

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

September 4, 2026

[REDACTED], OWNER
HARMONY HOUSE MANOR INC
[REDACTED]
[REDACTED]

RE: HARMONY HOUSE MANOR
601 LAMBERD AVENUE
JOHNSTOWN, PA, 15904
LICENSE/COC#: 31439

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/23/2026, 06/24/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HARMONY HOUSE MANOR

License #: 31439

License Expiration: 05/09/2027

Address: 601 LAMBERD AVENUE, JOHNSTOWN, PA 15904

County: CAMBRIA

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: HARMONY HOUSE MANOR INC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 10/25/1994

Issued By: Department of Labor & Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 52

Waking Staff: 39

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Complaint, Incident

Exit Conference Date: 06/26/2026

Inspection Dates and Department Representative

06/23/2026 - On-Site: [REDACTED]

06/24/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 84

Residents Served: 37

Secured Dementia Care Unit

In Home: Yes

Area: Touchstones

Capacity: 26

Residents Served: 14

Hospice

Current Residents: 3

Number of Residents Who:

Receive Supplemental Security Income: 2

Are 60 Years of Age or Older: 37

Diagnosed with Mental Illness: 3

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 15

Have Physical Disability: 0

Inspections / Reviews

06/23/2026 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: 08/31/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 08/14/2026

08/17/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/31/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 09/01/2026

09/04/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/31/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report**1. Requirements**

2600.

15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident #1 resided in the Secured Dementia Care Unit. On [REDACTED], Staff member A tapped Resident #1 on the right-side buttocks and asked if that helped the resident forget about [REDACTED] pain on the left side. Resident #1 laughed and told the staff member to do it again. Staff Member A tapped Resident #1 on the buttocks again. A written statement was documented by Staff member A of the above incident on [REDACTED] and filed in the staff member's employee record. The written statement indicated "I was informed that I was sexually inappropriate with a resident on [REDACTED]"; However, this incident was not reported to the local Area Agency on Aging.

Plan of Correction**Accept [REDACTED] - 08/17/2026)**

Administrator educated staff on abuse reporting requirements with all staff 8/5/26. Administrator filed an incident report and Act 13 8/10/26. Administrator implemented an abuse reporting checklist 8/11/26. Administrator will review every incident made by staff immediately with a lead aide to ensure incidents are reported timely. Quarterly reviews will be conducted of all incident reports among two staff by 9/30/26 (**Directed-quarterly reviews will be conducted on all incident reports starting no later than 8/31/26** - [REDACTED] Staff interactions, interviews will be done weekly, beginning 8/11/26.

Licensee's Proposed Overall Completion Date: 08/30/2026

Implemented [REDACTED] - 09/04/2026)**15b - Supervisor Plan****2. Requirements**

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

Resident #1 resided in the Secured Dementia Care Unit. On [REDACTED] Staff member A tapped Resident #1 on the right-side buttocks and asked if that helped the resident forget about [REDACTED] pain on the left side. Resident #1 laughed and told the staff member to do it again. Staff Member A tapped Resident #1 on the buttocks again. A written statement was documented by Staff member A of the above incident on [REDACTED] and filed in the staff member's employee record. The written statement indicated "I was informed that I was sexually inappropriate with a resident on [REDACTED]"; However, the home did not develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Plan of Correction**Accept [REDACTED] - 08/17/2026)**

Administrator implemented procedures requiring immediate supervision or suspension when abuse is alleged. Staff were trained on violation 8/5/26. Staff member resigned 6/25/26. PCH and AAA PS dismissed the claim 8/11/26. PCH filed final report to DHS 8/11/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

15b Supervisor Plan *(continued)**Implemented () - 09/04/2026)*

16c Written Incident Report

3. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 resided in the Secured Dementia Care Unit. On [REDACTED] Staff member A tapped Resident #1 on the right-side buttocks and asked if that helped the resident forget about [REDACTED] pain on the left side. Resident #1 laughed and told the staff member to do it again. Staff Member A tapped Resident #1 on the buttocks again. A written statement was documented by Staff member A of the above incident on [REDACTED] and filed in the staff member's employee record. The written statement indicated "I was informed that I was sexually inappropriate with a resident on [REDACTED]"; However, this incident was not reported to the Department.

Plan of Correction

Directed () - 08/17/2026)

Administrator filed an incident report 8/10/26 and final report 8/11/26 to DHS. Administrator implemented an incident reporting checklist which includes interactions, interviews with residents and what needs reporting, beginning 8/11/26. Administrator will review all incidents within 24 hours, quarterly audits of incident reports by 9/30/26. Staff were trained on violation 8/5/26.

(Directed)

In addition to the above plan of correction:

- Education on abuse and appropriate staff to resident interactions will be completed with all staff members in the home no later than 8/30/26.*
- Quarterly audits of incident reports will begin no later than 8/30/26.*

Directed Completion Date: 08/30/2026

Implemented () - 09/04/2026)

17 Record Confidentiality

4. 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 6/23/26 at 9:50 AM, resident information was unlocked, unattended and accessible on a laptop in the dining room, permitting access to information for Resident #2 which included the resident's date of birth, primary care physician, diagnosis, and medication information. A list of resident names of those who wear briefs and need checked more than once and reminder note about Resident #3's "potty" was also unlocked, unattended, and accessible on the kitchenette counter adjacent to the medication area.

17 - Record Confidentiality (continued)

On 6/24/2026 at 9:03 AM, resident information was unlocked, unattended and accessible on a laptop system in the dining room, permitting access to all active resident medication records.

Plan of Correction**Accept () - 08/17/2026)**

PCH set up the med cart EMAR to sleep, log out of workstation whenever the nurse walks away effective 8/5/26. Staff will have to log back in. Administrator will check daily to ensure compliance effective 8/5/26. Staff were trained on violation 8/5/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/04/2026)**42b - Abuse****6. 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 #4 was diagnosed with Dementia and required dementia-related care in a secured area as per the resident's medical evaluation dated [REDACTED]. Resident #4 required extensive supervision to include regular supervision in the home, could not leave the home unattended and was unaware of unsafe areas as per the resident's assessment and support plan dated [REDACTED]. On [REDACTED] at 11:22 AM, Resident #4 informed Staff Member B that [REDACTED] had an appointment and was getting the bus. Staff Member B entered the code and opened the door of the Secure Dementia Care Unit to allow the resident to leave. The resident was reported missing to the police around 12:00 PM and was found by the home's owner's [REDACTED] at approximately 3:30 PM at the CamTram bus station in Johnstown, located approximately 4 miles from the home.

Plan of Correction**Accept () - 08/17/2026)**

Staff B was terminated immediately [REDACTED] after incident. Staff educated on dementia supervision and elopement prevention 8/5/26. Support plans were reviewed by Administrator 8/4/26 and quarterly review of SP will be done again by 11/4/26.

Licensee's Proposed Overall Completion Date: 08/17/2026

Implemented () - 09/04/2026)**42c - Treatment of Residents****7. Requirements**

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #1 resided in the Secured Dementia Care Unit. On [REDACTED] Staff member A tapped Resident #1 on the right-side buttocks and asked if that helped the resident forget about [REDACTED] pain on the left side. Resident #1

42c - Treatment of Residents (continued)

laughed and told the staff member to do it again. Staff Member A tapped Resident #1 on the buttocks again. A written statement was documented by Staff member A of the above incident on [REDACTED] and filed in the staff member's employee record. The written statement indicated "I was informed that I was sexually inappropriate with a resident on [REDACTED]".

Plan of Correction**Accept ([REDACTED] - 08/17/2026)**

Staff educated on dignity, respect and professional boundaries 8/5/26. Administrator will observe all staff to at least 3 residents interactions weekly beginning 8/11/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented ([REDACTED] - 09/04/2026)**42s - Privacy****8. Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 6/23/2026 at 9:19 AM, the toilet stalls in the common bathroom B in the home's Secured Dementia Care Unit were not equipped with latches or locks to ensure privacy.

Plan of Correction**Accept ([REDACTED] - 08/17/2026)**

Latches were installed 7/31/26 on all common area bathrooms. Weekly checks will be conducted to ensure compliance beginning 7/31/26. Staff were trained on violation 8/5/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented ([REDACTED] - 09/04/2026)**81b - Resident Personal Equipment****9. 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 6/23/2026, Resident #5's bed had a bedside enabler device. The enabler device was not covered and had an opening measuring 17" x 6", creating a potential entrapment hazard.

Plan of Correction**Accept ([REDACTED] - 08/17/2026)**

The bedside enabler bar was removed immediately 6/24/26. Resident did not need assist bar and was not incorporated in SP. Administrator will conduct weekly checks to ensure residents do not have uncovered devices beginning 6/24/26. Staff were trained on violation 8/5/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented ([REDACTED] - 09/04/2026)**82c - Locking Poisonous Materials****10. Requirements**

82c - Locking Poisonous Materials (continued)

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

On 6/23/2026 at 9:20 AM, a can of Plaster Patching materials with a manufacturer's label indicating for emergencies relating to inhalation, skin contact, eye contact, or ingestion to "call your poison control", was unlocked, unattended, and accessible underneath the bathroom sink in the Secured Dementia Care Unit common bathroom. Not all residents in the SDCU, including Resident #4, are assessed to be capable of recognizing and using poisons safely.

Plan of Correction**Accept () - 08/17/2026)**

Plaster was immediately disposed of during inspection 6/23/26. Administrator will conduct weekly checks to ensure compliance beginning 6/23/26. Staff were trained on violation 8/5/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/04/2026)**85a - Sanitary Conditions****11. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 6/23/2026 at 10:10 AM, a bedside commode containing urine and feces was present in the bathroom on the main floor by rooms Main 1, 102 to the left of the kitchen.

On 6/23/2026 at 1:00 PM, a stained handheld urinal with urine in the bottom was present in Resident # room.

On 6/23/2026 at 10:10AM there were no paper towels, mechanical hand dryer or other sanitary means of hand-drying in the main floor bathroom as the paper towel dispenser was empty and the automatic hand dryer was not functioning.

Plan of Correction**Directed () - 08/17/2026)**

The bedside commode and handheld urinal was discarded immediately 6/24/26. A new urinal was ordered for Resident received 6/25/26. Administrator or designee will monitor compliance through daily checks to ensure sanitary conditions are maintained beginning 6/24/26. Staff were trained on violation 8/5/26.

Notices were posted by every hand dryer in the home stating the lights must be on to operate hand dryer 6/24/26. Administrator will conduct weekly checks to ensure compliance beginning 6/24/26.

(Directed)

In addition to the above plan of correction:

- Education will be provided to all staff on sanitation and the use of resident handheld urinals; handheld urinals should be emptied and sanitized after each use to maintain sanitary conditions. Education to be completed by 8/30/26.*

Directed Completion Date: 08/30/2026

Implemented () - 09/04/2026)

92 - Windows

13. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 6/24/2026 at 9:17 AM, the window in resident room #109 was open and without a secured screen.

Plan of Correction

Accept () - 08/17/2026

A screen was put in immediately 6/24/26. Staff were trained on violation 8/5/26. Administrator will conduct weekly checks to ensure compliance beginning 6/24/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/04/2026

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

2600.

- 101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 6/23/2026, the bed for Resident #6 had no fitted sheet over the mattress and the resident's pillow was heavily stained.

Plan of Correction

Directed () - 08/17/2026

Bed sheets and pillowcases were changed after resident care was completed during inspection on 6/23/26. New pillow protector covers were put on resident's pillows 8/12/26. Staff were trained on violation 8/5/26. Weekly checks will be done by Administrator to ensure bed linens, pillows, coverings are clean 6/23/26.

(Directed)

In addition to the above plan of correction:

- Resident #6's pillow will be discarded and a new pillow will be purchased and provided by 8/30/36.
- The administrator or designee will complete an audit on all other resident pillows (not just pillowcases/covers) by 8/30/26 to ensure pillows are clean and in good repair. Pillows found to be heavily stained and soiled will be removed and a clean pillow will be provided by 8/30/26.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026

Implemented () - 09/04/2026

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

15. 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.

102d Grab/Hand/Assist Bar/Slip Resistant Surface (continued)**Description of Violation**

There was no grab bar, handrail or assist bar in the "public bathroom" located between resident rooms 110 and 109.

Plan of Correction

Accept () - 08/17/2026)

A grab bar was installed on 7/31/26. Staff were trained on this violation 8/5/26. Weekly checks will be done by Administrator to ensure compliance beginning 7/31/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/04/2026)

103e - Left Overs**17. Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 6/23/26 at 10:00 AM, there were three unlabeled, undated stainless steel storage containers in the home's upright cooler containing leftover beans, ham and bean soup and potato soup.

Plan of Correction

Accept () - 08/17/2026)

The leftovers were removed from the kitchen refrigerator 6/24/26 by the Administrator and the Administrator posted instructions on the kitchen refrigerator immediately 6/24/26 stating 'all food must be sealed, labeled and dated'.

Staff were trained on violation 8/5/26. Administrator will conduct daily checks to ensure compliance beginning 6/24/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/04/2026)

132b - Safety Inspection/Fire Drill**18. 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 most recent fire safety inspection and fire drill observed by a fire safety expert was conducted on 7/10/2025. The previous fire safety inspection and supervised fire drill was conducted 6/20/2024.

Plan of Correction

Directed () - 08/17/2026)

Fire safety training, fire safety inspection and a fire drill were scheduled 6/4/25 but RFD had an emergency call and rescheduled to 7/10/25. Annual fire safety training, fire safety inspection and a fire drill were held this year on 7/7/26. Administrator will review the annual training plan monthly beginning 8/5/26 and monthly checks to ensure compliance beginning 8/5/26. Staff were trained on violation 8/5/26.

(Directed)

By 8/30/26, the administrator or designee will ensure the annual fire safety inspection and drill, completed by a fire safety exit, is scheduled to be held no later than 7/9/27. Documentation of the confirmed scheduled inspection and drill will be kept by the home.

132b - Safety Inspection/Fire Drill (continued)

Directed Completion Date: 08/30/2026

Implemented () - 09/04/2026)

142a - Secure Medical Care

19. Requirements

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

As per [REDACTED] Hospital Patient Visit Information dated [REDACTED] Resident #9 was discharged with instructions to call 911 if experiencing [REDACTED] as the result of a [REDACTED] diagnosis and return to ER if [REDACTED]. As indicated in Resident #9's record, on [REDACTED] Resident #9 was [REDACTED]. On [REDACTED] Resident #9 was [REDACTED]. Upon Staff Member A's arrival to the home on [REDACTED] early afternoon, Resident #9 was shaking uncontrollably and having difficulty speaking. Staff attempted to feed the resident mashed potatoes and Ensure at which time the food and drink rolled from [REDACTED] mouth. The resident was not sent back to the hospital until [REDACTED].

Plan of Correction

Directed () - 08/17/2026)

Resident [REDACTED] Initially, the resident improved. Staff notified Dr. [REDACTED] on [REDACTED] and then sent to the hospital [REDACTED] Staff were trained on 'securing medical care' 8/5/26. Administrator will conduct daily checks to ensure compliance beginning 8/5/26.

(Directed)

- The home will develop a process to check resident medical summaries from hospitalization or appointments to ensure all staff receive education on discharge instructions and when to seek emergency care. This process will be implemented by 8/30/26.
- Beginning no later than 8/30/26, the administrator or designee will review hospital discharge summaries within 24 hours of the resident returning home and provide education to all staff on discharge and follow-up instructions to ensure resident's receive medical care as directed by the physician.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026

Implemented () - 09/04/2026)

181c - Self-administration Assessment

20. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

181c - Self-administration Assessment (continued)**Description of Violation**

Resident #7 self-administered [REDACTED] own blood sugar checks on [REDACTED] As per the resident's most recent medical evaluation dated [REDACTED] cannot self-administer medications.

Plan of Correction**Directed [REDACTED] - 08/17/2026)**

All glucometers are locked in med carts 6/24/26. Administrator, med techs will check to ensure glucometers are locked shift change, beginning 6/24/26. Also during shift change, it will be documented if any resident can self administer. Staff were trained on violation 8/5/26.

(Directed)

In addition to the above plan of correction:

- Education will be provided to all staff and residents on staff administering medications if a resident's physician indicated a resident cannot self-administer their medications.
- The administrator will complete an audit of each resident's medical evaluation and assessment to create a list of residents who are properly assessed to self-administer medications and provide additional education to all staff members in the home on which residents are capable of self-administering medications by 8/30/26.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026

Implemented [REDACTED] - 09/04/2026)**183b - Meds and Syringes Locked****21. 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 6/24/2026 at 9:10 AM, a Trelegy Ellipta inhaler, Albuterol Inhaler, and 4 Loperamide caplets in their original foil packaging were unlocked, unattended and accessible in resident room #114.

On 6/24/2026 at 3:15 PM, Hydroxyzine 25 mg tablets, Equate cold and flu liquid, CVS brand C-Lax, Equate brand loperamide, Guaifenesin caplets, Spring Valley Brand Glucosamine Joint Health, 500 mg Acetaminophen caplets, Ozempic, and Equate eye health complete tablets were unlocked, unattended and accessible in resident room #114.

Plan of Correction**Accept [REDACTED] - 08/17/2026)**

Administrator removed all medications from Resident's room 6/24/26. Staff were trained on violation 8/5/26. Administrator, med techs will conduct weekly checks to ensure compliance beg. 8/11/26.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented [REDACTED] - 09/04/2026)**184a - Resident's Meds Labeled****22. Requirements**

2600.

184a Resident's Meds Labeled (continued)

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #2 had prescriber orders for Albuterol Sulfate 1.25mg/3mL inhale 1 vial via nebulizer every 4 hours as needed. The medication was in a Ziploc bag that indicated "See EMAR" and did not include a pharmacy label.

Resident #6 had prescriber orders for Terazosin 2MG caps, take 1 capsule by mouth at bedtime [REDACTED]. The pharmacy label of the medication indicated Terazosin 2MG caps, take one capsule by mouth at bedtime [REDACTED].

Resident #6 had prescriber orders for Ketotif Fu drops, instill 1 drop into both eyes as needed. The pharmacy label of the medication indicated Ketotif Fu drops, instill one drop in both eyes every day.

Plan of Correction

Accept ([REDACTED] - 08/17/2026)

Administrator reordered pharmacy label 6/24/26. FH Pharmacy changed diagnosis on EMAR to reflect diagnosis on medication and drops direction to coincide with label. Staff were trained on violation 8/5/26. FH Pharmacy and Administrator will conduct a med cart audit 9/1/26 and will continue med cart audits quarterly thereafter, next audit will be due 12/1/26.

Licensee's Proposed Overall Completion Date: 09/01/2026

Implemented ([REDACTED] - 09/04/2026)

185a - Implement Storage Procedures**23. 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

The home's Medications and Controlled Substances Accountability of Medication Policy and Procedures indicated that all medications are stored in secured areas and carts, accessible only by medication technicians and approved personnel. On 6/23/2026 at approximately 12:10 PM, Staff Member A entered the dining area where the medication cart was located and retrieved the keys to the medication cart from an unlocked file cabinet next to the medication cart; accessible to non approved personnel.

Resident #7 was prescribed Insulin Lispro Kwikpen inject twice a day per sliding scale: if >60 call MD; 200 250 5 units; 251 300 8 units; >300 10 units and call MD with a schedule of daily at 7:00, daily at 17:00.

- *On 6/23/2026 at 5:00 PM, a reading of 189 was documented Resident #7's June 2026 Medication Administration Record (MAR). On 6/23/2026 at 2:24 PM, Resident #7's glucometer indicated a blood sugar reading of 289*
- *On 6/22/2026 at 5:00 PM, a reading of 180 was documented on Resident #7's June 2026 MAR. On 6/22/2026 at 4:28 PM, Resident #7's glucometer indicated a blood sugar reading of 380.*
- *On 6/17/2026 at 5:00PM, a reading of 202 was documented on Resident #7's June 2026 MAR. On 6/17/2026 at 2:11 PM, Resident #7's glucometer indicated a blood sugar reading of 219.*

185a Implement Storage Procedures (continued)

- On 6/14/2026 at 5:00 PM, a reading of 143 was documented on Resident #7's June 2026 MAR. On 6/14/2026, there were no readings in Resident #7's glucometer.
- On 6/13/2026 at 7:00 AM, an exception note was documented indicating that Resident #7 was out of facility for the blood sugar check and insulin administration. However, at 7:44 AM, the glucometer indicated a blood sugar reading of 151.

Repeated Violation 12/3/2024, et al

Plan of Correction

Directed () - 08/17/2026)

A lock box was installed on the med cart 8/5/26. Staff were trained on violation 8/5/26. Administrator, med techs will audit glucometers to EMAR monthly to ensure accuracy beg. 8/12/26. The physician gave permission for staff to take extra sugar readings if a resident or family ask. Every resident has their own glucometer and does not use one on multiple residents. Staff were trained on repeated violation 8/5/26.

(Directed)

In addition to the above plan of correction:

- The home will develop a process for staff to document additional as needed blood sugar testing results by 8/30/26 to account for readings in a resident's glucometer.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026

Implemented () - 09/04/2026)

187b - Date/Time of Medication Admin.**24. 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 #8 was prescribed Hydroxyzine Pam Cap 25mg take 1 capsule by mouth 3 times a day. Resident #8's June 2026 Medication Administration Record did not include the initials of the staff person who administered Hydroxyzine Pam Cap on 6/7/2026 at 12:00 PM.

Plan of Correction

Accept () - 08/17/2026)

Staff were trained on violation 8/5/26. Administrator, med techs will audit MAR's monthly to ensure complete documentation of medication administration beg. 8/17/26, complete by 8/30/26 **(Directed-monthly audits will continue for a minimum of 3 months beginning 8/17/26-**)

Proposed Overall Completion Date: 08/30/2026

Licensee's Proposed Overall Completion Date: 08/30/2026

Implemented () - 09/04/2026)

187d - Follow Prescriber's Orders

25. Requirements

2600.

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

Description of Violation

Resident #7 was prescribed Insulin Lispro Kwikpen inject twice a day per sliding scale: if >60 = call MD; 200-250 = 5 units; 251-300 = 8 units; >300 = 10 units and call MD. with a schedule of daily at 7:00, daily at 17:00.

On 6/23/2026 at 5:00PM, a reading of 189 was documented on Resident #7's June 2026 Medication Administration Record (MAR) and indicated that insulin was withheld per DR/RN orders. On 6/23/2026 at 2:24 PM the glucometer indicated a blood sugar reading of 289 for which the resident should have received 5 units of insulin.

On 6/22/2026 at 5:00 PM, a reading of 180 was documented on Resident #7's June 2026 MAR and indicated that insulin was withheld per DR/RN orders. On 6/22/2026 at 4:28 PM the glucometer indicated a blood sugar reading of 380 for which the resident should have received 10 units of insulin and the medical doctor should have been called.

Plan of Correction**Directed () - 08/17/2026)**

Staff were trained on violation 8/5/26. Administrator, med techs will audit MAR's weekly to ensure staff are following the direction of the prescribed beg. 8/13/26.

(Directed)

- In addition to the above plan of correction, education will be provided to all staff who administer medications on how to properly administer insulin based on a resident's order for sliding scale by 8/30/26.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026**Implemented () - 09/04/2026)****190a - Completion Medication Course****26. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member A, who has not successfully completed the Department-approved medications administration course as evidenced by a Staff Member A not completing annual practicum summaries since 4/4/2025. The staff member administered medications to the following residents:

Resident #7 Carvedilol 6.25MG - 6/9/2026 5:30 PM, 6/12/2026 5:30 PM, 6/18/2026-6/23/2026 5:30 PM

Resident #8 Donepezil 10MG - 6/4/2026-6/9/2026 5:00 PM, 6/4/2026-6/9/2026 5:00 PM

Plan of Correction**Directed () - 08/17/2026)**

Staff member did receive the Department-approved Medication Administration course on [REDACTED] and annual practicum observations were completed thru 4/1/26 and provided during inspection in front of two staff while inspector was reviewing [REDACTED] documentation. Staff member acknowledged [REDACTED] did not complete the on-line course which was not required. Staff member did resign 6/25/26. Administrator ensures certified and observed

190a Completion Medication Course (continued)

medication technicians are scheduled to pass medications. During shift change, Administrator and med techs will ensure certified med techs are passing meds. Administrator will review training due dates monthly to ensure compliance beg. 8/12/26.

(Directed)

- The administrator or designee will complete an audit on all other staff member medication administration certification and annual training documentation by 8/30/26. Audits will ensure annual observations and MAR reviews are documented properly on the annual practicum summary form.
- Education will need to be provided to the staff member responsible for medication administration training on annual practicum requirements and proper documentation by 8/30/26.
- Beginning no later than 8/30/26, the administrator will audit all staff member medication administration training record and documentation monthly to ensure requirements are completed and properly documented. Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026

Implemented (█ - 09/04/2026)

190b - Insulin Injections**27. Requirements**

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 6/1/2026, 6/6/2027, 6/7/2026, 6/9/2026, 6/15/2026, and 6/21/2026 at 5:00PM, Staff Member A, who had not completed a Department approved diabetes patient education program since 4/1/2025 administered insulin to Resident #7.

On 6/6/2026 and 6/20/2026 at 7:00AM, Staff Member C, who had not completed a Department approved diabetes patient education program since 4/1/2025 administered insulin to Resident #7.

Plan of Correction

Directed (█ - 08/17/2026)

Diabetes training was completed on 6/24/26 and both staff attended the training. A calendar reminder will be in place and monthly reminders of training will be reviewed beginning 8/5/26. Staff were trained on violation 8/5/26.

(Directed)

In addition to the above plan of correction:

- An initial audit of all other staff members records will be completed by 8/30/25 to ensure staff assisting with blood sugar checks and insulin administration are current in diabetic education.
- Beginning 9/1/26, the administrator or designee will review all staff diabetic education at least once quarterly to ensure current training.
- Documentation of training and completed audits will be kept by the home and available for review by the Department.

190b Insulin Injections (continued)**Directed Completion Date:** 09/01/2026**Implemented** () - 09/04/2026)**225c - Additional Assessment****28. 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 #9's assessment, dated [REDACTED] indicated that the resident experienced a fall on [REDACTED] and was weak from [REDACTED] the hospital discharge summary obtained after receiving care for this fall documented diagnoses of [REDACTED]. The assessment was not updated to include this information nor instructions to contact a healthcare provider for [REDACTED] to get help right away for [REDACTED], if symptoms get worse, and to follow a soft and bite sized diet type.

Plan of Correction**Directed** () - 08/17/2026)

Staff were trained on violation 8/5/26. Administrator will audit SP every 3 months to ensure updates are made reflecting resident needs beg. 8/4/26. An audit tracker will be in place showing the next audit will be due 11/4/26. Administrator and staff will document on shift change report changes in resident's condition beginning 8/5/26.

(Directed)

- Resident #9's assessment updated will be updated by 8/30/26.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 08/30/2026**Implemented** () - 09/04/2026)**227d - Support Plan Medical/Dental****29. 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.

227d - Support Plan Medical/Dental (continued)

Description of Violation

Resident #5's assessment, dated [REDACTED], indicated that the resident was independent in transferring in/out of bed/chair and had a need for and used a bed assist for turning and positioning in bed/chair. The resident's bed assist is located toward the foot of the resident's bed and the resident reported using it for transferring into [REDACTED] wheelchair. The resident's support plan, dated [REDACTED], did not document the need for the device for transfers, any risks associated with the use, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident #11's assessment, dated [REDACTED] indicated that the resident had a need for prompting and cueing for managing [REDACTED] finances with supervision and that the home met this need with a PNA account made at the facility and documentation was kept. The resident's support plan, dated [REDACTED] did not document that the home met this need as the resident's representative payee.

Resident #6's assessment, dated [REDACTED], indicated Resident #6 requires total physical assistance for toileting, is incontinent of bowel and bladder and wears pull-ups; requires some assistance. However, Resident #6 utilizes a [REDACTED] which is not indicated in the resident's support plan, dated [REDACTED]

Resident #6's assessment, dated [REDACTED] indicated that the resident cannot go from sit to stand without being assisted, supervision and assist will be available for all transfers for optimal safety, requires minimal assistance and will request help if needed for turning and positioning in bed, and assistance will be provided for turning and repositioning upon request. The assessment also indicated that the resident used a hand assist rail on [REDACTED] hospital bed. However, Resident #6 utilizes an alternating pressure mattress on [REDACTED] bed which is not indicated in the resident's support plan, dated [REDACTED]

Resident #6's assessment, dated [REDACTED] indicated that the resident had a need for and used a hand assist rail on [REDACTED] hospital bed. The resident's most current support plan, dated [REDACTED] did not document any risks associated with the use, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction**Directed ([REDACTED] - 08/17/2026)**

Resident 5 bedside assist bar was removed immediately 6/24/26 and documented on SP. Resident 11 SP noted 'representative payee' and Resident 6 SP to show resident utilizes an alternating pressure mattress and resident is aware of the risks in using the hand assist bar, both SP updated 6/24/26 by Administrator. Staff were trained on Violation 8/5/26. Administrator will audit SP every 3 months, beg. 6/24/26 to ensure updates are made reflecting resident needs, the next due 9/30/26.

(Directed)

In addition to the above plan of correction:

- Resident #11's support plan should indicate what supports the home provides while being the representative payee; please update.
- Resident #6's support plan will be updated to specifically document any risks associated with the use of the assist rail, identification of the specific device to be used and whether a cover is required to meet FDA guidelines as well as the use of a handheld urinal.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

227d Support Plan Medical/Dental (continued)**Directed Completion Date:** 08/30/2026**Implemented (** [REDACTED] **- 09/04/2026)****233c - Key-Locking Devices****30. 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 6/23/2026 at approximately 9:30 AM and 6/24/2026 at approximately 4:35 PM, the directions for operating the home's locking mechanism posted near the back door of the Secure Dementia Care Unit (SDCU) displayed a code of [REDACTED]. The posted code did not include the "#" sign required at the end of the code in order to release the door lock.

On 6/23/2026, the directions for operating the home's locking mechanism at the main front stair tower were not posted.

Plan of Correction**Accept (** [REDACTED] **- 08/17/2026)**

A new code was put above exit door in the SDU where # was worn and all exit doors checked to ensure codes were posted by Administrator 6/24/26. The second exit in the SDU already had the code posted which was shown to the other inspector earlier. Staff were trained on violation 8/5/26. Administrator will check during shift changes to ensure codes are posted beginning 6/24/26. An audit of all four doors ensuring codes posted will be done monthly, beg. 8/12/26.

Licensee's Proposed Overall Completion Date: 08/14/2026**Implemented (** [REDACTED] **- 09/04/2026)**