



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MOON OPERATIONS LLC**

LEGAL ENTITY

To operate **HARMONY AT DIAMOND RIDGE**

NAME OF FACILITY OR AGENCY

Located at **3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108**

(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 **107**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 36**

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 **October 16, 2026** until **April 16, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **456442**

[Signature]
ISSUING OFFICER

[Signature]
ACTING 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 628P - 04/23



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 16, 2026

[REDACTED]
Moon Operations, LLC
[REDACTED]

RE: Harmony at Diamond Ridge
3301 Market Place Boulevard
Coraopolis, Pennsylvania 15108
License/COC #: 456442

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on April 2, 2026, April 8, 2026, May 6, 2026, May 7, 2026, May 8, 2026, May 11, 2026, May 27, 2026, July 14, 2026, and July 15, 2026, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (LICENSE NO. 456441) dated April 29, 2026 – October 29, 2026, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from OCTOBER 16, 2026 to APRIL 16, 2027.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
42(b)	II	55	\$ 5	\$ 275	5 calendar days from mailing date of this letter
187(a)(6)	III	55	\$ 3	\$ 165	15 calendar days from mailing date of this letter
225(a)	III	55	\$ 3	\$ 165	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675


This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



Facility Information

Name: HARMONY AT DIAMOND RIDGE

License #: 45644

License Expiration: 02/10/2027

Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108

County: ALLEGHENY

Region: WESTERN

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: MOON OPERATIONS, LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 89

Waking Staff: 67

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint, Incident

Exit Conference Date: 04/27/2026

Inspection Dates and Department Representative

04/02/2026 - On-Site: [REDACTED]

04/08/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107

Residents Served: 60

Secured Dementia Care Unit

In Home: Yes

Area:

Capacity: 36

Residents Served: 27

Harmony Square 1st floor

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 60

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 29

Have Physical Disability: 1

Inspections / Reviews

04/02/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/11/2026

05/19/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/11/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/25/2026

Inspections / Reviews (*continued*)

05/27/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/11/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/11/2026

09/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/11/2026

Reviewer: [REDACTED]

Follow Up Type:

25b - Contract Signatures**1. 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 for resident [REDACTED] dated [REDACTED], was not signed by the resident. The updated contract following a room and rate change on [REDACTED], was not signed by the resident or the resident's designated person/POA.

Plan of Correction**Accept [REDACTED] - 05/27/2026)**

1. Resident [REDACTED] still resides in the community; therefore, the Executive Director will meet with the resident and their responsible party on 5/20/2026 and have the resident sign the resident-home contract and room rate change form.

2. Beginning 5/18/26, the Executive Director/Designee will conduct a community wide audit of all active personal and memory care resident contracts to ensure the appropriate signatures are present on every contract per the regulation. Any issues will be corrected.

3. Beginning 5/18/26, the Executive Director/Designee will conduct a weekly audit on all new move-ins for the next twelve weeks to ensure the appropriate signatures are present on every new resident-home contract per the regulation.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026**Not Implemented [REDACTED] - 09/04/2026)****25c4 - Payment Responsibility****2. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

4. The party responsible for payment.

Description of Violation

Resident [REDACTED]'s resident-home contract dated [REDACTED] does not include the person responsible for payment. This section is blank.

Plan of Correction**Accept [REDACTED] - 05/27/2026)**

1. Resident [REDACTED] still resides in the community; therefore, on 5/20/2026 when the Executive Director meets with the resident and their responsible party, the Executive Director will ensure that the resident's contract states the party who is responsible for payment.

2. Beginning 5/18/26, the Executive Director/Designee will conduct a community wide audit of all active personal and memory care resident contracts to ensure every contract states the party who is responsible for payment. Any issues will be corrected.

3. Beginning 5/18/26, the Executive Director/Designee will conduct a weekly audit on all new move-ins for the next twelve weeks to ensure all new resident contracts state the party who is responsible for payment.

25c4 Payment Responsibility (continued)

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] 09/04/2026)

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 5:33 a.m., direct care staff person A entered resident [REDACTED]'s bedroom where [REDACTED] was lying in bed. Staff person A proceeded to hit resident [REDACTED] in the chest area with a pillow and said "Jesus, you cannot help yourself".

In January of 2026, the home determined that resident [REDACTED] required 1 on 1 supervision between 8:00 a.m. to 8:00 p.m. and notified the family. However, on [REDACTED] the family stopped providing 1 on 1 supervision and the home did not provide the required supervision. Resident [REDACTED] has numerous documented events of aggressive behaviors toward staff and residents since December 30, 2025. On [REDACTED] at approximately 5:30 a.m., direct staff person B entered resident [REDACTED]'s room on the home's secure dementia care unit (SDCU) to administer medication and found resident [REDACTED] lying on the floor next to [REDACTED] bed. Resident [REDACTED] was sleeping in resident [REDACTED]'s bed.

Repeat Violation - [REDACTED]

Plan of Correction

Accept [REDACTED] - 05/27/2026)

1. On 5/5/2026, all staff will be required to participate in Mandatory Abuse and Privacy Education conducted by the community's local Ombudsman. The staff member involved in the associate to resident abuse was immediately removed from the community, suspended, was not permitted to return to the community's property and was then terminated.

2. The residents involved in the resident to resident incident were immediately separated and assessed for physical and psychosocial well being. Physicians and responsible parties were notified of these incidents, and increased supervision was immediately implemented at the time. Required reports were sent to PA DHS and APS per regulations.

3. On 5/5/2026 the community's Healthcare Director/designee began a comprehensive audit of all residents and their RASPs to ensure care needs related to behaviors and triggers are accurately documented and reflected current conditions. Any discrepancies were corrected immediately, including updating RASPs and implementing appropriate supervision and interventions.

4. On 5/5/2026 the community's Healthcare Director/designee will begin conducting daily audits of resident behavior tracking within the EHR for four weeks, then weekly for one month. Mandatory RASP updates for any behavior changes will be completed. Staff will be notified of any changes to RASPs, particular to those involving resident behaviors or supervision needs through shift to shift report. Healthcare Director/Designee will verify

42b - Abuse (continued)

compliance during routine rounds. Beginning 5/5/26, all staff will be reeducated on community's zero tolerance abuse policy by Executive Director/designee. Executive Director/designee will increase management presence through daily rounds conducted on random shifts to monitor staff resident interactions and ensure resident safety. During rounds, direct observation of staff interactions, resident well being and supervision levels will be completed. Any concerns identified will be addressed immediately through corrective action and staff re education as needed. These rounds will be conducted daily for three months to ensure substantial compliance. Beginning 5/19/26, the Executive Director/Designee will interview three residents a week for the next three months and then three residents a month thereafter to ensure compliance with Regulation 2600.42(b).

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] - 09/04/2026)

121a - Unobstructed Egress**6. 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

At 10:15 a.m., there was no key card present to open the magnetically locked emergency exit door near room [REDACTED] on the home's Secure Dementia Care Unit after entering the posted code and opening the box that is supposed to contain the key card.

Repeat Violation - [REDACTED]

Plan of Correction**Accept [REDACTED] - 05/27/2026)**

1. On 4/8/26, community Maintenance Director immediately corrected the identified area at time of discovery and placed a keycard in the box.
2. On 4/8/26, all SDCU lockbox keycard locations were audited immediately after to ensure that there was a keycard present in each box.
3. Beginning 4/8/2026, all SDCU lockbox keycard locations will be audited daily for the next twelve weeks to ensure a keycard is present in each box.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] 09/04/2026)

183b - Meds and Syringes Locked**7. Requirements**

2600.

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

Description of Violation

On [REDACTED] at 4:03 p.m., the medication room in the wellness station in the home's secure dementia care unit was unlocked, unattended and accessible. There was a blue plastic bin with antiseptic swabs and a container of test strips setting on the medication cart. There was also a [REDACTED] lying on the medication cart with a small label for resident [REDACTED] that indicated [REDACTED]

Plan of Correction**Accept [REDACTED] - 05/27/2026)**

1. At the time of discovery on 4/8/26, the medication room was immediately secured. Education was provided to all medication technicians and licensed staff on the requirement that medication storage areas must remain locked at

183b - Meds and Syringes Locked (continued)

all times when not under direct supervision. The staff member involved was re-educated on this requirement immediately. Compliance was verified through direct observation.

2. On 4/8/26, all medication storage areas throughout the community were immediately checked by the Healthcare Director to ensure no other areas were left unlocked or unattended. This ensured that all residents' medications remained safe and inaccessible to unauthorized individuals.

3. Beginning 4/8/26, staff have been re-educated on expectations related to medication security and supervision. Leadership presence in the unit has been increased to reinforce compliance.

4. Beginning on 5/5/2026, The Executive Director, Healthcare Director, or designee will conduct random daily checks of medication storage areas to ensure they are locked and secure. These checks will occur multiple times per week for four weeks. Any findings will result in immediate corrective action and re-education. Audit results will be documented and maintained for review.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026

Implemented [REDACTED] - 09/04/2026)

191 - Resident Right to Refuse**8. Requirements**

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident [REDACTED] admitted [REDACTED] has not been educated to the resident's right to question or refuse a medication if the resident believes there may be a medication error.

Plan of Correction

Accept [REDACTED] - 05/27/2026)

1. Resident [REDACTED] still resides in the community therefore on 5/20/26 the Executive Director will meet with the resident and their responsible party and will educate the resident on their right to question or refuse a medication if they believe there may be a medication error.

2. Beginning 5/18/26, the Executive Director/Designee will conduct a community wide audit of all active personal and memory care resident contracts to ensure that education on the right to question and refuse medications is provided to each resident. Any issues noted will be corrected.

3. Beginning 5/18/26, the Executive Director/Designee will conduct a weekly audit on all new move-ins for the next twelve weeks to ensure that education on the right to question and refuse medications is provided to each resident.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

191 - Resident Right to Refuse (continued)

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] 09/04/2026)

231b - Medical Evaluation

9. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [REDACTED] was admitted to the home's Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's initial medical evaluation was completed on [REDACTED]. Repeated violation [REDACTED]

Plan of Correction

Accepted [REDACTED] 05/27/2026)

1. On 5/5/2026 the Executive Director re-educated the Healthcare Director and relevant admission staff on regulatory requirements for SDCU admission documentation, specifically that a medical evaluation must be completed within 60 days prior to admission and must clearly document [REDACTED] diagnosis and need for secured dementia care services.
2. Resident [REDACTED] is no longer in the facility; therefore, no immediate resident-specific correction is required. The current Healthcare Director had previously identified this concern during an internal audit and ensured that a new medical evaluation was completed to address and correct the documentation deficiency.
3. Beginning 5/5/2026 the Healthcare Director started an audit of all current residents admitted to the Secure Dementia Care Unit to ensure each resident had a qualifying medical evaluation completed within 60 days prior to admission, including documentation of dementia diagnosis and need for secured dementia care.
4. Beginning 5/18/26, the Healthcare Director or designee will audit all SDU admissions weekly for 4 weeks, then monthly for 3 months to ensure compliance with medical evaluation requirements.⁵⁶ All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Repeat Violation 10/23/25

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] - 09/04/2026)

231c - Preadmission Screening

10. 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 [REDACTED] was admitted to the home's Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's written cognitive preadmission screening was completed on [REDACTED]

231c Preadmission Screening (continued)

Plan of Correction

Accept [REDACTED] 05/27/2026)

1. On 4/8/2026 the Executive Director re educated the Healthcare Director on regulatory requirements for completion of the written cognitive preadmission screening, including that it must be completed within 72 hours prior to admission to a secured dementia care unit and documented on the Department's approved form.
2. The facility reviewed Resident [REDACTED]'s admission documentation on 4/8/2026 and confirmed the cognitive preadmission screening was completed outside the required 72 hour window prior to admission to the Secure Dementia Unit. No additional corrective action is required for the resident as they are no longer in the facility.
3. The facility completed an audit of all current SDU residents on 5/5/2026 to ensure all cognitive preadmission screenings were completed within the required 72 hour timeframe.
4. Beginning 5/18/26, the Healthcare Director or designee will review all SDU admissions weekly for 4 weeks then monthly for 3 months to ensure cognitive preadmission screening compliance.
5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] - 09/04/2026)

234e - Involvement/Participation

11. Requirements

2600.

234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

Resident [REDACTED]'s initial support plan was completed [REDACTED]. Neither the resident nor the resident's designated person were involved in the development of the support plan.

Plan of Correction

Accept [REDACTED] 05/27/2026)

1. On 4/8/2026 the Executive Director re educated the Healthcare Director on requirements for support plan development and documentation. Resident [REDACTED] is no longer residing in the facility; therefore, an updated support plan cannot be completed.
2. On 4/8/2026 Healthcare Director began auditing all current support plans to ensure resident and/or designated person involvement.
3. Moving forward, all support plans and revisions will include resident and/or designated person participation, with documentation of involvement or refusal.
4. Beginning 5/25/26, the Healthcare Director will audit support plans weekly for 30 days, then monthly for 3 months to ensure compliance.
5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

234e - Involvement/Participation (continued)

Licensee's Proposed Overall Completion Date: 06/10/2026

Not Implemented [REDACTED] - 09/04/2026)

254a - Records Discharge/Active

12. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

At 4:30 p.m., the laptop attached to the medication cart in the unlocked, unattended medication room in the home's Secure Dementia Care Unit (SDCU) was opened and had resident [REDACTED]'s medication administration record displayed on the screen to include information such as the resident's allergies and displayed medications [REDACTED] caplet" and [REDACTED]

Plan of Correction

Accept [REDACTED] - 05/27/2026)

1. Upon discovery on 4/8/26, the laptop was immediately secured and closed to prevent further unauthorized access to resident information. Staff present were re-educated on maintaining confidentiality of resident records, including ensuring electronic records are not left open and unattended.
2. On 4/8/26, An audit of all medication carts and electronic devices within the community was conducted immediately to ensure no other medication rooms were open or devices were left unattended with resident information visible. No additional concerns were identified at this time.
3. Beginning 5/4/2026, all staff will be re-educated on HIPAA compliance and facility policy regarding confidentiality and protection of resident records, including electronic MARs. Staff are instructed to log off or lock screens when not in direct use and to ensure medication rooms remain secured when unattended. Medication room access protocols will be reinforced during the re-education to ensure rooms remain locked when not occupied by authorized staff.
4. On 5/5/26, the Healthcare Director or designee started conducting audits across random shifts of medication carts, laptops, and medication rooms for compliance with confidentiality practices for a period of 4 weeks, then monthly for 3 months. Findings will be and addressed promptly, with additional staff education provided as needed.
5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 06/10/2026

Implemented [REDACTED] - 09/04/2026)

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

Facility Information

Name: HARMONY AT DIAMOND RIDGE **License #:** 45644 **License Expiration:** 10/29/2026
Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108
County: ALLEGHENY **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MOON OPERATIONS, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I 1	Date: 08/24/2024	Issued By: Township of Moon
Type: I 2	Date: 08/06/2024	Issued By: Township of Moon
Type: Other	Date: 08/06/2024	Issued By: Township of Moon

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 88 **Waking Staff:** 66

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Fine **Exit Conference Date:** 05/11/2026

Inspection Dates and Department Representative

05/06/2026 On Site: [REDACTED]
05/07/2026 - Off-Site: [REDACTED]
05/08/2026 - Off-Site: [REDACTED]
05/11/2026 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107 **Residents Served:** 58

Secured Dementia Care Unit

In Home: Yes **Area:** **Capacity:** 36 **Residents Served:** 27
Harmony Square - First Floor

Hospice

Current Residents: 11

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 58
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 30	Have Physical Disability: 1

Inspections / Reviews

05/06/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *05/21/2026*

05/22/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *05/29/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *05/30/2026*

09/04/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *05/29/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

130g Smoke Detector Repair**1. Requirements**

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On the morning of [REDACTED], the smoke detector sensor for the smoke detector located in the living room of resident room [REDACTED] belonging to resident [REDACTED] malfunctioned and caused the fire alarm system panel to indicate trouble due to the inoperability of the smoke detector. A replacement sensor was ordered on [REDACTED], however, the replacement had not been received as of [REDACTED] and the home's fire alarm panel continued to indicate "2nd FL PCH 209 LIVING RM."

Plan of Correction**Accept [REDACTED] - 05/22/2026)**

1. To ensure continued fire safety monitoring, Apartment [REDACTED] smoke detector was immediately replaced on 5/5/26 with a battery-operated unit until the replacement part for the fire panel arrives from the vendor.
2. Executive Director/Designee educated the Maintenance Director and Assistant Maintenance Director on regulation 2600.130g on 5/8/26. Documentation of this education will be kept with the Executive Director.
3. Maintenance Director/Designee conducted a community-wide audit of all smoke detectors to ensure proper functionality on 5/5/2026.
4. Starting 5/5/2026, Maintenance Director/Designee will audit ten community smoke detectors weekly for the next three months to ensure proper functionality in correlation to the community's fire panel system.
5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 05/29/2026

Implemented [REDACTED] - 09/04/2026)**130h Inoperable Smoke Detector****2. Requirements**

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

On the morning of [REDACTED], the smoke detector sensor for the smoke detector located in the living room of resident room [REDACTED] belonging to resident [REDACTED] malfunctioned and caused the fire alarm system panel to indicate trouble due to the inoperability of the smoke detector. However, the home's staff did not implement emergency procedures immediately for if the home's smoke detector or fire alarms are inoperable, and as of [REDACTED] at approximately 11:45 a.m., had not initiated the procedure for monitoring that area of the home until the smoke detector or fire alarms were operable.

Plan of Correction**Accept [REDACTED] - 05/22/2026)**

1. To ensure continued fire safety monitoring, Apartment 209's smoke detector was immediately replaced on 5/5/26 with a battery-operated unit until the replacement part for the fire panel arrives from the vendor.

130h - Inoperable Smoke Detector (continued)

2. Executive Director/designee educated the Maintenance Director and Assistant Maintenance Director on regulation 2600.130h on 5/8/26. Documentation of this education will be kept with the Executive Director.
3. Maintenance Director/Designee conducted a community-wide audit of all smoke detectors to ensure proper functionality on 5/5/2026.
4. Community Emergency Procedures were initiated on 5/5/2026 per this regulation and a Fire Watch protocol was initiated on affected area until fire panel replacement part arrives from the vendor.
5. Starting 5/5/2026, Maintenance Director/Designee will audit ten community smoke detectors weekly for the next three months to ensure proper functionality in correlation to the community's fire panel system.
6. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 05/29/2026

Implemented [REDACTED] - 09/04/2026)

225c - Additional Assessment**3. Requirements**

2600.

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

2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [REDACTED]'s assessment, dated [REDACTED], was not updated to include an assessment for Oxygen, to administer 2-4 liters per minute via nasal cannula as needed for dyspnea or decreased oxygen saturation that was prescribed on [REDACTED]

REPEAT VIOLATION [REDACTED]**Plan of Correction**

Accepted [REDACTED] - 05/22/2026)

1. Upon identification of the concern, on 5/6/2026, Resident [REDACTED]'s assessment was immediately reviewed and updated to include the physician's order for oxygen administration at 2-4 liters per minute via nasal cannula as needed for dyspnea or decreased oxygen saturation. The resident's service plan was also updated to reflect this change in condition and care needs.
2. On 5/6/2026 the Executive Director provided education to the Healthcare Director on regulation 2600.225(c), emphasizing the requirement to complete an additional assessment when a resident experiences a significant change in condition, including updating RASPS when there are orders for new treatments such as oxygen therapy.
3. Beginning 5/19/2026 the Healthcare Director completed an initial audit of all resident assessments and service plans was conducted to identify any residents with physician orders for oxygen and ensure corresponding

225c - Additional Assessment (continued)

assessments accurately reflect this need. Any discrepancies identified during the audit were corrected at that time.

4. Beginning 5/29/2026 the Healthcare Director/designee will audit 5 random resident charts weekly for a period of 4 weeks to ensure that all current physician orders, including oxygen, as well as any changes in condition, new therapies, or treatments, are accurately reflected in the RASP. Any discrepancies identified will be corrected immediately and addressed with staff as needed. Following this, audits will be conducted monthly for an additional 3 months to ensure ongoing compliance.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 05/29/2026

Not Implemented [REDACTED] - 09/04/2026)

227d - Support Plan Medical/Dental**4. Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident [REDACTED]'s support plan, dated [REDACTED] did not include a summary and determination, that section was left incomplete.

Plan of Correction

Accept [REDACTED] - 05/22/2026)

1. Upon identification of the concern, on 5/6/2026, Resident [REDACTED]'s support plan was immediately reviewed and updated to include the required summary and determination section, ensuring all medical, dental, vision, hearing, mental health, and behavioral care service needs were appropriately documented.

2. On 5/6/2026 the Executive Director provided re-education to the Healthcare Director on regulation 2600.227(d), emphasizing the requirement to ensure each resident's support plan includes a completed summary and determination and reflects all necessary medical and behavioral care services or referrals.

3. Beginning 5/19/2026 an initial audit of all resident support plans was conducted to ensure that the summary and determination section is complete and that all required services and/or referrals are properly documented. Any discrepancies identified during the audit were corrected at that time.

4. Beginning 5/29/2026 the Healthcare Director/designee will audit 5 random resident RASPs weekly for a period of 4 weeks to ensure that support plans include a completed summary and determination and accurately reflect all required services and/or referrals. Any discrepancies identified will be corrected immediately and addressed as needed. Following this, audits will be conducted monthly for an additional 3 months to ensure ongoing compliance.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on June 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

227d Support Plan Medical/Dental (*continued*)

Licensee's Proposed Overall Completion Date: 05/29/2026

Not Implemented [REDACTED] - 09/04/2026)

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

Facility Information

Name: HARMONY AT DIAMOND RIDGE **License #:** 45644 **License Expiration:** 10/29/2026
Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108
County: ALLEGHENY **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MOON OPERATIONS, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I 1 **Date:** 08/06/2024 **Issued By:** Township of Moon
Type: I 2 **Date:** 08/06/2024 **Issued By:** Township of Moon

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 95 **Waking Staff:** 71

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 05/27/2026

Inspection Dates and Department Representative

05/27/2026 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107 **Residents Served:** 62

Secured Dementia Care Unit

In Home: Yes **Area:** first floor **Capacity:** 36 **Residents Served:** 30

Hospice

Current Residents: 10

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 62
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 33 **Have Physical Disability:** 1

Inspections / Reviews

05/27/2026 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 07/12/2026

07/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/03/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 07/24/2026

07/30/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/03/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 08/03/2026

09/04/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/03/2026

Reviewer: [REDACTED]

Follow Up Type: Exception

42b - Abuse

1. 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

Resident [REDACTED] was admitted to the home on [REDACTED] and resides in the secure dementia care unit and has been on hospice since [REDACTED]. As early as a physician encounter on [REDACTED], the resident had a deformity and skin growth on the [REDACTED] identified as [REDACTED] and [REDACTED] the resident's durable power of attorney, has been notified multiple times.

Resident [REDACTED] has been ordered treatment for the ear wound since prior to admission to this PCH. The home's medication administration staff and hospice have been providing prescribed treatment when the resident permits. According to staff interviews and hospice notes, the resident expresses pain and resists having the treatment applied to [REDACTED] ear. Resident [REDACTED] often removes the ear dressing. The condition of resident [REDACTED]'s right ear has continued to deteriorate to the point that according to staff interviews, "pieces of [REDACTED] ear are coming off." On [REDACTED], the resident was sent to the hospital due to the observation of [REDACTED] on the resident's right ear wound.

Repeated Violation: [REDACTED] et al.; [REDACTED]

Plan of Correction

Accept [REDACTED] - 07/30/2026)

1. The community disagrees with the issuance of this violation, and this plan of correction does not constitute admission that this violation is accurate.
2. Resident [REDACTED] was evaluated at the hospital on 5/9/26 after maggots were identified in the right ear wound. Upon return to the home, all physician and hospice orders were implemented. The resident's service plan was reviewed and updated to reflect current wound care needs.
3. By 7/31/2026 the Healthcare Director will complete an audit of all residents with wounds to ensure current treatment orders are in place, dressings are being completed as ordered, documentation is current, and appropriate home health/or hospice involvement has been initiated as indicated.
4. By 7/31/2026 all Med Techs will be re-educated on monitoring wound dressings, promptly reporting changes in condition, documenting treatment refusals, and notifying the physician, hospice, home health and the resident's responsible party as appropriate.
5. Beginning 7/8/2026 staff will monitor the resident's ear dressing each shift to ensure it remains clean, dry, intact, and in place. If the dressing is found to be removed, the Med Tech will contact Hospice and request a visit for the Hospice nurse to re-apply the dressing. If the dressing is displaced, the Med Tech will resecure the dressing when able, document the intervention in the progress notes, and notify Hospice.
6. Beginning 7/8/2026 the Healthcare Director will meet with the hospice team weekly to review the resident's condition, discuss any changes or concerns, and ensure coordination of care. The Healthcare Director or designee will audit documentation of each-shift dressing checks weekly to ensure compliance.
7. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on August 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

42b - Abuse (continued)

8. On 7/21/2026, the community issued Resident [REDACTED] a 30-day notice of discharge. The community and the hospice team are working collaboratively with the resident's family to identify an appropriate alternate placement that can meet the resident's ongoing care needs. Until discharge, the community will continue to provide care and services in accordance with the resident's physician orders, hospice plan of care, and current service plan. The service plan will be reviewed on an ongoing basis and revised as necessary to reflect any changes in the resident's condition or care needs.

Licensee's Proposed Overall Completion Date: 07/31/2026

Not Implemented [REDACTED] - 09/04/2026)

130g - Smoke Detector Repair**2. Requirements**

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

According to the home's fire panel, the smoke detector in room [REDACTED] was inoperable on [REDACTED] when the Department was onsite. However, on [REDACTED], the smoke detector still had not been repaired.

Plan of Correction

Accept [REDACTED] 07/14/2026)

1. On 6/19/2026, the smoke detector for Room [REDACTED] was repaired by the community's external fire panel service vendor. The Executive Director in-serviced the community's Maintenance Director regarding fire panel standards and timely repairs.

2. Starting 7/9/2026, the Maintenance Director or designee will audit the community's fire panel daily for the next 30 days to ensure all fire safety equipment and smoke detectors are functioning properly throughout the community. Any issues will be corrected within 48 hours of notification, via contacting the fire panel service vendor if necessary.

3. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on August 26th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 07/31/2026

Implemented [REDACTED] - 09/04/2026)

Facility Information

Name: HARMONY AT DIAMOND RIDGE **License #:** 45644 **License Expiration:** 10/29/2026
Address: 3301 MARKET PLACE BOULEVARD, CORAOPOLIS, PA 15108
County: ALLEGHENY **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MOON OPERATIONS, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-1 **Date:** 08/06/2024 **Issued By:** Township of Moon
Type: I-2 **Date:** 08/06/2024 **Issued By:** Township of Moon

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 93 **Waking Staff:** 70

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 07/14/2026

Inspection Dates and Department Representative

07/14/2026 - On-Site: [REDACTED]
07/15/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 107 **Residents Served:** 55

Secured Dementia Care Unit

In Home: Yes **Area:** Harmony Square 1st fl **Capacity:** 36 **Residents Served:** 32

Hospice

Current Residents: 12

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 55
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 38 **Have Physical Disability:** 1

Inspections / Reviews

07/14/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 08/06/2026

Inspections / Reviews (*continued*)

08/07/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 08/06/2026

08/12/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/27/2026

09/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow Up Type:

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 [REDACTED] at 11:21 a.m., the door to the unattended Power Back Rehabilitation office on the second floor of the home was left wide open. There was a wire basket setting on the Director of Rehab-PT's desk which had "Home Health/Hospice Visit Notes" for several residents setting face up to include resident [REDACTED] resident [REDACTED] and resident [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On 8/5/26, the Community's Maintenance Director installed a keypad lock for the Power Back Rehabilitation Office door in order to protect patient records more securely.

2. On 8/7/26, the Executive Director will educate the Community's Rehabilitation Director and their staff on this regulation. Documentation of the education will be kept with the Executive Director.

3. Starting 8/7/26, the Executive Director or designee will audit the Power Back Rehabilitation Office twice a week for the next eight weeks to ensure record confidentiality is being properly adhered to.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

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 Personal Care Home Residency Agreement completed 4/29/26 for resident [REDACTED] admitted [REDACTED] was not signed by the resident.

The Personal Care Home Residency Agreement completed 1/9/26 for resident [REDACTED] admitted [REDACTED], was not signed by a designee of the home.

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. By 8/14/26, the Community's Executive Director will meet with Resident [REDACTED] to obtain their signature on the contract and Resident [REDACTED]'s contract will be corrected with a signature of a designee of the home.

2. On 8/7/26, the Regional Director of Resident Care will educate the Community's Executive Director on this regulation. Documentation of the education will be kept with the Executive Director.

25b - Contract Signatures (continued)

3. Starting 8/7/26, the Executive Director or designee will audit all current resident contracts to ensure all required signatures are present.

4. Starting 8/7/26, contracts for all new community move ins will be audited by the Executive Director or designee weekly for the next eight weeks to ensure that all required signatures are present on every contract per this regulation.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

96a - First Aid Kit**5. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On [REDACTED] at 1:42 p.m., the only accessible first aid kit located at the reception desk in the main lobby did not include tweezers.

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On July 14, 2026, the day the concern was identified, the Healthcare Director verified that an additional first aid kit located on the first floor contained all required first aid supplies, including tweezers. The first aid kit located at the reception desk was immediately reviewed, and tweezers were added to ensure that the kit contained all items required by 2600.96.a.

2. On July 16, 2026, the Healthcare Director was educated by the Executive Director regarding the required contents of first aid kits in accordance with 2600.96.a.

3. Beginning August 12th, 2026, to ensure ongoing compliance, the Healthcare Director/designee will conduct an audit of all first aid kits within the home monthly for three consecutive months. The audit will verify that each first aid kit contains all required items. Any missing item identified during an audit will be replaced immediately.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

97 - Elevators/Lifting Devices**6. Requirements**

2600.

97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The home has Initial Certificates of Operation for each of the home's elevators labeled as Location Number 61435 and Equipment Numbers 001, 002, 003 and 004. However, the home only has a current Certificate of Operation with 6 month re-inspections from the Department of Labor and Industry with required inspection and re-inspections for Equipment number 001.

97 Elevators/Lifting Devices (continued)**Plan of Correction****Accept** [REDACTED] - 08/12/2026)

1. On 8/7/26, the Executive Director or designee will contact the PA Department of Labor and Industry in order to obtain the remaining elevator certificates.
2. On 8/7/26, the Executive Director will educate the Community's Maintenance Director and Maintenance Assistant on this regulation.
3. Once the remaining certificates are obtained by the PA Department of Labor and Industry, the Maintenance Director or designee will conduct a monthly audit for the next six months to ensure the presence of all elevator certificates are within the community.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026**Implemented** [REDACTED] - 09/04/2026)**101j7 - Lighting/Operable Lamp****7. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On [REDACTED] at 11:56 a.m., there was no operable lamp or other source of lighting that can be turned on at bedside for resident [REDACTED]'s bed located next to the window in resident room [REDACTED]

Plan of Correction**Accept** [REDACTED] - 08/12/2026)

1. On 7/14/26, the Community's Maintenance Director immediately corrected the issue upon discovery by placing the lamp that was on the desk and placing it on the nightstand.
2. On 8/7/26, the Regional Director of Clinical Services will educate the Community's Department Heads on this regulation.
3. Starting 8/7/26, the Executive Director or designee will audit three resident rooms for the next eight weeks to ensure operable lamps are at resident bedside tables.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026**Not Implemented** [REDACTED] 09/04/2026)**102d - Grab/Hand/Assist Bar/Slip-Resistant Surface**

8. Requirements

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip resistant surfaces.

Description of Violation

On [REDACTED] at 2:20 p.m., there was no grab bar, hand rail or assist bar for the toilet in the stall to the right in the first floor women's room across from the Independent Living dining room.

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On 8/7/26, the Community's Maintenance Director will install grab bars for this identified location within the community.
2. On 7/14/26, the Community's Maintenance Director completed a community-wide audit to ensure that all restrooms in the community adhere to this regulation.
3. On 8/7/26, the Executive Director will educate the Community's Maintenance Director and Maintenance Assistant on this regulation.
4. Starting 8/7/26, the Community's Maintenance Director or designee will audit three resident restrooms weekly for the next eight weeks to ensure that this regulation is being properly adhered to.
5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

103g Storing Food**9. Requirements**

2600.

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

Description of Violation

On [REDACTED] at 11:13 a.m., the following opened and unsealed items were in the cabinet above the sink in the 3rd floor activity room:

- A 5 pound bag of Market Pantry All-purpose flour
- A 4 pound bag of Domino granulated sugar

Plan of Correction

Accept [REDACTED] 08/12/2026)

1. On 7/15/26, both identified food items located within the third-floor activity room were discarded.
2. On 8/7/26, the Regional Director of Clinical Services will educate the Community's Department Heads on this regulation.
3. On 7/15/26, a community-wide audit was conducted to ensure that all food was stored in closed or sealed containers.
4. Starting 8/7/26, the Executive Director or designee will audit three locations within the community weekly for

103g Storing Food (continued)

the next eight weeks to ensure that this regulation is being adhered to.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

132b - Safety Inspection/Fire Drill**10. Requirements**

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home has not had a fire safety inspection and fire drill conducted by a fire safety expert since [REDACTED]

Plan of Correction

Accepted [REDACTED] - 08/12/2026)

1. The Community's Maintenance Director has scheduled a date and time with a Fire Safety Expert on August 12th at 1:30pm.

2. On 8/7/26, the Executive Director will educate the Community's Maintenance Director and Maintenance Assistant on this regulation.

3. Once services are rendered, the Executive Director will obtain proof of the annual fire safety inspection and fire drill event, documentation shall be kept in the Executive Director's office.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Implemented [REDACTED] - 09/04/2026)

132c - Fire Drill Records**11. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home does not have documentation for fire drills held in July, August, and September 2025.

Plan of Correction

Accepted [REDACTED] 08/12/2026)

1. The community cannot retroactively correct the missing fire drills for July, August and September of 2025.

132c Fire Drill Records (continued)

2. On 8/7/26, the Executive Director will educate the Community's Maintenance Director and Maintenance Assistant on this regulation to ensure continuance of monthly fire drills occurs.
3. Starting 8/12/26, the Executive Director or designee will audit the community's conducted fire drills for the next twelve months in ensure continued compliance of this regulation.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29th, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Implemented [REDACTED] - 09/04/2026)

183e - Storing Medications**12. 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 10:20 a.m., there was an [REDACTED] in a clear bag with pharmacy label for resident [REDACTED] that was not dated when opened.

Repeated Violation [REDACTED] et al.

Plan of Correction

Accept [REDACTED] 08/12/2026)

1. On July 15, 2026, the [REDACTED] medication card for Resident [REDACTED] was identified as a discontinued medication that remained in the medication cart. The medication was immediately removed from the medication cart and wasted according to facility procedure.
2. On July 15th, 2026, the [REDACTED] for Resident [REDACTED] was identified without a documented date opened. Since the date opened could not be confirmed, the [REDACTED] was immediately removed from the med cart and new [REDACTED] was opened and dated immediately upon opening.
3. Beginning August 12th, 2026, all Med Techs will be educated that discontinued medications must be removed from the medication cart and handled according to facility medication disposal procedures. Staff were also educated that medications requiring an opened date must be dated immediately upon opening and that medications with an unknown opened date are not to be used.
4. Beginning on August 12th, 2026, the HCD/Designee will audit all medication carts monthly for three months to ensure discontinued medications have been removed, medications have current pharmacy labels that correspond

183e - Storing Medications (continued)

with current orders, and medications requiring an opened date are appropriately dated. Any identified concerns will be corrected immediately and staff will be re-educated as needed.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

185a - Implement Storage Procedures**13. Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [REDACTED] is ordered [REDACTED] three times daily prior to meals, check blood glucose level and administer [REDACTED] per sliding scale: [REDACTED]

[REDACTED]. However, the following blood glucose measurements as indicated in the resident's glucometer were not documented on the following dates/times:

- [REDACTED] 6:52 a.m. reading of [REDACTED]
- [REDACTED] 6:48 a.m. reading of [REDACTED]
- [REDACTED] 10:39 a.m. reading of [REDACTED]

Plan of Correction

Accept [REDACTED] 08/12/2026)

1. On July 15, 2026, immediately following the discovery of the concern, the Healthcare Director reviewed the medication and blood glucose monitoring process for Resident [REDACTED]. A sliding scale insulin administration form was implemented immediately to assist Med Techs with documenting the resident's blood glucose reading and corresponding insulin dose. In addition, the Healthcare Director received instructions on how to correct the eMAR configuration so that sliding scale insulin orders will prompt the Med Tech to enter the number of insulin units administered at the time of administration.

2. Beginning August 12th, 2026, all Med Techs will be educated on the procedure for documenting blood glucose readings and administering sliding scale insulin according to the physician's order. Staff were reminded that the blood glucose reading and corresponding insulin dose must be documented at the time of administration.

3. Beginning on August 12th, 2026 and continuing for three consecutive months, the HCD/Designee will audit all residents receiving sliding scale insulin to ensure blood glucose readings and corresponding insulin doses are documented accurately and at the time of administration. Any identified concerns will be corrected immediately and staff will be re-educated as needed.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

185a Implement Storage Procedures (*continued*)

Implemented [REDACTED] - 09/04/2026)

187a Medication Record

14. Requirements

2600.

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

6. Dose.

Description of Violation

Resident [REDACTED] is ordered [REDACTED] three times daily prior to meals, check blood glucose level and administer [REDACTED] per sliding scale: [REDACTED]. However, the resident's July 2026 medication administration record for this medication does not include the amount of units administered per sliding scale coverage from 8:00 a.m. on [REDACTED] through 8:00 a.m. on [REDACTED].

Repeated Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On July 15, 2026, immediately following identification of the concern, a sliding scale insulin administration form was created for each resident who currently has a sliding scale insulin order. Med Techs began using the forms immediately to document the number of insulin units administered. In addition, the Healthcare Director received instructions on how to correct the eMAR configuration so that sliding scale insulin orders will prompt the Med Tech to enter the number of insulin units administered at the time of administration.
2. Beginning August 12th, 2026 all Med Techs will be educated that the dose of medication administered must be documented on the medication record at the time of administration. Med Techs will be instructed to document the exact number of insulin units administered according to the resident's sliding scale order.
3. Beginning on August 12th, 2026, and continuing for three consecutive months, the HCD/Designee will audit all residents receiving sliding scale insulin to ensure the dose/number of units administered is documented on the MAR at the time of administration. Any identified concerns will be corrected immediately and staff will be re-educated as needed.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

187b Date/Time of Medication Admin.

15. 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 [REDACTED] is ordered [REDACTED] – take 1 capsule by mouth once daily for constipation. On [REDACTED] at

187b - Date/Time of Medication Admin. (continued)

11:23 a.m., this medication was not included on the resident's July 2026 medication administration record (MAR). Eight tablets have been removed from the blister pack dispensed on [REDACTED]. However, this medication was not documented as having been administered.

Repeated Violation [REDACTED] et al.

Plan of Correction**Accept [REDACTED] - 08/12/2026)**

1. On July 15, 2026 the medication order for Resident [REDACTED] was obtained from hospice and sent to the pharmacy to be profiled to ensure the medication is accurately reflected on the resident's medication profile and MAR.

2. Beginning August 12th, 2026, all Med Techs were educated that all medications must be documented on the MAR at the time the medication is administered. Med Techs were also educated to verify that medications being administered are listed on the current MAR.

3. Beginning on August 12th, 2026 and continuing for three consecutive months, the HCD/Designee will audit all resident MARs monthly to ensure medications administered are accurately reflected on the MAR. Any identified concerns will be corrected immediately, and staff will be re-educated as needed.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

225a - Assessment 15 Days**16. 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

Resident [REDACTED] was admitted to the home on [REDACTED]. However, an initial assessment has not been completed.

The initial assessment completed [REDACTED] for resident [REDACTED] admitted [REDACTED], did not include the degree of for the following topics in Section 3: Behavioral or Cognitive Need to include:

[REDACTED] and [REDACTED].

The initial assessment completed [REDACTED] for resident [REDACTED] admitted [REDACTED] does not include the Personal Care Need and Degree for the topics in Part III, Section 1 nor the Cognitive or Behavioral Need and degree for the topics in Part III, Section 3. Also, the resident's assessment does not include numerous diagnoses as indicated on the medical evaluation dated [REDACTED] to include: [REDACTED].

Repeated Violation [REDACTED]

225a - Assessment 15 Days (continued)

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On July 15, 2026, resident [REDACTED]'s initial assessment was completed using the Department's required assessment form. Resident [REDACTED]'s assessment was reviewed and updated to include the degree of need for the identified behavioral and cognitive areas. Resident [REDACTED]'s assessment was reviewed and updated to include the Personal Care Need and Degree, Cognitive or Behavioral Need and Degree, and applicable diagnoses identified on the medical evaluation.

2. On July 16, 2026, the Healthcare Director was educated by the Executive Director that all residents must have a complete initial assessment documented on the Department's assessment form within 15 days of admission. Staff were also educated by the Healthcare Director/Designee on the importance of completing all applicable sections, documenting the degree of need, and ensuring diagnoses are consistent with the resident's current medical evaluation.

3. Beginning on August 12th, 2026, and continuing for three consecutive months, the Healthcare Director/Designee will audit all new move-ins to ensure an initial assessment is completed within 15 days of admission and that all required sections are completed, including the degree of need and applicable diagnoses. Any identified concerns will be corrected immediately.

4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

225c - Additional Assessment

17. Requirements

2600.

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

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

Description of Violation

The annual assessment completed [REDACTED] for resident [REDACTED] admitted [REDACTED] does not include the degree of need in the Behavioral or Cognitive Need and Degree section. This section is blank in several topics to include: [REDACTED]

[REDACTED] Also, the assessment dated [REDACTED] indicates resident has moderate mobility needs, however the resident's medical evaluation dated [REDACTED] indicates the resident is "Total (Immobile)."

The most recent assessment completed for resident [REDACTED] admitted [REDACTED], was completed [REDACTED].

Repeated Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On July 15, 2026, resident [REDACTED]'s assessment was reviewed and updated by the Healthcare Director to include the degree of need for the identified behavioral and cognitive areas. The resident's mobility status was also reviewed and corrected to accurately reflect the resident's current needs and medical evaluation. The Healthcare Director completed a new assessment for Resident [REDACTED] on July 16, 2026. Additionally, the Healthcare Director corrected the medical evaluation for Resident [REDACTED] to accurately reflect the resident's status as moderately immobile.

225c Additional Assessment (continued)

2. On July 16, 2026, the Healthcare Director was educated by the Executive Director on completing all required sections of the assessment, accurately documenting the resident's degree of need, and ensuring the assessment is consistent with current medical information and the resident's condition.
3. Beginning on August 12th, 2026, and continuing for three consecutive months, the Healthcare Director/Designee will audit all resident assessments completed during the month to ensure all required sections are completed, the degree of need is documented, and the assessment accurately reflects the resident's current condition and available medical information. Any identified concerns will be corrected immediately.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)

227a - Support Plan 30 Days**18. Requirements**

2600.

- 227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident [REDACTED] was admitted to the home on [REDACTED]. However, an initial support plan has not been completed.

Plan of Correction

Accept [REDACTED] - 08/12/2026)

1. On July 15, 2026, resident [REDACTED]'s initial support plan was completed using the Department's required support plan form.
2. On July 16, 2026, the Healthcare Director was educated by the Executive Director that all residents requiring personal care services must have a written support plan developed and implemented within 30 days of admission using the Department's support plan form.
3. Beginning on August 12th, 2026, the Healthcare Director/Designee will audit all new move ins for three consecutive months, to ensure a support plan has been completed and implemented within 30 days of admission. Any identified concerns will be corrected immediately.
4. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Implemented [REDACTED] 09/04/2026)

227d - Support Plan Medical/Dental**19. Requirements**

227d - Support Plan Medical/Dental (continued)

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The annual support plan completed [REDACTED] for resident [REDACTED] admitted [REDACTED], does not include the plan to meet the medical needs for the diagnoses of pain and gout. The support plan does not include the frequency or responsible party for meeting the need of the following diagnoses: [REDACTED] and [REDACTED].

Plan of Correction**Accept [REDACTED] - 08/12/2026)**

1. On July 15, 2026, resident [REDACTED]'s support plan was reviewed and updated to include the medical needs related to pain and gout, as well as the frequency and responsible party for addressing neuropathy, itching, excoriation, inflammation, and GERD.
2. On July 16, 2026, the Healthcare Director was educated by the Executive Director that support plans must identify the medical, dental, vision, hearing, mental health, and behavioral care services needed by each resident, including the frequency and responsible party for meeting the identified needs.
3. By August 25th, 2026, an audit of all current resident support plans will be completed by the Healthcare Director/Designee to ensure identified medical and other healthcare needs are addressed, including the frequency and responsible party when applicable. Any identified concerns will be corrected.
4. Beginning September 1st, 2026, the Health Care Director/Designee will audit 5 resident support plans monthly for three consecutive months. Audits will ensure that identified medical, dental, vision, hearing, mental health, and behavioral care needs are included in the support plan, with the frequency and responsible party identified when applicable. Any identified concerns will be corrected immediately.
5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026**Not Implemented [REDACTED] - 09/04/2026)****227g -Support Plan Signatures****20. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The annual support plan completed [REDACTED] for resident [REDACTED] admitted [REDACTED], was not signed by the resident and does not indicate if the resident was unable or refused to sign the support plan.

Plan of Correction**Accept [REDACTED] - 08/12/2026)**

1. The support plan for Resident [REDACTED] was reviewed, and the resident signed and dated the support plan on 8/4/2026.
2. On July 16, 2026, the Healthcare Director was educated by the Executive Director that all individuals who participate in the development of a support plan must sign and date the support plan. If a resident is unable or

227g -Support Plan Signatures (continued)

refuses to sign, this must be documented on the support plan.

3. By August 25, 2026, an audit of all current resident support plans will be completed by the Healthcare Director/Designee to ensure required signatures and dates are present or that documentation is present when a resident is unable or refuses to sign. Any identified concerns will be corrected.

4. Beginning September 1, 2026, the Healthcare Director/Designee will audit 5 resident support plans monthly for three consecutive months. Audits will ensure that individuals who participated in the development of the support plan have signed and dated the plan, or that appropriate documentation is present when a resident is unable or refuses to sign. Any identified concerns will be corrected immediately.

5. All monitoring activities, findings, and corrective actions will be reviewed at the community's monthly QAPI meeting on September 29, 2026. The results of the audits will be documented in the monthly QAPI meeting minutes.

Licensee's Proposed Overall Completion Date: 08/26/2026

Not Implemented [REDACTED] - 09/04/2026)