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

May 19, 2026

FOX CHAPEL OPERATIONS LLC

RE: HARMONY AT HARTS RUN
3450 HARTS RUN ROAD
GLENSHAW, PA, 15116
LICENSE/COC#: 45322

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/14/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HARMONY AT HARTS RUN* **License #**: *45322* **License Expiration**: *09/19/2026*

Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *178* **Waking Staff**: *134*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *04/14/2026*

Inspection Dates and Department Representative

04/14/2026 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *136* **Residents Served**: *124*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st floor Memory Care* **Capacity**: *40* **Residents Served**: *37*

Hospice

Current Residents: *26*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *124*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *54* **Have Physical Disability**: *1*

Inspections / Reviews

04/14/2026 - Partial

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *04/29/2026*

04/24/2026 POC Submission

Submitted By: **Date Submitted**: *05/14/2026*

Reviewer: **Follow Up Type**: *POC Submission* **Follow Up Date**: *04/30/2026*

Inspections / Reviews *(continued)*

04/27/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/14/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/14/2026*

05/19/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/14/2026*

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

82c Locking Poisonous Materials

1. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 2:00pm, the following poisonous materials with manufacturers' labels indicating, "If swallowed, get medical help or contact poison control center right away", were unlocked, unattended and accessible to residents under resident [redacted] private bathroom sink, located in the home's secured dementia care unit (SDCU):

- *A 3 ounce bottle of Remedy anti-fungal powder*
- *A 4 ounce bottle of Medline Sparklefresh Mouthwash*
- *A 1.69 ounce squeeze tube of Dercos Selenium Sulfide Anti-Dandruff shampoo*
- *A box of gel toilet bowl cleaner*
- *A 4 ounce squeeze tube of Remedy Essentials Zinc Oxide paste skin protectant*

Numerous residents in the SDCU, including resident [redacted] have not been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 04/27/2026)***

The listed items in resident [redacted] private bathroom have been removed. Resident's in the SDCU have private bathrooms with locking cabinets to keep personal hygiene items out of reach of resident's who cannot safely use and avoid poisonous materials.
Beginning 4/21/26, the Memory Care Director (MCD) or designee will complete five (5) daily room sweeps to ensure any poisonous materials with manufacturer's labels indicating "if swallowed get help or contact poison control center right away" are removed from the room or located behind an actively working locking cabinet. Documentation of the room sweeps will be kept in a binder in the MCD office. MCD/designee will train all new MC staff regarding safety measures at hire and as needed and current MC staff will be re-educated on this regulation by 5/14/26. Documentation of the education will be kept in the Executive Director's office. Executive Director or designee will audit MC apartments monthly for six months, to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented ([redacted] - 05/19/2026)

103d Storing Food Off Floor

2. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At approximately 9:30am, the following food items were stored on the floor in the home's main kitchen:

- *A full box of cooked turkey breast was stored on the floor in the walk-in cooler*
- *A full box of bagels were stored on the floor in the walk-in freezer*

103d Storing Food Off Floor *(continued)*

Plan of Correction ***Accept (04/27/2026)***

The box of cooked turkey breast and full box of bagels were removed from the floor at the time of the visit by the dietary staff.
Beginning 4/21/26 the Dining Services Director(DSD) or designee will complete daily kitchen/freezer/refrigerator audits to ensure no food is stored on the floor in accordance to food safety. Documentation of the kitchen/freezer/refrigerator audits will be kept in a binder in DSD office. DSD/designee will train all new dining staff regarding food safety measures at hire and as needed and current dining staff will be re educated on this regulation by 5/14/26. Executive Director or designee will audit the kitchen storage area monthly for six months to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented - 05/19/2026)

162c - Menus Posted

3. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

At the time of inspection, the home's menu posted outside the main dining room ended on , and the menu posted outside the SDCU dining room ended on .

Plan of Correction ***Accept 04/24/2026)***

The menu outside the main dining room and outside the SDCU dining room were both updated at the time of the visit by the Dining Services Director.
Beginning 4/21/26 the Dining Services Director or designee will keep a daily checklist to confirm the dining menus are posted to ensure compliance. Documentation of the posted menus will be kept in a binder. The Executive Director will audit the postings weekly, for six months to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/23/2026*

Implemented (05/19/2026)

225c - Additional Assessment

4. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident 's most recent assessment was completed on

Plan of Correction ***Accept - 04/27/2026)***

The Healthcare Director or designee will complete a new assessment for Resident by 5/1/26. Executive

225c - Additional Assessment (continued)

Director/designee will in-service the nursing team regarding expectations for annual assessments by 5/14/26 and documentation of the in-service will be kept in a binder in the Executive Director's office.
Healthcare Director or designee will review all resident assessments to ensure assessments are updated annually. Executive Director or designee will audit resident assessments, monthly, for six months to ensure compliance. By 5/1/26, the Healthcare Director/designee will have a tracking system implemented that will be reviewed/updated monthly to ensure timely assessments are completed.

Proposed Overall Completion Date: 05/14/2026

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/19/2026)

227g -Support Plan Signatures

5. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] support plan, dated [redacted], is not signed by the assessor. Also, resident [redacted]s support plan is not signed by resident [redacted] and does not indicate if resident [redacted] was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Accept [redacted] 04/27/2026)***

Healthcare Director or designee will update resident [redacted]s support plan and will ensure it is signed by the assessor and the resident by 5/1/26. Executive Director/designee will in-service the nursing team regarding expectations for signatures regarding support plans by 5/14/26 and documentation of the education will be kept in a binder in the Executive Director's office.
Healthcare Director or designee will review all resident support plans to ensure they have been signed and dated by both the assessor and the resident by 5/1/26. Additionally, beginning 5/1/26, Executive Director or designee will audit ten (10) support plans monthly for six months to ensure compliance. Documentation of the audit will be kept in a binder in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented ([redacted] 05/19/2026)

234b - Support Plan Needs Elements

6. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #[redacted] assessment, dated [redacted] is blank in the following areas and does not include an assessment of resident [redacted] needs:

234b Support Plan Needs Elements (continued)

- *Short term memory*
- *Long term memory*
- *Ability to use and avoid poisonous materials*

Also, resident [redacted] began receiving Hospice services on or around [redacted]; however, resident [redacted] support plan, dated [redacted] does not include the specific services or frequency of services resident [redacted] is receiving from Hospice. Resident [redacted] was admitted to the SDCU on [redacted]

Plan of Correction ***Accept [redacted] - 04/27/2026)***

Healthcare Director will update resident [redacted] support plan to identify the resident's needs and specific frequency and services of hospice by 5/1/26. Executive Director/designee will in service the nursing team regarding expectations for support plans by 5/14/26 and documentation of the education will be kept in a binder in the Executive Director's office.
Healthcare Director or designee will review all resident support plans to ensure the plan identifies the resident's needs by 5/1/26. Additionally, beginning 5/1/26, Executive Director or designee will audit ten (10) support plans monthly for six months to ensure compliance. The Healthcare Director/designee will update resident assessment/support plans as care needs change and will document the update in the community tracking system as needed.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/19/2026)