act, and Falls and accident prevention.

Direct care staff person B did not receive annual training in the following during training year 2025:
Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and The Older Adult Protective Services Act, and Falls and accident prevention.

Ancillary staff person C did not receive annual training in the following during training year 2025:
The Older Adult Protective Services Act, and Falls and accident prevention.

Plan of Correction ***Accept - 03/19/2026)***

An audit of Relias was completed on 3/19/26 to ascertain training needs for all associates.
Annual Fire Safety training, OAPSA, and Fall/Accident Prevention will be completed in 4/26 for all staff, including staff A, staff B, and staff C.
The Executive Director/designee will assign training to all newly hired staff upon hire, and annually to ensure training compliance for all staff. Adjustments will be made, if appropriate, to assigned training plans.
Effective 3/19/26 the Executive Director and/or designee will perform an audit of Relias, monthly for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented (- 05/04/2026)

121a - Unobstructed Egress

9. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 12:32p.m., residents' walkers blocked egress from the home's dining room exit.

Plan of Correction ***Accept [redacted] - 03/19/2026)***

Immediate action was taken on 2/18/26 during the renewal survey by the Executive Director. All devices were moved away from the doors for unobstructed egress.
Executive Director/designee alerted residents to the standards regarding egress doors remaining unobstructed and where to place their mobile devices. All associates will be trained on unobstructed egress at the monthly staff meeting 3/23/26. All new hired staff will be trained upon hire regarding the standards of the egress doors.
Effective 3/19/26, the leadership team and ancillary staff will perform daily audits of all exit doors in the dining room to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/04/2026)

183e - Storing Medications

10. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] at approximately 2:00P.M., P.M. the home's medication cart contained [redacted] for resident [redacted] that did not have the date of opening. According to the manufacturer's instructions the drops should be used within 28 days of opening.

Plan of Correction ***Accept [redacted] - 03/19/2026)***

Immediate action was taken on 2/24/26. The expired eye drops for Resident #9 were removed from the cart, reordered and replaced from the pharmacy.
Healthcare Director/designee in-serviced Med Tech's/Nurses regarding standards for medication storage.
HCD/designee will train all newly hired staff upon hire regarding medication storage standards.
Effective 2/24/26, the MT/LPNs will perform weekly cart audits ongoing to maintain compliance. HCD and/or designee will review for any deficiencies and will ensure corrections immediately. All findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *03/24/2026*

Implemented [redacted] - 05/04/2026)

224a - Preadmission Screen Form

11. 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.

Repeated violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 03/19/2026)***

Healthcare Director obtained the preadmission screening form, as a late entry, for Resident [redacted]
An audit of all residents' pre-admission screenings was completed by HCD/designee and appropriate corrections were completed at that time. Executive Director in-serviced HCD regarding preadmission form standards.
Effective 3/19/26, the Executive Director and/or designee will perform a review of all resident pre-admission screenings prior to admission, monthly for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented [redacted] - 05/04/2026)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] current assessment was completed on [redacted]. However, the resident's previous assessment was completed on [redacted].

Repeated violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 03/19/2026)***

Immediate action was taken by the Health Care Director. Resident [redacted] annual assessment was completed.
A comprehensive audit of all residents' assessments was completed and appropriate corrections completed at that time, by HCD.
Effective 3/19/26, the Executive Director and/or designee will perform a review of all resident assessments monthly to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented [redacted] - 05/04/2026)

225c - Additional Assessment *(continued)*

231e - No Objection Statement

13. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept[redacted] 03/19/2026)***

The no objection statement was located for resident [redacted] and provided to the DHS on 3/15/26.
A full audit of all resident contracts/no objection statements will be completed with a completion date of 4/19/26, by Executive Director/designee.
Effective 3/19/26 the Business Office Manager/designee will perform a monthly audit of all resident contracts/no objections statements, monthly for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented[redacted] - 05/04/2026)

234d - Support Plan Revision

14. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [redacted] assessment, dated [redacted], does not include the resident's need for a mobility device.
Repeat violation [redacted]

Plan of Correction ***Accept[redacted] - 03/19/2026)***

Immediate action was taken by the Health Care Director on 2/18/26 and the enabler device was added to Resident [redacted] assessment and service plan.
An audit of all residents with enabler devices was completed by the Healthcare Director and any updates were added to the RASP immediately. Executive Director in-serviced HCD regarding updated assessments needing to be completed on an annual or change of condition basis.
Effective 3/19/26, the Executive Director and/or designee will perform a review of all resident RASPS, monthly for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented[redacted] - 05/04/2026)

236 - Staff Training

15. 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 care staff person A, who works in the Secure Dementia Care Unit (SDCU) had no documented hours of training in dementia care during the [redacted] to [redacted] training year.
Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had no documented hours of training in dementia care during the [redacted] to [redacted] training year.

Plan of Correction ***Accept [redacted] 03/19/2026)***

An audit in Relias was completed on 3/19/26 to ascertain training needs for all Staff. Staff A and Staff B SDCU annual training will be completed by 3/31/2026.
The Executive Director/designee will assign training to all newly hired staff upon hire, and annually to ensure training compliance for all staff. Adjustments will be made, if appropriate, to assigned training plans.
Effective 3/19/26 the Executive Director and/or designee will perform an audit of Relias, monthly for three months, to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *07/19/2026*

Implemented [redacted] - 05/04/2026)