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

July 1, 2026

[redacted], AUTHORIZED REPRESENTATIVE
CAPITOL OPERATOR LLC
[redacted]

RE: THE TERRACES AT CAPITOL VILLAGE
4004 LINGLESTOWN ROAD
HARRISBURG, PA, 17112
LICENSE/COC#: 33798

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/06/2026, 05/07/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE TERRACES AT CAPITOL VILLAGE* **License #**: *33798* **License Expiration**: *06/01/2026*

Address: *4004 LINGLESTOWN ROAD, HARRISBURG, PA 17112*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *CAPITOL OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/17/2001* **Issued By**: *Lower Paxton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *62* **Waking Staff**: *47*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/07/2026*

Inspection Dates and Department Representative

05/06/2026 - On-Site: [redacted]

05/07/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *56*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*

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

Have Mobility Need: *6* **Have Physical Disability**: *1*

Inspections / Reviews

05/06/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/05/2026*

06/08/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/30/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/01/2026*

Inspections / Reviews *(continued)*

07/01/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2026*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 5/6/26, the home's current license, dated 6/1/25 to 6/1/26, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. Current Facility License was posted at the front desk located in the public binder with survey results. The Executive Director posted the facility license in a frame at entryway on 5/7/26.
2. Executive Director will assure all license renewals are posted when due.
3. Executive Director posted the 6/1/2026 to 6/1/2027 license effective 6/1/2026 at the entryway.
4. Executive Director established a TELS task to set annually in May to assure new license is posted by 6/4/2026.
5. Executive Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/04/2026*

Implemented ([redacted] - 07/01/2026)

17 - Record Confidentiality

2. 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 5/6/26 at 12:01 PM, a pink nursing clipboard containing residents' personal information including Resident #1's vital signs and measurements was unlocked, unattended and accessible on medication cart #3.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. Wellness Director immediately removed the clipboard from med cart and provided verbal education to the employee responsible on 5/6/2026.
2. Executive Director will re-educate all team members on responsibility to maintain record confidentiality by 6/8/2026.
3. Executive Director will complete walking rounds 5 times per week for 2 weeks and then 3x per week for 2 weeks to observe for maintaining record confidentiality to begin on 6/8/2026 and conclude by 7/13/2026.
4. Executive Director will report findings at August quality management meeting following completion of audits to present findings and further recommendations.
5. Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

17 Record Confidentiality *(continued)*

Implemented (- 07/01/2026)

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 , Staff Member A yelled at Resident #2 to take pills and then threw water in Resident #2's face because refused to take the medication. As a result of the incident, Staff Member A was terminated on

Plan of Correction ***Accept (- 06/08/2026)***

1. Executive Director immediately suspended Staff Member A on upon notification of allegation of Staff Member A throwing water towards Resident #2.
2. Executive Director reported alleged incident immediately to DHS and Protective Services on
3. Executive Director following completion of investigation Staff Member A was separated from employment on following completion of facility internal investigation.
4. Executive Director will complete additional re-education on Resident Rights and Abuse, Respect and Dignity by 6/8/2026 for all employees.
5. Executive Director provided re-education on Resident Rights including right to be free of abuse on resident council on 4-15-2026.
6. Executive Director will continue to promote resident rights and abuse education in new hire general orientation and all staff annual training requirements.
7. Executive Director will audit new hire general orientation documents for 1 month to ensure all new staff are provided education on resident rights and abuse upon hire, to begin on 6/1/26 to 7/1/26.
8. Executive Director will review any potential incidents as they occur daily for 1 month beginning 6/1/26 to 7/1/26.
9. Executive Director will report findings at August Quality Management Meeting to identify compliance and make recommendations to maintain compliance.
10. Executive Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented (- 07/01/2026)

81b Resident Personal Equipment

4. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 5/16/26 at 12:16 PM, the bedside mobility device installed on the right side of Resident #2's bed was missing pins that connect the device to its base, allowing the two pieces of the device to be easily pulled apart.

Plan of Correction ***Accept (- 06/08/2026)***

1. On 5/6/26 Executive Director assured Maintenance Supervisor immediately replaced the pins on Resident #2

81b - Resident Personal Equipment (continued)

right side bedside mobility device to assure the 2 pieces were secure.
2. The Maintenance Supervisor was re-educated on the installation and safe use of bedside mobility devices by Executive Director on 5/6/2026.
3. Maintenance Supervisor will inspect all facility bedside mobility devices for safe installation by 6/8/2026.
4. Maintenance Supervisor will audit All bedside mobility devices weekly beginning 6/8/2026 for 4 weeks.
5. Executive Director will implement a Tels task by 6/4/26 to include ongoing monthly audits of all bedside mobility device to check proper installation and safe working order.
6. Executive Director will report at August Quality Management Meeting audit findings and recommendations for ongoing compliance.
7. Maintenance Supervisor responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/6/26 at 12:03 PM, there was a puddle of urine on the floor in Resident #2's bathroom.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. On 5/6/2026 upon identification of the puddle of urine on Resident #2 bathroom floor was immediately cleaned by housekeeping supervisor.
2. Resident #2 full apartment flooring was replaced on 6/1/26 to assist with ease of cleaning.
3. Executive Director re-educated housekeeping supervisor on 5/6/2026 inspecting bathrooms on daily trash rounds to observe for evidence of sanitary conditions.
4. Executive Director will re-educate all facility staff on expectation to maintain sanitary conditions by 6-8-2026.
5. Executive Director will conduct full facility audit to include all resident apartments to observe for sanitary conditions by 6-8-2026.
6. Housekeeping Supervisor will complete walking rounds 5 times per week for 2 weeks and then 3x per week for 2 weeks to observe for maintaining sanitary conditions to begin on 6/8/2026 and conclude by 7/13/2026.
7. Executive Director will report findings at August Quality Management Meeting to identify compliance and make recommendations to maintain compliance.
8. Housekeeping Supervisor responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

88a - Surfaces

6. Requirements

88a Surfaces *(continued)*

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 5/6/26 at 11:26 AM, the areas/surfaces in the kitchen including the front of cabinets, food warmers and floor were soiled with dried liquid and food debris. In addition, water was on the floor towards the back of the walk-in freezer.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. On 5/6/2026 Executive Chef immediately assured the completion of cleaning tasks to assure identified areas of front of cabinets, food warmers, floor were free of dried liquid, food debris, and the walk in freezer free of water on the floor.
2. Executive Director immediately re-educated the Executive Chef on compliance expectations on 5/6/2026.
3. Executive Director will re-educate all dietary team members on expectations for compliance to maintain all surfaces clean, in good repair, and free of hazards by 6-8-2026.
4. Executive Chef will audit 2x per day and provide corrective actions 5x per week for 2 weeks then 2x per day 3x per week for 2 weeks beginning 6-8-2026.
5. Executive Director will review findings at August Quality Management Meeting and make recommendations for ongoing compliance.
6. Executive Chef is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

101o Walls, Floors, Ceilings

7. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 5/6/26 at 12:11 PM, a hole measuring approximately 1 inch by 3.5 inches in the door leading into Resident #4's bedroom.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. On 5/7/2026 Maintenance Supervisor completed work to repair the hole in Resident #4'sbedroom door.
2. Resident #4 is currently receiving PT services to assure safe operation of motorized scooter which has been determined to be the root cause of this hole.
3. Executive Director will re-educate all Care and Maintenance team members understand the compliance requirement for all bedroom walls,floors, ceilings, to be clean and in good repair, along with completing work orders to properly identify concerns by 6-8-2026.
4. Executive Director will complete walking rounds 5 times per week for 2 weeks and then 3x per week for 2 weeks to observe for maintaining bedrooms walls, floors, ceilings in clean and good repair to begin on 6/8/2026 and conclude by 7/13/2026.
5. Executive Director will report at August Quality Management meeting findings and make recommendations for ongoing compliance.

101o - Walls, Floors, Ceilings (continued)

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

103f - Refrigerator/Freezer Temps

8. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the freezer located in the main activity room.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. On 5/6/2026 a thermometer was immediately placed in the activity room freezer and verified temperature was below 0 degrees by Maintenance Supervisor.
2. Life Enrichment Director was immediately educated on 5/6/2026 on requirement for thermometer to be in place in both the refrigerator and freezer of all activity units.
3. Executive Director re-educated all leadership team members on the requirement for thermometers to be in place in all freezers and refrigerators, and the required temperature parameters on 5/7/2026.
4. Executive Director inspected all facility refrigerators and freezers to assure all units had thermometers in place and temperatures were in compliance on 5/7/2026.
5. Life Enrichment Director implemented a temperature recording log to include freezer temperatures daily beginning 6/1/2026 to monitor temperature readings ongoing.
6. Life Enrichment Director will audit compliance of assuring thermometer is in place and temperatures are recorded 1x per day and provide corrective actions 5x per week for 2 weeks then 1x per day 3x per week for 2 weeks beginning 6-8-2026.
7. Executive Director will review findings at August Quality Management Meeting and make recommendations for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/6/26 at 11:27 AM, multiple foods in the main kitchen were opened and unsealed including a bottle of olive oil, a container of melon chunks, a container of sugar sitting on a scale and a container of flour.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1.On 5/6/2026 Executive Chef immediately assured food items sealed to include the olive oil, melon chunks, and container of sugar in the food preparation space for the lunch meal.

103g - Storing Food (continued)

2. Executive Director immediately re-educated the Executive Chef on compliance expectations on 5/6/2026.
3. Executive Director will re-educate all dining team members on expectations for compliance to maintain all food items sealed and closed by 6-8-2026.
4. Executive Chef ordered additional sealed containers and plastic bags for food storage to be in place by 6/8/2026.
5. Executive Chef will audit compliance to ensure food items are properly sealed 2x per day and provide corrective actions 5x per week for 2 weeks then 2x per day 3x per week for 2 weeks beginning 6-8-2026.
6. Executive Director will review findings at August Quality Management Meeting and make recommendations for ongoing compliance.
7. Executive Chef responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is prescribed Colace 100mg docusate tablets. The pharmacy label states take 1 capsule by mouth every 12 hours as needed for constipation. However, the medication administration record (MAR) states to give 1 capsule by mouth every 12 hours for constipation hold for loose stool.

Resident #4 is prescribed Artificial Tears Ophthalmic Solution. The pharmacy label states to instill 1 drop into left eye 2 times a day for rearing into left eye. However, the MAR states to instill 1 drop into left eye 2 times a day for rearing into left eye for 10 days.

Resident #5 is prescribed Humalog Kwikpen subcutaneous solution 100mg inject per sliding scale: 1-79=0, 80-99=0, 100-150=0, 151-225=1, 226-300=2, 301-375=3, 376-450=4, 451-999=5, subcutaneously with meals for diabetes. However, the pharmacy label for the medication does not include sliding scale instructions.

Resident #5 is prescribed Baqsimi two-ack Nasal powder 3mg/Dose (Glucagon). The pharmacy label states to instill 1 actuation into the nostril dose does not need to be inhaled) as needed for severe hypoglycemia. May repeat in 15 minutes if no response. However, the MAR states 1 spray in nostril as needed for blood glucose less than 70 given when unable to take anything by mouth.

Repeated Violation - 1/22/25, et al.

184a Resident's Meds Labeled *(continued)*

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. On 5/7/2026 Wellness Director added a sticker to Resident #3's Colace to reflect change in instruction to follow the physician order as indicated on the Medication Administration Record.
2. On 5/7/2026 Wellness Director added a sticker to Resident #4's Artificial Tears to reflect change in instruction to follow the physician order as indicated on the Medication Administration Record.
3.On 5/7/2026 Wellness Director add sticker to Resident #5 Glucagon to reflect change in instruction to follow the physician order as indicated on the Medication Administration Record.
4 On 5/7/2026 Wellness Director add sticker to Resident #5 Humalog pen to reflect full instruction for sliding scale insulin to follow physician order as indicated on the Medication Administration Record.
5.Wellness Director will provide education to Med Tech's and LPN's assure medication labels match physician orders by 6/8/2026.
6.Wellness Director will audit all physician orders compared to pharmacy labels and assure the pharmacy label has proper indication of the correct instruction by 6/15/2026.
7.Wellness Director will randomly audit new orders 1x per week for 4 weeks to assure compliance beginning 6/15/2026.
8. Wellness Director will report findings at April Quality Management Meeting to identify compliance and make recommendations to maintain compliance.
9. Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

185a - Implement Storage Procedures

11. 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 #2 is prescribed blood sugar checks 3 times daily. The following blood sugar readings were observed in the resident's glucometer but were not recorded in the resident's record:

- *On 5/1/26 at 8:30 PM; reading of 372*
- *On 5/2/26 at 8:34 PM; reading of 164*
- *On 5/3/26 at 8:50 PM; reading of 302*
- *On 5/4/26 at 8:51 PM; reading of 246*
- *On 5/5/26 at 9:09 PM; reading of 237*

Repeated Violation 1/22/25, et al.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. The Executive Director can not retroactively correct the MAR blood glucose recordings. It was determined that 5/1/2026 MAR indicated 237 and Resident #2 5/1/2026 glucometer recording at 8:30pm was 327.
2. The Executive Director completed a late entry note in resident #2's 5/1/2026 progress notes to indicate blood glucose level documented as 327 in the glucometer for the 8:30pm administration.
3. Wellness Director will audit all resident with blood glucose monitoring current May Medication Administration records and compare the corresponding glucometer readings to assure there are no further documentation errors by 6/8/26.
4.Wellness director will provide re-education to Med Tech's and LPN's on implementing procedures for safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons to specifically include care and handling of glucometers and recording on the MAR by 6/8/26.
5. Wellness Director will assign daily glucometer to MAR audits to night shift Med Tech beginning 6/8/2026 as a measure to monitor.
6. Wellness Director will review the daily audits glucometer to MAR audits weekly for accuracy and compliance one time per week for four weeks beginning 6/15/26.
7. Executive Director will report findings at August Quality Management Meeting to identify compliance and make recommendations to maintain compliance.
8. Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)

225c - Additional Assessment

12. 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

Resident #3's current medical evaluation, dated [redacted] indicates the resident is on a "no sodium added" diet. However, the resident's current assessment, dated [redacted], does not include the resident's special diet.

Resident #6 utilizes a walker. However, the resident's current assessment support plan, dated [redacted], indicates the resident is "independent" with ambulating and does not include the resident utilizes a walker.

Repeated Violation - 6/5/25 and 1/22/25, et al.

Plan of Correction ***Accept ([redacted] - 06/08/2026)***

1. On 5/7/2026, Executive Director made addendum to Resident #3's 12/1/25 RASP to reflect Quality Assurance review to correct the resident diet to indicate Resident's current diet order.
2. Executive Director provided re-education to Wellness Director on assuring resident assessments and support plans accurately reflect the resident's current needs for diet and ambulation status on 5/7/2026.
3. Wellness Director will audit all resident most recent RASP's compared to medical evaluations to assure

225c Additional Assessment (continued)

ambulation status and diet status is accurately reflected to be completed by 6/15/2026.
4. Executive Director will audit initial, annual, and significant change RASP's beginning 6/15/2026 weekly for four weeks to assure accuracy of the RASP compared to DME and current updated orders.
5. Executive Director will report findings at August Quality Management Meeting to identify compliance and make recommendations to maintain compliance
6. Executive Director and Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/01/2026)