pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: October 14, 2022
HAND DELIVERED: NOVEMBER 29, 2022

[redacted]
Fox Chapel Operations, LLC
[redacted]
[redacted]

RE: Harmony at Harts Run
3450 Harts Run Road
Glenshaw, Pennsylvania 15116
License/COC #: 453221

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 11, 2022, May 12, 2022, May 13, 2022, June 21, 2022, June 22, 2022, and June 23, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 453220) dated November 15, 2021 – November 15, 2022, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 14, 2022 to April 14, 2023.

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

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

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *HARMONY AT HARTS RUN* **License #:** *45322* **License Expiration:** *11/15/2022*

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

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

Administrator

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

Legal Entity

Name: *FOX CHAPEL OPERATIONS LLC*

Address: [redacted]

Phone: *4*[redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *05/18/2021* **Issued By:** *Township of Indiana*

Type: *I-2* **Date:** *08/23/1921* **Issued By:** *Township of Indiana*

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff:** *60* **Waking Staff:** *45*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *06/17/2022*

Inspection Dates and Department Representative

05/11/2022 - On-Site: [redacted]

05/12/2022 - On-Site: [redacted]

05/13/2022 - On-[redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* **Residents Served:** *44*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square, 1st floor* **Capacity:** *40* **Residents Served:** *11*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *44*

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

Have Mobility Need: *15* **Have Physical Disability:** *0*

Inspections / Reviews

05/11/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/01/2022*

07/05/2022 - POC [redacted]

[redacted] [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2022*

07/12/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/31/2022*

09/02/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type**: *Exception* **Follow-Up Date**:

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 5/11/22 at 12:17 p.m., the records of residents #1, #2, #3, #4 and #5 were unlocked, unattended and accessible on the table in the Undercliff private dining room.

Plan of Correction ***Accept***

All confidential records were kept locked in the Undercliff private dining room for the remainder of the survey. During surveys, the Undercliff private dining room will be locked at any time a staff person or Department agent is not present. The Business Office Manager, Executive Director or Designated Person will be responsible to ensure this. All staff will be in-serviced on confidentiality of resident information by 7/31/22. BOM or designee will audit employee files to ensure compliance. [redacted] 9/2/22

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation **Not I[redacted]emented**

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #4 was admitted to the home on [redacted] *Resident #4 signed the resident-home contract; however, is undated, so it is unable to be determined if resident #4 signed the resident-home contract within 24 hours of admission. Also, resident #4's resident-home contract was not signed by the administrator until 11/24/21.*

Plan of Correction ***Directed***

Resident-home contracts will be signed by all appropriate parties the day prior to admission or upon arrival by the resident to the community on day of admission. The contract will be reviewed by the Business Office Manager no later than day of admission to ensure required signatures were obtained. Audits of new resident contracts will be conducted monthly by the Executive Director, Business Office Manager or Designated Person and results will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation. The Executive Director, BOM or Designee will be responsible to review resident contracts for signatures of all parties by 7/31/22. The Resident Administrative checklist will be used and signed for audit of this regulation the day of Admission by the Executive Director, Business Office Manager or Designee and will begin 7/15/22. All staff persons involved in the admission process will be educated on this plan of correction and responsibilities by 7/15/22. (DIRECTED: Documentation of the education shall be kept. Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] *7/12/22)*

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation [redacted]/22 **N[redacted]ented**

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted]; however, a Pennsylvania criminal background check was not completed for staff person A until 11/25/21.

Plan of Correction ***Directed***

Criminal History checks will be completed prior to hire date, placed in the employee file and signed off on by the Executive Director or Designated Person. Audits of new employee files will be conducted monthly by the Executive Director, Business Office Manager or Designated Person and results will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation. The Personnel File checklist will be used to monitor compliance with this regulation and all staff involved with the hiring of staff persons will educated on this by 7/20/22, (DIRECTED: Documentation of the education shall be kept. Copies of the completed new hire checklists shall be kept in each staff person's record. [redacted] 7/12/22)

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review all current staff person records to ensure a Pennsylvania criminal background check has been completed for each staff person. Copies of the completed background checks shall be kept in each staff person's record. [redacted] 7/12/22

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

54a - Direct Care Staff [redacted] 9/2/22

1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person B, hired on [redacted] does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse registry.

Plan of Correction ***Directed***

Staff person B no longer works for the company. Newly hired staff will provide required documentation under this regulation prior to hire date. It will be placed in the employee file and signed off on by the Executive Director or Designated Person to ensure compliance. The Personnel File checklist will be used to monitor compliance with this regulation and all staff involved with the hiring of staff persons will educated on this by 7/20/22. (DIRECTED: Documentation of the education shall be kept. Copies of the completed new hire checklists shall be kept in each staff person's record. [redacted] 7/12/22)

Audits of new employee files will be conducted monthly by the Executive Director, Business Office Manager or Designated Person and results will be reviewed at the monthly Quality Management meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review all current direct care staff person records to ensure qualifications for each direct care staff person are present in

54a - Direct Care Staff (continued)

accordance with 2600.54a. Copies of direct care staff person qualifications shall be kept in each staff person's record. [redacted] *7/12/22* 9/2/22

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation **Not emented**

85e - Trash Outside Home

1. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/11/22 at 11:47 a.m., the right lid of the dumpster was open. At the time of inspection, the dumpster was full of trash.

Plan of Correction ***Directed***

The trash dumpster was closed immediately upon finding it open during this survey. is checked daily by the Maintenance Director, Executive Director and a Designated Person to ensure no overflow of trash and that dumpster lids are closed. All staff will educated that the trash dumpster lids need to be closed by 7/20/22. (DIRECTED: Documentation of the education shall be kept. LM 7/12/22). This process will be reviewed for effectiveness at the monthly Quality Management meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation [redacted] 9/2/22

Document Submission ***emented***

The trash dumpster was closed immediately upon finding it open during this survey. is checked daily by the Maintenance Director, Executive Director and a Designated Person to ensure no overflow of trash and that dumpster lids are closed. All staff will educated that the trash dumpster lids need to be closed by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] *7/12/22). This process will be reviewed for effectiveness at the monthly Quality Management meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.*

88a - Surfaces

1. 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 5/11/22 at 10:58 a.m., the fire-rated doors in the hallway near bedroom [redacted] *did not completely close and had to be physically pushed shut when the doors were disengaged from the release magnet.*

Plan of Correction ***Accept***

The fire-rated doors in the hallway near bedroom #120 were repaired immediately during survey by the Maintenance Director. Doors, Floors, walls, ceilings, windows, doors and other surfaces will be checked daily by the Maintenance Director and/or designated person. Walk through findings will be addressed at Daily Stand up meeting beginning 7/15/22. A date of completion will be assigned and reviewed at daily stand up by the meeting Designee

88a - Surfaces (continued)

to ensure completion.

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation [redacted] 9/2/22

No [redacted] mented

103f - Refrigerator/Freezer Temps

1. 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

On 5/11/22 at 11:25 a.m., no thermometer was present in the freezer section of the 2nd floor activities room. A thermometer was added to the freezer; however, at 3:42 p.m., the temperature was 9 degrees Fahrenheit.

Plan of Correction ***Directed***

The freezer cited in this violation was serviced during this survey to be in compliance. All common area refrigerators and freezers will be checked daily by Dining Service Staff to ensure a thermometer is present and temperature meets the requirements of this regulation. Documentation of date checked, staff initials and temperature will be kept on the refrigerator. Dining staff will alert the Dining Services Director and Maintenance Director of any variance in temperature from the requirements or missing thermometers for same day correction. The Maintenance Director will be responsible to ensure units are checked daily by performing a weekly audit of the refrigerator logs by signing and dating each log. All staff responsible for checking and recording daily refrigerator/freezer temperatures will be educated to this POC by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). Results of the weekly audit will be reviewed at the monthly Quality Management meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

[redacted] 9/2/22

103g - Storing Food

1. Requirements

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

Description of Violation

On 5/11/22 at 10:38 a.m., there were 2 open and unsealed cupcakes in the kitchen's walk-in freezer.

Plan of Correction ***Directed***

The un-sealed cupcakes were disposed of upon finding during survey. All kitchen refrigerators and freezers will be checked for unsealed food 3 times daily and documented on kitchen checklists. Checklists will be reviewed weekly by the Dining Service Director to ensure completion. Dining Services Director will perform additional checks when in the community and also document these checks on the kitchen checklists. Dining Service Director will audit kitchen checklists twice weekly to ensure completion of checklist and document date, time and initials of this audit. All kitchen and dining staff will be educated to this POC by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). Results of the weekly audit will be reviewed for effectiveness at the monthly Quality Management meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation

[redacted] 9/2/22

Not I [redacted] mented

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 12/13/21 at 11:30 p.m. does not include the exit routes used.

The fire drill records for the following fire drills do not include the number of residents that were evacuated:

- *12/13/21 at 11:30 p.m.-14 residents present in the home at the time of the fire drill*
- *1/23/22 at 10:00 a.m.-44 resident present in the home at the time of the fire drill*
- *2/15/22 at 7:00 p.m.-44 resident present in the home at the time of the fire drill*
- *3/29/22 at 2:30 a.m.-40 residents present in the home at the time of the fire drill*
- *4/24/22 at 10:15 a.m.-44 residents present in the home at the time of the fire drill*
- *5/2/22 at 1:30 p.m.-60 residents present in the home at the time of the fire drill, which includes residents who reside in independent living*

Plan of Correction ***Accept***

The regulatory requirements under this regulation were reviewed with the Maintenance Director on 7/5/22. The Fire Drill Record Department form will be utilized and reviewed within 2 days of fire drill by the Executive Director to ensure all requirements of this regulation are met. The Executive Director will sign and date fire drill record to indicate the review was completed. The Executive Director will review fire drill requirements under this regulation with the Maintenance Director, who is responsible for conducting fire drills at the community, to ensure knowledge and understanding of requirements.

Completion Date: *07/05/2022* Licensee's Proposed Date for POC Implementation [redacted]/2/22

Not [redacted]mented

132d - Evacuation

1. 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

The fire drill records for the following fire drills do not include the number of residents evacuated, so it is unable to be determined if all residents evacuated 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:

- *12/13/21 at 11:30 p.m.-14 residents present in the home at the time of the fire drill*
- *1/23/22 at 10:00 a.m.-44 resident present in the home at the time of the fire drill*
- *2/15/22 at 7:00 p.m.-44 resident present in the home at the time of the fire drill*
- *3/29/22 at 2:30 a.m.-40 residents present in the home at the time of the fire drill*
- *4/24/22 at 10:15 a.m.-44 residents present in the home at the time of the fire drill*

132d - Evacuation (continued)

- *5/2/22 at 1:30 p.m.-60 residents present in the home at the time of the fire drill, which includes residents who reside in independent living*

The home's most recent fire safety inspection conducted by a fire safety expert on 2/15/22 indicates the maximum evacuation time to the home's multiple fire-safe areas is 15 minutes; however, the evacuation time exceeded the maximum evacuation time during the following fire drills:

- *3/29/22 at 2:30 a.m.-evacuation time was 15 minutes, 30 seconds*
- *4/24/22 at 10:15 a.m.-evacuation time was 15 minutes, 3 seconds*

Plan of Correction ***Directed***

Regulatory requirements under this regulation were reviewed with the Maintenance Director on 7/5/22. The Fire Drill Record Department form will be utilized and reviewed within 2 days of fire drill by the Executive Director to ensure all requirements of this regulation are met. The Executive Director will sign and date fire drill record to indicate the review was completed. The Executive Director will review fire drill requirements under this regulation with the Maintenance Director, who is responsible for conducting fire drills at the community, to ensure knowledge and understanding of requirements. (DIRECTED: The education conducted with the Maintenance Director shall be completed within 7 calendar days of receipt of the plan of correction. Documentation of the education shall be kept. [redacted]7/12/22). A second Manager designated by the Executive Director will present at time of fire drills to ensure the 15 minute evacuation time is met under this regulation. This Manager will sign and date the Fire Drill Record Department Form indicating the requirements of this regulation have been met and will be audited by the Executive Director within 2 days of the fire drill. This POC will be reviewed with the management team by 7/20/22. [redacted]9/2/22

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation **Not Im mented**

141a 1-10 Medical Evaluation Information

1. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's initial medical evaluation does not include the following: The type of medical evaluation, the date resident #1 was evaluated, the date the medical evaluation was signed by physician, resident #1's height, weight, pulse rate, allergies and body positioning. These sections of the form are blank.

Resident #4 was admitted on [redacted]; however, only page 2 of resident #4's medical evaluation is present in the

141a 1-10 Medical Evaluation Information (continued)

home. Also, the medication addendum on page 2 of resident #4's medical evaluation is blank. Resident #4 is prescribed numerous medications, to include Amlodipine-5mg and Loratadine-10mg.

Plan of Correction ***Directed***

A new DME will be finalized by the physician of resident #1 on [redacted]. Resident #4 no longer resides at the community. The Healthcare Director, Executive Director or Designee will review all resident medical evaluation forms of current residents for their completion in entirety by 07/31/22. All resident medical evaluation forms will be reviewed by the Healthcare Director prior to move in for compliance with this regulation. The Resident Administrative/Business Office Checklist will be utilized starting 7/12/22 to ensure compliance to this regulation and will be the responsibility of the Executive Director or Business Office Manager/Designee. All staff involved in the admission process will be educated to this POC and checklist by 7/20/22. (DIRECTED: Documentation of the education shall be kept. Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 7/12/22). An audit will be conducted by the Executive Director or designated person to ensure completion of the review and medical evaluation form monthly x 3 and decrease to an every 6 month basis and the audit will be reviewed at the monthly Quality Management Meeting for effectiveness.

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation [redacted]/2/22

Not I ented

162c - Menus Posted

1. 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 5/11/22, the only menu posted in a conspicuous and public place in the home ended on 5/14/22.

Plan of Correction ***Accept***

The menus under this violation were corrected during survey. Dining Services Director or Designated Person will be responsible for posting the menus, which will be posted weekly for menus week 1 and week 2 and daily for the daily menus. The Dining Services Director and/or Designee will send the Executive Director a picture of the posted week 1 and week 2 menus one week in advance of the menu start date to ensure compliance to this regulation. All kitchen and dining staff will receive education as to this POC and posting menus by 7/20/22.

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation [redacted]9/2/22

Document Submission ***Implemented***

The menus under this violation were corrected during survey. Dining Services Director or Designated Person will be responsible for posting the menus, which will be posted weekly for menus week 1 and week 2 and daily for the daily menus. The Dining Services Director and/or Designee will send the Executive Director a picture of the posted week 1 and week 2 menus one week in advance of the menu start date to ensure compliance to this regulation. All kitchen and dining staff will receive education as to this POC and posting menus by 7/20/22.

182c - Medication Administration

1. Requirements

2600.

182c - Medication Administration *(continued)*

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.

Description of Violation

Resident #2 is prescribed Preservation AREDS-Take 1 tablet and chew 2 times a day, as well as Budesonide 0.5 mg/2 ml-Inhale 1 vial via nebulizer 2 times a day. On 5/13/22 at 12:12 p.m., these 2 medications were present on resident #2's bedside table. Staff members indicated they sat the medications on the resident's bedside table that morning and did not assist resident #2 with taking the medications.

Plan of Correction ***Directed***

Medications were removed from resident #2's room during the time of inspection and were administered to the resident on that day. All medication technicians will be re-trained on medication safety and medication administration requirements under this regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). This will also be reviewed and documented quarterly at an All Staff Meeting to ensure ongoing training on this regulation. All Staff Meeting trainings will be reviewed at at Quarterly Quality Management meeting to ensure effectiveness of this POC, to begin by 9/30/22 and be ongoing.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall interview at least 5 residents per month for 6 months to ensure residents receive their medications as prescribed, and that staff assistance with medication administration is provided to the resident, if necessary. During the resident interviews, the designated staff person shall also inspect the resident's bedroom to ensure there are no medications that are unlocked and accessible. Documentation of the interviews shall be kept. [redacted] 7/12/22

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation [redacted] 2/22

Document Submission ***mented***

Medications were removed from resident #2's room during the time of inspection and were administered to the resident on that day. All medication technicians will be re-trained on medication safety and medication administration requirements under this regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). This will also be reviewed and documented quarterly at an All Staff Meeting to ensure ongoing training on this regulation. All Staff Meeting trainings will be reviewed at at Quarterly Quality Management meeting to ensure effectiveness of this POC, to begin by 9/30/22 and be ongoing.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall interview at least 5 residents per month for 6 months to ensure residents receive their medications as prescribed, and that staff assistance with medication administration is provided to the resident, if necessary. During the resident interviews, the designated staff person shall also inspect the resident's bedroom to ensure there are no medications that are unlocked and accessible. Documentation of the interviews shall be kept. [redacted] 7/12/22

183b - Meds and Syringes Locked

1. Requirements

2600.

183b - Meds and Syringes Locked *(continued)*

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

Resident #2 is prescribed Preservation AREDS-Take 1 tablet and chew 2 times a day, as well as Budesonide 0.5 mg/2 ml-Inhale 1 vial via nebulizer 2 times a day. On 5/13/22 at 12:12 p.m., the 8:00 a.m. doses of these 2 medications were unlocked, unattended and accessible on resident #2's bedside table. According to resident #2's medical evaluation, dated 2/9/22, resident #2 is unable to self-administer medications.

Plan of Correction ***Directed***

Medications were removed from resident #2's room during the time of inspection and were administered to the resident on that day. The Healthcare Director will be responsible to ensure upon resident admission that no prescription medications, OTC meds, CAMs or syringes are unlocked, unattended or accessible in a resident's room. If the resident is unable to self-administer, these items will be retained and locked in a Harmony Medication Room. All medication technicians will be re-trained on medication safety and medication administration requirements under this regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). The Executive Director and or Designee will audit rooms of new admissions the day of move in to ensure compliance to this regulation monthly x 2 and then quarterly thereafter. This process will be reviewed for effectiveness at the Quarterly Management meeting to begin 9/30/22 x 2 and to decrease to every 6 months thereafter.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall interview at least 5 residents per month for 6 months to ensure residents receive their medications as prescribed, and that staff assistance with medication administration is provided to the resident, if necessary. During the resident interviews, the designated staff person shall also inspect the resident's bedroom to ensure there are no medications that are unlocked and accessible. Documentation of the interviews shall be kept. [redacted] 7/12/22 9/2/22

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 5/12/22, the following medications for resident #4 were present in the home's medication cart; however, were discontinued:

- *Furosemide*
- *Banophen-25 mg tablet*

Plan of Correction ***Directed***

The cited medications were removed from the home at the time of inspection. Discontinued medication will be removed by the Nurse, Medication Technician or Healthcare Director from medication carts upon receipt of a discontinuation medication notice from the doctor. Medication carts will be audited weekly by the Nurse, Medication Technician or Healthcare Director to ensure adherence to this process and will begin on 7/20/22. All medication technicians will be re-trained on medication safety and medication administration requirements under this

183d - Prescription Current (continued)

regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). Results of cart audits and compliance to this regulation will be discussed weekly at daily stand up meetings for effectiveness.

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

[redacted] 9/2/22

184a - Labeling OTC/CAM

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #5 is prescribed Acetaminophen 500 mg tablet-Take 1 tablet by mouth every 6 hours as needed; however, the pharmacy label indicates Acetaminophen 500 mg tablet-Take 2 tablets by mouth every day as needed.

Plan of Correction ***Directed***

Resident #5's pharmacy label for Acetaminophen was corrected 5/14/22. An initial cart audit was completed by Express Care Pharmacy on 4/20/22. Medication Cart audit will be conducted quarterly by Express Care Pharmacy (next cart audit is 7/13/22) and reviewed by the Healthcare Director, Executive Director or Designated Person at the Quality Management meeting on a quarterly basis to ensure effectiveness of these procedures in remaining compliant to this regulation. Medication labels will be checked against the MAR and prescription to ensure accuracy prior to being placed in the medication cart for administration. A Nurse or Healthcare Director will be responsible for this process. All medication technicians will be re-trained on medication safety and medication administration requirements under this regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22).

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

[redacted] 9/2/22

186a - Authorized Prescriber

1. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

Resident #4 does not have a list of current medications from an authorized prescriber present in the home.

Plan of Correction ***Directed***

Resident #4 no longer resides at the Community. All resident charts will be audited by 7/31/22 to ensure a list of current medications from an authorized prescriber is present. New admissions physician paperwork, to include a medication list, will be reviewed by the Healthcare Director prior to move in to ensure compliance with this regulation. This process will be reviewed at the Monthly Quality Management Meeting to ensure effectiveness. The Healthcare Director and Nurse will be re-trained on the requirements of this POC regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22).

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation

[redacted] 9/2/22

Not Implemented

224b - Assessment Referral

1. Requirements

224b - Assessment Referral *(continued)*

2600.
224.b. An applicant whose personal care service needs cannot be met by the home shall be referred to a local appropriate assessment agency.

Description of Violation

Resident #3's preadmission screening form, dated [redacted], indicates the home cannot meet this resident's needs; however, resident #3 was not referred to a local appropriate assessment agency.

Plan of Correction ***Directed***

Resident #3 pre-admission screening was not properly completed and the needs of this resident can be met in the home and will be finalized on 7/13/22. All current resident prescreens will be reviewed by the Healthcare Director, Executive Director or Designated Person for accuracy by 7/31/22. Pre-admission screenings for new admissions will be reviewed by the Healthcare Director prior to move in for accuracy. The Executive Director or Designated Person will audit The Executive Director, Business Office Manager or Designee will utilize the Resident Administrative Checklist to ensure pre-admission screenings are complete and placed in the business office file at time of contract signing beginning 7/13/22. All staff persons involved with the admission process will be educated on the trained on the requirements of this POC regulation by 7/20/22. (DIRECTED: Documentation of the education shall be kept. Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 7/12/22). Pre-admission Screenings for new residents weekly at Daily Stand up meeting to ensure compliance to this plan of correction x 2 months, at which time results will be reviewed for effectiveness and if a need for additional audits is necessary, the audit period will be extended.

[redacted] 9/2/22

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation **Not I[redacted]emented**

225a - Assessment 15 Days

1. 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 #5's medical evaluation, dated [redacted] indicates a diagnosis of dementia and the need for the resident to be served in the home's secured dementia care unit (SDCU). However, resident #5's assessment, dated [redacted], does not include the diagnosis of dementia and indicates the resident has no cognitive needs.

Plan of Correction ***Directed***

Resident #5's assessment was updated [redacted] All SDCU assessments for current residents will be reviewed by 7/31/22 to ensure a diagnosis of dementia and that cognitive needs are properly documented. (DIRECTED: By 7/31/22: A designated staff person shall review the records of all current residents to ensure each resident has an assessment completed in its entirety within 15 days of admission. [redacted] 7/12/22). The Healthcare Director or Designated person will check the initial assessment for new residents against the Medical Evaluation to ensure correct diagnosis and that resident needs are properly documented. Assessment due dates will be reviewed at Stand Up meetings Monday through Friday to ensure the assessment is completed within 15 days of admission under this regulation, to begin 7/15/22. All staff persons involved in the admission process will be educated on this new process as part of the POC by 7/15/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). The Executive Director or Designated Person will audit this process monthly to ensure completion and results of this audit will reviewed at the monthly Quality Management Meeting x 3 months and every 6 months thereafter.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and

225a - Assessment 15 Days (continued)

implement a new admission checklist to ensure an assessment is completed in its entirety within 15 days of admission for all newly-admitted residents. Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist. Documentation of the education shall be kept. [redacted] 7/12/22). [redacted] 9/2/22

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

227d - Support Plan Medical/Dental

1. 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 #4's support plan, dated [redacted], does not include the resident's use of a rollator walker or the services the resident is currently receiving from hospice.

Plan of Correction ***Directed***

Resident #4 no longer resides at Harmony at Harts Run. All Current residents on will have their support plan reviewed by the Healthcare Director or Designated Person to ensure all care needs and services are documented ~~by 08/31/22~~ (Unacceptable date for plan of correction. [redacted] 12/22) (DIRECTED: By 7/31/22: A designated staff person shall review all current resident support plans for accuracy and completeness. [redacted] 7/12/22) will be reviewed at Monthly Quality Management Meetings to ensure compliance to this regulation has been met.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement procedures to ensure resident support plans are updated as resident care needs change. Documentation of the new procedures shall be kept. All staff persons involved in the completion of resident assessment/support plans shall be education on the new procedures. Documentation of the education shall be kept. [redacted] 7/12/22).

Completion Date: *08/31/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

231c - Preadmission Screening [redacted] 9/2/22

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the home's SDCU on [redacted]; however, a written cognitive preadmission screening was not completed.

Plan of Correction ***Directed***

The preadmission screening was completed for resident #5 on 7[redacted]. The Executive Director, Business Office Manager or Designee will utilize the Resident Administrative Checklist to ensure pre-admission screenings are complete and placed in the business office file at time of contract signing beginning 7/13/22. All staff persons involved with the admission process will be educated on the trained on the requirements of this POC regulation by

231c - Preadmission Screening (continued)

7/20/22. (DIRECTED: Documentation of the education shall be kept. Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 7/12/22)
All SDCU pre-admission screenings for current residents will be reviewed by the Healthcare Director, Executive Director or Designated Person to ensure the screening indicates a need for a secured dementia care unit, to be completed by 7/31/22. All new admissions will have pre-admission screenings completed within 72 hours prior to admission to a secured dementia care unit, to be completed by the Healthcare Director, Executive Director or Designated Person. Pre-admission screenings will be audited weekly x 2 months by the Executive Director for compliance to this regulation and results will be reviewed at Monthly Quality Management meetings x 2 months and every 6 months thereafter.

[redacted] 9/2/22

Completion Date: *07/31/2022* Licensee's Proposed Date for POC Implementation

Not I ented

231e - No Objection Statement

1. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #5 was admitted to the home's SDCU on [redacted]; however, resident #5's record does not include documentation that the resident and the resident's designated person have not objected to the admission to the SDCU.

Plan of Correction ***Directed***

The Designated person will acknowledge in writing that they do not object to the admission to the SDCU by 7/20/22. All current SDCU resident files will be audited by the Healthcare Director, Executive Director or Designated Person to ensure a no objection statement has been completed, to be done by 7/31/22. All new admissions will complete a no objection statement at time of contract signing. All staff persons involved in the admission process will be educated on this POC by 7/20/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 7/12/22). All contract paperwork to include this no objection statement will be reviewed by the Business Office Manager, Executive Director or Designated Person at or within 72 hours of admission to ensure completion. Results of this audit will be reviewed a the monthly Quality Management Meeting x 2 months and every 6 months thereafter.

DIRECTED: By 7/20/22: A designated staff person shall obtain written documentation from resident #5 and resident #5's designated person that the resident and the resident's designated person have not objected to the admission to the SDCU. The documentation shall be kept in resident #5's record. [redacted] 7/12/22

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure documentation is obtained from the resident and the resident's designated person that they do not object to the admission or transfer to the secured dementia care unit. Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist. Documentation of the education shall be kept.[redacted] 7/12/22).

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

[redacted]/2/22

234a - Admission Support Plan

1. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #5 was admitted to the home's SDCU on [redacted] however, the resident's support plan is undated, so it is unable to be determined if the support plan was completed within 72 hours of the admission or within 72 hours prior to the admission. The resident's assessment was completed on [redacted]

Plan of Correction ***Directed***

Resident #5 support plan will reviewed for accuracy and any necessary updates will be made by 7/20/22. The Healthcare Director will be educated on this POC by 7/20/22. This support plan will be reviewed with the resident and/or designated person for this resident by the Healthcare Director, Executive Director or Designated Person by 7/20/22. Assessment and support plan due dates will be reviewed at daily stand up meetings to ensure compliance to this regulation to begin 7/15/22. This POC will be reviewed at the Monthly Quality Management meeting x 3 and then reduce to a quarterly basis thereafter.

By 7/31/22: A designated staff person shall review all current resident records for those residents who reside in the home's secured dementia care unit to ensure each resident has a support plan completed in its entirety within within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit. [redacted] 7/12/22

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a support plan is completed in its entirety within 72 hours of the admission, or within 72 hours prior to a resident admission to the secured dementia care unit. Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist. Documentation of the education shall be kept. [redacted] 7/12/22).

[redacted]9/2/22

Completion Date: *07/20/2022* Licensee's Proposed Date for POC Implementation **Not [redacted]mented**