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

August 7, 2026

[redacted], REGIONAL DIRECTOR OF OPERATIONS
HAMPDEN OPERATIONS LLC
[redacted]

RE: HARMONY AT WEST SHORE
1910 TECHNOLOGY PARKWAY
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33381

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2026, 05/27/2026, 05/28/2026 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: *HARMONY AT WEST SHORE* **License #**: *33381* **License Expiration**: *12/16/2026*

Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *05/01/2016* **Issued By**: *Hampden Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *142* **Waking Staff**: *107*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *06/30/2026*

Inspection Dates and Department Representative

05/21/2026 - On-Site: [redacted]

05/27/2026 - On-Site: [redacted]

05/28/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *94*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Harmony Square* **Capacity**: *35* **Residents Served**: *30*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *94*

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

Have Mobility Need: *48* **Have Physical Disability**: *2*

Inspections / Reviews

05/21/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/20/2026*

Inspections / Reviews *(continued)*

07/21/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *07/31/2026*

07/31/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/05/2026*

08/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

The following records for Resident #1 were requested by an Agent of the Department and not provided by the home:

- *On 5/28/2026 at 9:30 AM - documentation relating to a [redacted] order, procedure, and/or preparation medication.*
- *On 5/28/2026 at 4:00 PM - April 2026 Medication Administration Record and a list of physician orders active on the date of the resident's admission to the home.*
- *On 5/29/2026 at 12:00 PM - Pharmacy receipts from 4/17/26 to present, for medications delivered to the home.*
- *6/1/2026 at 1:32 PM - Progress notes for April and May of 2026.*

Repeated Violation- 6/24/2025, et al.

Plan of Correction ***Directed ([redacted] - 07/31/2026)***

On 7/1/2026 the Executive Director re-educated department heads on regulation 2600.5.a. regarding providing immediate access to records by any agent from the department. All department heads are required to document the requested information, gather information, and report to the agent all information requested to the agent, upon request. The HCD or designee will ensure all medical documents are filed properly and readily accessible for survey purposes. This will be on-going.

(Directed)
In addition to the above plan of correction:

- *Education will be provided to all staff responsible for resident records on ensuring resident records include all pertinent medical information including physician orders, medical appointments, medical discharge summaries, Medication Administration Records, etc. from time of admission until discharge. Education will be provided no later than 8/5/26.*

Directed Completion Date: *08/05/2026*

Implemented ([redacted] - 08/06/2026)

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 5/21/2026 at 9:20 AM, confidential resident information was unlocked, unattended, and accessible in the 2nd floor nurse's station including controlled drug records for Residents #2 and #3. These documents listed the resident's names, the medication prescribed, and corresponding diagnoes.

17 Record Confidentiality (continued)

On 5/27/2026 at 10:06 AM the receptionist desk in the lobby was unattended and a binder labeled "Labs to be Drawn" was unlocked and accessible. Confidential resident information in this binder included the name, date of birth, insurance information, diagnosis, and lab work order for Residents #4 and #5.

Repeated Violation 9/30/2025, 6/24/2025 et al.

Plan of Correction ***Accept (- 07/21/2026)***

On 5/21/2026 the Executive Director removed all resident information from the 2nd floor nurses station.
On 5/27/2026 the Executive Director locked the Lab binder in the cabinet behind the Concierge desk.
On 5/29/2026 the department head team was re education on regulation 2600.17.
On 6/4/2026 all staff were re educated on regulation 2600.17 regarding securing resident records.
Beginning on 6/4/2026 the ED, HCD, or Designee will complete a weekly audit for a period of 12 weeks, of all nurses stations and the front desk to ensure that all resident information is secure. Executive Director or designee will train newly hired staff, upon hire and as needed regarding regulation 2600.17. Audit findings will be reviewed at QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan for Resident #1, dated indicated Resident #1 required total assistance with managing healthcare, including overall healthcare coordination such as tracking doctor's appointments and medications. With assistance from family, staff will coordinate healthcare and track both appointments and medications. However, the home could not provide documentation of the resident's medical appointments, medications, or physician orders from the time of admission to present.
Staff Members A and B indicated that Resident #1 is required to update staff when schedules an appointment. A physician communication form is sent along to the appointment for documentation of any new orders. If the form is not returned by the resident, staff are unaware of any changes to the resident's orders.

Plan of Correction ***Accept (- 07/31/2026)***

On 7/1/2026 the department head team was re educated by the Executive Director, on regulation 2600.23.a. On 7/2/2026 all Med Techs have been educated on regulation 2600.23.a as well as the need for documentation packets to be sent with each resident to appointments. Any change in their orders, and any discussion that occurred with POA or resident regarding medications or general health concerns, will be addressed by the HCD or designee upon receiving written changes.
On 6/4/2026 an audit will be conducted by the Executive Director, HealthCare Director or Designee that will be completed on all PC and MC RASP's to ensure that assistance levels are correct for each resident. The audit will

23a Activities of Daily Living Assistance (continued)

also identify which residents require assistance with managing their healthcare. The home will review upcoming appointments with those residents to ensure accuracy. Upon return from the appointment the home will contact the physician if the facility paperwork is not returned to ensure that all orders and follow up appointments are recorded and changes in ordered followed. The audit will be reviewed at the QA meeting.

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

Implemented ([redacted] - 08/06/2026)

82a - Poisonous Materials

4. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 5/27/2026 at 10:59 AM an unlabeled clear plastic spray bottle was in the Memory Care laundry room. Staff Member A indicated the spray bottle contained the cleaning product CLR.

On 5/27/2026 at 3:48 PM a clear plastic spray bottle, with "CLR" written in black marker, was in the janitor's closet within the kitchen.

Repeated Violation 9/30/2025, 6/24/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/27/2026 the Executive Director removed the clear spray bottle marked "CLR" and discarded it.
On 5/29/2026 all department heads were re educated on regulation 2600.82.a storage of poisonous materials in their original containers.
On 6/10/2026 all staff were re educated on regulation 2600.82.a storage of poisonous materials in their original containers.
On 6/4/26 an audit will be conducted weekly for 8 weeks, then biweekly for 8 weeks by the Executive Director, Maintenance Director, or Designee to ensure that all poisonous materials are secured and that chemicals are labeled and in their proper containers. Newly hired staff will be trained on regulation 2600.82, upon hire and as needed. The results of the audits will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)

85a - Sanitary Conditions

5. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 5/27/2026 an accumulation of dark dust and mold was present on the ceiling tiles around three vents located in the home's kitchen over cooking and food preparation areas.

On 5/28/2025 at 10:32 AM and again at 3:20 PM, brown liquid streamlines and feces were surrounding the outside of the toilet bowl in the bathroom of Resident #1.

Plan of Correction ***Accept (- 07/21/2026)***

On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.85.a.
On 5/28/2026 the Executive Director called the housekeeper to the clean bathroom of resident #1. The cleaning took place at 4:00 pm when was finishing up other apartments.
On 6/10/2026 The Executive Director re-educated the nursing team, the housekeeping team, and the dining team regarding regulation 2600.85.a sanitary conditions.
On 6/7/2026 the ceiling tiles in the kitchen were cleaned so that there was no visible dust or debris.
On 6/5/2026 an audit was initiated to be completed by the Executive Director, Maintenance Director, Culinary Director or Designee weekly for both the kitchen/dining areas and the resident rooms for 12 weeks. The results will then be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

85d - Trash Receptacles

6. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/27/2026 at 3:49 PM, two uncovered trash cans containing food and food items were observed in the food prep area of the kitchen. One trash can was missing the swing lid. The other trash can had broken lid flaps which were stuck in the down/open position. Meal prep was not being completed at this time.

Repeated Violation- 9/30/2025, 6/24/2025 et al.

Plan of Correction ***Accept (- 07/21/2026)***

On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.85.d.
On 6/10/2026 the kitchen staff was re-educated on regulation 2600.85.d regarding trash receptables.
On 6/10/2026 an audit was initiated to be completed by the Executive Director, Culinary Director or Designee weekly for 8 weeks and then biweekly for 8 weeks to ensure that all trash receptacles have operational lids. Newly hired kitchen staff will be trained on regulation 2600.85.d. upon hire and as needed. The audit will be reviewed at QA meetings.

Licensee's Proposed Overall Completion Date: *07/21/2026*

85d - Trash Receptacles *(continued)*

Implemented ([redacted] - 08/06/2026)

88a - Surfaces

7. Requirements

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 5/21/2026 at 3:30 PM, the floors of the common area and hallway of the Memory Care Unit had a sticky residue causing shoes to stick to the floors while walking throughout the unit. This creates a fall and/or tripping hazard for residents with limited mobility.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/22/2026 the Executive Director had the housekeeping team clean the floors with hot water to remove the chemical residue related to the stickiness on the floors.
On 5/29/2026 the Executive Director re-educated all department heads on regulation 2600.88.a
On 6/10/26 all housekeeping staff were re-educated on regulation 2600.88.a regarding surfaces being in good repair and free of hazards. It was also reviewed with them the directions for use of the floor cleaner that the community is using.
On 6/10/2026 an audit was initiated to inspect all common areas and 10 resident apartments weekly for 12 weeks and biweekly for 8 weeks. The audit will be completed by the Executive Director, Maintenance Director, HealthCare Director or Designee. The audits will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

A thermostat unit mounted to the wall in the bedroom of Resident #6 did not have a cover, exposing a circuit board and wiring creating a potential safety hazard.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.95 regarding furniture and equipment being in good repair and free of hazards.
On 6/1/2026 the Executive Director re-educated the Maintenance team on regulation 2600.95.
On 6/8/2026 the thermostat was repaired in resident #6 apartment.
On 6/10/2026 an audit was initiated to inspect all common areas and 10 resident apartments weekly for 12 weeks

95 Furniture and Equipment (continued)

and biweekly for 8 weeks. The audit will be completed by the Executive Director, Maintenance Director, HealthCare Director or Designee. The audits will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

132d - Evacuation

9. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 2/11/2026 at 11:30 PM, the evacuation time was 24 minutes and 14 seconds. This exceeds the maximum safe evacuation time of 15 minutes, specified within the past year by a fire safety expert.

Repeated Violation 6/24/2025, et al.

Plan of Correction ***Accept (- 07/31/2026)***

On 6/4/2026 the Executive Director re educated all staff on regulation 2600.132.d
Immediately after the failed drill, the Executive Director investigated the failed requirement to determine proper changes for the next fire drill, with department head staff. The home provided all staff training on emergency procedures including fire drills and timeliness of drills.
The community ran another drill in the same month on February 26, 2026 evacuated all 79 residents taking 11 minutes and 56 seconds. Community will continue to conduct fire drills to ensure compliance. The home will also review any failed drills and re educate staff regarding the obstacle to passing the drill at QA meetings. This will be on going.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/06/2026)

141b1 - Annual Medical Evaluation

10. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #10's most recent medical evaluation, dated did not indicate the resident's ability to self administer medication.

Repeated Violation 6/24/2025, et al.

Plan of Correction ***Directed (- 07/31/2026)***

On 5/29/2026 the Executive Director re educated the department head team on regulation 2600.141.b.1 regarding

141b1 Annual Medical Evaluation (continued)

medical evaluations.
On 6/2/2026 The Executive Director re educated Med Techs on regulation 2600.141.b.1 regarding self administer status.
On 6/4/2026 an audit was initiated of all resident DME's in Personal Care regarding the physician indicating they may self administer medications. The audit will be completed by the Executive Director, HealthCare Director, or Designee and will be reviewed at the QA meeting. Any findings will be addressed immediately. The Healthcare Director or designee will review all DME's for a period of 3 months.

(Directed)
In addition to the above plan of correction:
Resident #10's medical evaluation will be updated by 8/5/26.

Directed Completion Date: *08/05/2026*

Implemented ([redacted] - 08/06/2026)

162c - Menus Posted

11. 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

On 5/21/2026, the menu for the week of 5/10/26 through 5/16/26, was posted in the personal care unit. The menus for the current week and one week in advance were not posted.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/21/26 the Culinary Director immediately replaced the missing menu that was posted in the hallway.
On 5/29/26 the Executive Director re educated all department heads on regulation 2600.162.c 2 weeks of menus must be posted.
On 6/10/2026 the Executive Director re educated the dining team the Concierge team regarding regulation 2600.162.c. posting of menus.
An audit was initiated on 6/10/2026 that will be completed by the Executive Director, Culinary Director, Concierge Team or Designee to ensure that menus are posted according to regulation 2600.162.c. The audit will occur weekly for 12 weeks and the results will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)

171b4 - Staff Training

12. Requirements

2600.

171b4 - Staff Training *(continued)*

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff Member D has not completed the new hire direct care staff person training and regularly transports residents independently.

Plan of Correction ***Accept (- 07/31/2026)***

On 5/29/26 the Executive Director re-educated the department heads on regulation 2600.171.b. regarding staff training requirements.
On 06/01/2026 Staff Member D completed Direct Care Training.
On 6/01/2026 an audit of all staff files was completed to ensure that Direct Care Training Certificates were filed for all staff who are required, per regulation 2600.171.b. Any staff not certified will be removed from transportation/accompanying duties until certificate is received. The home will have all new hires complete Direct Care Training upon hire if they do not have a current certificate. This is on-going.

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

Implemented (- 08/06/2026)

183b - Meds and Syringes Locked

13. 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 5/28/2026 at 10:32 AM, PreviDent 5000 booster plus, Mupirocin ointment 2%, and Clindamycin Phosphate were unlocked, unattended, and accessible in Resident #1's room.

On 5/27/2026 at 12: 11PM, Bausch + Lomb lubricating eye drops (1.0 fl. oz., Polyethylene Glycol 400 0.25%), Afrin nasal spray (1 fl. oz., Oxymetazoline Hydrochloride 0.05%), Biofreeze menthol-pain relieving gel (4 fl. oz., Menthol 5%) , and Diclofenac Sodium Topical Gel 1% (100 g) were unlocked, unattended, and accessible in Resident #11's room.

Repeated Violation- 6/24/2025, et al.

Plan of Correction ***Accept (- 07/31/2026)***

On 5/28/2026 the medication that was not in a lock box was removed by the HealthCare Director from Resident #1's room.
On 5/27/2026 the medication that was not in a lock box and unattended was removed by the Health Care Director from Resident #11's room.
On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.183.b.
On 6/10/2026 The Executive Director re-educated the Med Tech's and Care Team regarding regulation 2600.183.b.

183b Meds and Syringes Locked (continued)

On 6/10/2026 an audit was initiated that will be completed by Executive Director, HealthCare Director, or Designee and will consist of 10 resident's rooms per week. This audit will continue for 12 weeks and then will continue biweekly for 8 weeks. Any findings will be addressed immediately. The results will be reviewed at the QA meeting.

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

Implemented ([redacted] - 08/06/2026)

183e - Storing Medications

14. 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 5/21/2026 at 4:05 PM, a white, round pill was loose in the medication cart within the Memory Care Unit.

On 5/28/2026 at 10:46 AM, the blister pack of Tramadol prescribed to Resident #10 had a hole in the seal of pill #6.

On 5/28/2026 at 10:50 AM, a white, triangular pill was loose in medication cart #2 on the 4th floor of the home.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/21/2026 the white pill was destroyed that was found on the SDCU cart.
On 5/28/2026 the Tramadol was returned to the pharmacy for re packaging. The white triangular pill that was found loose on Med Cart #2 of the 4th floor was destroyed by the Health Care Director.
On 5/29/2026 the Executive Director re educated all department heads on regulation 2600.183.e
On 6/10/2026 the Executive Director re educated the Med Techs and Care Team regarding regulation 2600.183.e.
On 6/10/2026 an audit was initiated and will be completed weekly of each med cart, by the Health Care Director, Med tech or Designee. The audit will continue for weekly for 12 weeks. The audit will be reviewed at the QA meeting.
All new hired Med Techs will be trained regarding medication standards, upon hire and as needed.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)

184a - Resident's Meds Labeled

15. 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

The pharmacy label for Resident #1's Humalog (Insulin Lispro) 100 unit/ml does not include the sliding scale protocol ordered.

184a - Resident's Meds Labeled (continued)

The pharmacy label for Resident #8's Pioglitazone HCL 45 MG states "Take 1 tablet by mouth every day with breakfast for DM- Hold for BS<200". However, the current order for this medication is "Take 1 tablet by mouth one time per day at 8:00 AM".

The pharmacy label for Resident #11's Insulin Lispro 100 unit/ml does not include the full sliding scale protocol.

The pharmacy label for Resident #11's Lantus Solostar 100 unit/ml states "Inject 14 units subcutaneously at bedtime". The current order for this medication is "Inject 10 units subcutaneously at bedtime". The pharmacy label was worn and illegible.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.184.a.
On 6/10/2026 the Executive Director re-educated the Med Techs and Care Team on regulation 2600.184.a.
The corrections have been made to the prescribed dosage and instructions for administration for Resident #1, Resident #8, and the two medications for Resident #11.
On 6/10/2026 an audit was initiated for each medication cart by the Health Care Director, Med Tech, or Designee to ensure that all medication labels match the current medication orders. This audit will continue weekly for the next 3 months. The audits will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)

185a - Implement Storage Procedures

16. 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 #11 is prescribed blood glucose checks before meals.
-On 5/22/2026 at 4:30 PM. Resident #11's May 2026 Medication Administration Record (MAR) indicated the resident's blood glucose was 136. However, this reading was not in the resident's glucometer.
-On 5/25/2026 at 4:30 PM, Resident #1's May 2026 MAR indicated the resident's blood glucose was 152. However, this reading was not in the resident's glucometer.
-On 5/21/2026 at 7:30 AM, Resident #1''s glucometer indicated the resident's blood glucose was 87. However, this reading was not documented on the resident's May 2026 MAR, and the space was left blank.

Repeated Violation- 6/24/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/22/2026 the Health Care Director removed the glucometer from the resident's apartment and explained that it would need to be kept on the medication cart for documentation purposes.
On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.185.a.
On 6/10/2026 the Executive Director re-educated the Med Techs and Care Team on regulation 2600.185.a.
On 6/10/2026 an audit of the MAR vs. glucometer was established on all diabetic residents. This audit was completed by the Health Care Director, Med Tech or Designee and will occur weekly for each resident for the 12

185a Implement Storage Procedures (continued)

weeks. The audits will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)

187a - Medication Record

17. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 is prescribed Clobetasol.05% Solution, Dorzolamide Timolol Eye Drops, Ivizia .5% eye drops, Insulin Lispro 100 unit/ml, Metformin 500 mg, Methenamine 1gram, and Rivastigmine 4.5 mg. However, Resident #1's May 2026 Medication Administration Record (MAR) did not indicate the diagnosis or purpose for these medications.

On 3/12/26, Resident #1 was prescribed Linzess 145 mcg once daily x4 prior to colonoscopy which was administered per resident interview. However, this medication was not included on the resident's May 2026 MAR in accordance with regulation 2600.187(a).

Plan of Correction ***Directed ([redacted] - 07/31/2026)***

The medications for Resident #1 that did not have diagnoses were immediately corrected by the Health Care Director.
On 7/1/2026 the Executive Director re educated the department head team on regulation 2600.187.a.
On 7/2/2026 the Executive Director re educated the Med Techs on regulation 2600.187.a.
On 7/3/2026 an audit was initiated and will be completed by the Health Care Director, Med Techs, or Designee. The audit will be completed for each resident and all of their medications to ensure that all required information is present on the medication record. This audit will continue daily until all resident medication has been reviewed. The home will complete the audit by 9/4/2026. A monthly audit will continue thereafter on 10 random resident's medications and will continue through the end of the year. Monthly the results of the audit will be reviewed at the QA meeting.

(Directed)

187a - Medication Record (continued)

In addition to the above plan of correction:

- *The initial audit on all resident medication administration records will be completed no later than 8/5/26 and will continue monthly thereafter for 10 random resident's medications.*

Directed Completion Date: *08/05/2026*

Implemented ([redacted] - 08/06/2026)

187d - Follow Prescriber's Orders

18. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #8 is prescribed blood sugar checks 4 times a day before meals and at bedtime. However, on 5/3/2026 the resident's blood sugar was only checked 2 times; at 8:00 AM and 11:00 AM.

Resident #8 is prescribed Pioglitazone HCL 45 MG, 1 tablet by mouth one time per day every day at 8:00 AM. On 3/16/2026 the instruction to hold this medication when the resident's blood sugar is under 200 was discontinued. However, the resident's blood sugar was under 200 on 5/21/2026, 5/20/2026, 5/19/2026, 5/15/2026, 5/14/2026, and 5/12/2026 and this medication continued to be held.

Resident #10 is ordered Hydralazine 50 mg, hold for systolic blood pressure (SBP) under 120. This medication was not administered per the prescriber's order on the following dates and times:
-5/22/2026 at 7:00 PM -SBP 113, medication administered and not held as ordered.
-5/22/2026 at 8 :00AM- The resident's blood pressure was not taken; however, the medication was administered.
-5/18/2026 at 8:00 AM- The resident's blood pressure was not taken; however, the medication was administered.
-5/15/2026 at 8:00 AM- The resident's blood pressure was not taken; however, the medication was administered.
-5/13/2026 at 8:00 AM -The resident's blood pressure was not taken; however, the medication was administered.
-5/13/2026 at 7:00 PM- SBP 105, medication administered and not held as ordered.
-5/4/2026 at 8:00 AM-The resident's blood pressure was not taken; however, the medication was administered.
-5/4/2026 at 7:00 PM-SBP 111, medication administered and not held as ordered.
-5/1/2026 at 8:00 AM- The resident's blood pressure was not taken; however, the medication was administered.

Resident #11 is prescribed Insulin Lispro 100 unit/ml, check blood sugar before meals and administer per SSI for DM: 200-250=6U, 251-300= 10U, 301-350= 14U, 351-400= 18U, under 60/over 400 Call MD. Per the physician's order additional units of insulin should have been administered to the residents on the following dates and times:
-5/12/26 4:30 PM BS 221, 6 units required
-5/14/26 11:30 AM BS 221, 6 units required
-5/15/26 4:30 PM BS 262, 10 units required
-5/17/26 4:30 PM BS 240, 6 units required
-5/19/26 11:30 AM BS 212, 6 units required
-5/26/26 11:30 AM BS 302, 14 units required
-5/24/26 4:30 PM BS 271, 10 units required
-5/25/26 11:30 AM BS 277, 10 units required
However, Resident #11' was not administered insulin for the above dates and times.

187d Follow Prescriber's Orders (continued)

Repeated Violation 1/21/2026, et al., 9/30/2025, 6/24/2025, et al.

Plan of Correction ***Accept (- 07/21/2026)***

On 5/29/2026 the Executive Director re educated the department head team on regulation 2600.187.d.
On 7/2/2026 the Executive Director re educated the Med Techs on regulation 2600.187.d.
On 7/19/2026 the PCP's for Residents #8, #10, #11 were notified of the medications error found during the annual inspection of the community.
On 7/17/2026 the last 3 months of MARs was printed for resident #11 and sent to the PCP to request routine dosing of her insulin.
On 7/17/2026 the PCP for resident #10 was notified of the need to continue perimeters.
On 7/21/2026 Med Techs involved in the above errors were disciplined of the findings.
A Med Tech training will be scheduled before the end of July that will include Sliding Scale Insulin administration, and Blood Pressure Parameter training.
An audit was initiated, by a Med Tech or Designee on 7/17/2026 of all residents with BP parameters and sliding scale insulin to ensure that all medication is being administered appropriately and as per physician orders. The audit will continue one time per week for 3 months and will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

225a - Assessment 15 Days

19. 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 #1's initial assessment, completed [redacted] indicated the resident has a sensory need related to vision and requires glasses. However, the resident has Glaucoma for which [redacted] receives routine medications/treatments. The resident's diagnosis was not indicated in the resident's assessment.

Resident #1's initial assessment, completed [redacted] indicated the resident has no sensory needs related to hearing. However, Resident #1 has a history of hearing loss and wears bilateral hearing aids.

Resident #6's initial assessment, dated [redacted], indicated the resident ambulates independently. However, the resident utilizes a single point cane which is included in the resident's initial medical evaluation, dated [redacted]

Repeated Violation 1/21/2026, et al., 6/24/2025, et al.

Plan of Correction ***Accept (- 07/21/2026)***

On 6/1/2026 the Executive Director re educated the department head team on regulation 2600.225.a.
On 6/1/2026 the Executive Director completed an addendum form for each resident to update their current needs.
An audit was initiated on 6/5/2026 and will be completed by the Health Care Director, or Designee and will complete a review of 10 resident RASP's each week for 3 months to ensure that all information is correct and

225a - Assessment 15 Days (continued)

complete. The Executive Director will audit any new admissions or change of condition RASPs to ensure compliance with regulation 2600. 225.a for a period of 3 months. Any findings will be addressed immediately.

Proposed Overall Completion Date: 08/28/2026

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

225c - Additional Assessment

20. 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 #6's assessment, dated indicated the resident has no personal care needs related to irritability, agitation, or aggression. However, on agitation and verbal aggression were reported to Resident #6's physician resulting in a prescription for Seroquel 25mg. On Resident #6 was transported to Emergency Department after a physical altercation with another resident. On the resident's Seroquel prescription was increased. Resident #6's physician was contacted again on due to agitation and physical aggression and the Seroquel prescription was again modified, increasing the midday dose and discontinuing the morning dose. Resident #6 continues to have behavioral needs, on the resident was in a verbal altercation with another resident which turned physical, resulting in a report to the police department and Resident #6 was transported to the emergency room for evaluation. The resident's assessment was not updated to reflect the resident's current personal care needs related to behavior.

Resident #11's , completed , indicated the resident is mobile and has minimal mobility needs. However, the support plan states the resident is "Immobile" and the resident's medical evaluation, dated , stated the resident uses assistive devices to include a walker and electric wheelchair. This assessment has not been updated to reflect the resident's current mobility needs.

Resident #11's t, completed indicated the resident can self-administer medications with assistance in offering medications at prescribed times. However, the medical evaluation completed and the resident's support plan dated stated Resident #11 cannot self-administer medication.

Resident #11's assessment, completed , stated the resident has a regular diet and no dietary needs are indicated. However, the assessment was not updated to reflect the dietary need of no added sodium, indicated on the resident's medical evaluation.

Repeated Violation- 1/21/2026, et al., 6/24/2025 et al.

Plan of Correction ***Accept (- 07/21/2026)***

On 6/1/2026 the Executive Director re-educated the department head team on regulation 2600.225.c.

225c Additional Assessment (continued)

On 7/17/2026 a request was sent to Resident #11 PCP for a new DME.
On 7/20/2026 new RASPs were completed on Resident #6 and #11.
An audit was initiated on 7/20/2026 and completed by the Health Care Director, or Designee of 10 resident's DMEs and RASPS to ensure that all information matches appropriately. This audit will continue for 3 months. The Executive Director, or Designee will review all new admits and/or change of condition DMEs and RASPs for a period of 3 months.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

227d - Support Plan Medical/Dental

21. 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 #1's assessment, dated, [redacted] indicated the resident requires some physical assistance when eating. However, the support plan, dated [redacted], states "Independent" and does not specify how this service need will be met.

Resident #11's assessment, dated [redacted], indicated the resident requires some physical assistance with eating and writing. However, the support plan, dated [redacted] stated "Independent" for both of these personal care needs and does not specify how these needs will be met.

Repeated Violation 6/24/2025, et al.

Plan of Correction ***Accept (- 07/21/2026)***

On 5/29/2026 the Executive Director re educated the department head team on regulation 2600.227.d.
On 6/1/2026 the Executive Director completed an addendum to the RASP to indicate that Resident #1 is independent with eating therefore there is no support required. Also, Resident #11 addendum to the RASP was completed by the Executive Director and indicates Resident #11 is independent with both eating and writing, therefore there is no need for support.
On 6/5/2026 and audit was initiated. The audit will be completed by the Health Care Director, Executive Director, or Designee and will review all Current RASPS for all residents to ensure that the assessment matches the support plan. Each week the auditor will complete 10 resident files until all RASPs have been reviewed for accuracy. Any discrepancies will be corrected on an addendum sheet and will be placed with the RASP. This audit will also be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 08/06/2026)

231b Medical Evaluation

22. 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 #9 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's, dated [redacted] did not indicate if the resident required care in a Secure Dementia Care Unit.

Plan of Correction ***Accept ([redacted] - 07/31/2026)***

On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.231.b.
On 6/1/2026 and audit was initiated of all DME's for residents residing in the SDCU. The audit will be completed by the Health Care Director, Executive Director, or Designee and will occur monthly of all new residents in the neighborhood after initial audit is completed. This will continue for 6 months. All audits will be reviewed at the QA meeting. Resident #9 moved in [redacted] and moved out [redacted]

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

Implemented ([redacted] - 08/06/2026)

233c Key Locking Devices

23. Requirements

2600.
233.c. If key locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 5/21/2026 at 9:15 AM, accurate directions for operating the Secure Dementia Care Unit (SDCU) locking mechanisms on the courtyard gate, rear exit door, and stairwell door were not posted.

Repeated Violation- 6/24/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

On 5/21/2026 labels were placed on the SDCU courtyard gate, rear exit door, and stairwell door by the Executive Director to operate the locking mechanism.
On 5/29/2026 the Executive Director re-educated the department head team on regulation 2600.233.c.
On 6/4/2026 the Executive Director re-educated all staff on regulation 2600.233.c.
On 6/1/2026 an audit was initiated of the key locking devices to ensure they were properly labeled. This audit will be completed by the Executive Director, Harmony Square Director, Maintenance Director, or Designee and will occur daily for 4 week, then weekly for 3 months. The audit will be reviewed at the QA meetings.

233c Key Locking Devices *(continued)*

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented ([redacted] - 08/06/2026)