

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

October 24, 2025

[REDACTED]  
THE VILLAGES OF HARMAR, LLC  
[REDACTED]  
[REDACTED]

RE: THE VILLAGES OF HARMAR  
715 FREEPORT ROAD  
CHESWICK, PA, 15024  
LICENSE/COC#: 45456

[REDACTED],  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/15/2025, 09/16/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: THE VILLAGES OF HARMAR License #: 45456 License Expiration: 01/22/2026  
 Address: 715 FREEPORT ROAD, CHESWICK, PA 15024  
 County: ALLEGHENY Region: WESTERN

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: THE VILLAGES OF HARMAR, LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C 2 LP Date: 10/24/2006 Issued By: Labor and Industry

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 51 Waking Staff: 38

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Complaint Exit Conference Date: 09/16/2025

**Inspection Dates and Department Representative**

09/15/2025 On Site: [REDACTED]  
 09/16/2025 On Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 110 Residents Served: 45

Special Care Unit  
 In Home: No Area: Capacity: Residents Served:

Hospice  
 Current Residents: 2

Number of Residents Who:  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 45  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 6 Have Physical Disability: 0

**Inspections / Reviews**

09/15/2025 - Partial  
 Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 10/04/2025

Inspections / Reviews (*continued*)

## 10/03/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/23/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/09/2025

## 10/08/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/23/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/23/2025

## 10/24/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/23/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

183a Original containers / no pre pour / injections

1. Requirements

2800.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Resident [redacted] is currently prescribed [redacted] tablet-Take 1 tablet by mouth every 12 hours as needed. On [redacted] [redacted] were delivered to the residence for resident [redacted]. On [redacted], resident [redacted] Controlled Medication Accountability Record indicated 23 tablets were still present in the bottle. On [redacted], another [redacted] were delivered to the residence for resident [redacted]. On or around [redacted], direct care staff person A combined both bottles of resident [redacted] [redacted] into 1 bottle and altered the Controlled Medication Accountability Record to indicate 83 tablets were present.

Plan of Correction

Directed [redacted] - 10/08/2025)

Attending physician for Resident [redacted] reviewed and adjusted [redacted] to a straight order given twice daily. Newly packaged medication and count sheet were received and implemented. Medication is in original labeled container.

The Resident Care Coordinator completed on 9/16/2025 a baseline of all medications to ensure that medications were in their original labeled containers.

The facility med techs and nursing staff were educated by Resident Care Coordinator/designee on 9/16/2025 on regulation 2800.183a and the facility policy on Medication Management which includes packaging of medications. This education specifically addresses that staff are not permitted to combine bottles, Staff person A is part of the nursing staff that received the education. Documentation of the staff education will be kept in accordance with 2800.65L.

The Resident Care Coordinator/designee will audit that medications are maintained in their original labeled packaging. This audit will begin on 10/6/2025. Audit will be a random review 10 residents weekly for four weeks, then be included in medication administration audits monthly on an ongoing basis.

Results of the auditing will be reviewed at the facility's Quality Management Meeting, next meeting is 10/23/25. (DIRECTED: Documentation of the quality management review shall be kept. LM 10/8/25).

Proposed Overall Completion Date: 10/23/2025

Directed Completion Date: 10/23/2025

Implemented [redacted] - 10/24/2025)

187b Date/time of med admin

2. Requirements

2800.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

## 187b Date/time of med admin (continued)

**Description of Violation**

Resident [REDACTED] is currently prescribed [REDACTED] tablet Take 1 tablet by mouth 4 times daily at 5:00 AM, 11:00 AM, 5:00 PM and 11:00 PM. However, according to resident [REDACTED]'s Controlled Medication Accountability Record, on [REDACTED] at 8:00 AM, 2 [REDACTED] tablets were administered to resident [REDACTED] and no [REDACTED] was administered to resident [REDACTED] on [REDACTED] at 11:00 AM. However, resident [REDACTED] September 2025 medication administration record (MAR) includes the initials of a staff person indicating 1 [REDACTED] tablet was administered to resident [REDACTED] on [REDACTED] at 8:00 AM and 11:00 AM. Resident [REDACTED] also indicated [REDACTED] was given 2 tablets of [REDACTED] on [REDACTED] at 8:00 AM.

Resident [REDACTED] is currently prescribed [REDACTED] tablet Take 1 tablet by mouth every 12 hours as needed. According to resident [REDACTED] Controlled Medication Accountability Record, the [REDACTED] was administered to resident [REDACTED] on [REDACTED] at 4:00 PM and 11:00 PM, and on [REDACTED] 5 at 9:00 AM; however, these doses are not documented as administered on resident [REDACTED]'s August 2025 MAR or September 2025 MAR.

Resident [REDACTED] is currently prescribed [REDACTED] extended release 300mg tablet Take 1 tablet by mouth once daily. Resident [REDACTED] Controlled Medication Accountability Record indicates the medication was not administered to resident [REDACTED] on [REDACTED]; however, resident [REDACTED] September 2025 MAR is documented by direct care staff person B indicating the Tramadol was as administered to resident [REDACTED] on [REDACTED].

REPEAT VIOLATION: [REDACTED], et. al.

**Plan of Correction**

Directed [REDACTED] - 10/08/2025)

Supplemental documentation, in the form of progress notes, has been completed for Resident [REDACTED] Resident [REDACTED] and Resident [REDACTED] indicating their medication administration.

The Resident Care Coordinator/designee completed a 7 day review of medication records to ensure that proper documentation is completed after medication administration. This audit was completed by the Resident Care Coordinator/designee on 9/16/2025.

The Resident Care Coordinator/designee educated licensed nurses and med tech's on 9/16/2025 regarding medication administration, documentation, and their responsibility to document medication administration or refusal.

The Resident Care Coordinator will audit medication administration documentation for four weeks beginning 10/6/2025, then ongoing on a monthly basis. These audits will include a sampling of 10 residents weekly and will include a review of those resident's MAR, count sheets, etc. Any concerns identified will result in individual educations and/or disciplines.

Results of the auditing will be reviewed at the facility's Quality Management Meeting, next meeting is 10/23/25. (DIRECTED: Documentation of the quality management review shall be kept. [REDACTED] 10/8/25).

Documentation of the staff education will be kept in accordance with 2800.65L

Proposed Overall Completion Date: 10/23/2025

187b Date/time of med admin (continued)

Directed Completion Date: 10/23/2025

Implemented [redacted] - 10/24/2025)

187d Follow prescriber's orders

3. Requirements

2800.

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

Description of Violation

Resident [redacted] is currently prescribed [redacted] tablet-Take 1 tablet by mouth 4 times daily at 5:00 AM, 11:00 AM, 5:00 PM and 11:00 PM. However, according to the Controlled Medication Accountability Record, on [redacted] at 8:00 AM, 2 tablets of [redacted] were administered to resident [redacted]. Resident [redacted] also indicated [redacted] was given 2 tablets of [redacted] on [redacted] at 8:00 AM.

Resident [redacted] is currently prescribed [redacted] tablet-Take 1 tablet by mouth every 12 hours as needed. According to resident [redacted] Controlled Medication Accountability Record, the [redacted] was administered to resident [redacted] on [redacted] at 4:00 PM, then again at 11:00 PM on [redacted]

Resident [redacted] is currently prescribed [redacted] extended release [redacted] tablet-Take 1 tablet by mouth once daily; however, this medication was not administered to resident [redacted] on [redacted].

REPEAT VIOLATION: [redacted], et. al.

Plan of Correction

Directed [redacted] - 10/08/2025)

The facility is unable to reconcile the medication administration for Resident [redacted] Resident [redacted] and Resident [redacted]. There were no adverse affects for the residents. Physician and family notification were completed no later than 9/17/25 by Resident Care Coordinator/LPN supervisor. Staff involved received individual educations regarding following physician orders and will participate in medication administration observations performed by the Resident Care Coordinator/designee. (DIRECTED: The medication observations for the staff persons involved shall be completed by 10/20/25. Documentation of the observations shall be kept. [redacted] 10/8/25).

The Resident Care Coordinator/designee completed a 7-day review of medication records to ensure that medications were administered by the physician order. This audit was completed on 9/16/2025.

The Resident Care Coordinator/designee educated licensed nurses and med-techs on Regulation 2800.187d and their responsibility to review and administer care per the physician directions. This education took place on 9/16/2025.

The Resident Care Coordinator/designee will audit medication administration records and Controlled Medication Accountability Records to ensure the physician orders are followed. This audit will be completed weekly for four weeks beginning 10/6/2025 then ongoing on a monthly basis. These audits will include a sampling of 10 residents weekly. Any concerns identified will result in individual educations and/or disciplines.

Results of the auditing will be reviewed at the facility's Quality Management Meeting, next meeting is 10/23/25. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 10/8/25).

Documentation of the staff education will be kept in accordance with 2800.65L

187d Follow prescriber's orders (continued)

Proposed Overall Completion Date: 10/23/2025

Directed Completion Date: 10/23/2025

Implemented [REDACTED] - 10/24/2025)

221c Post activity calendar

4. Requirements

2800.

221.c. The week's daily activity calendar shall be posted in advance in a conspicuous and public place in the residence. The residence shall provide verbal cueing and reminders of activities, their start times and locations within the residence.

Description of Violation

On [REDACTED], the only activity calendar posted in a conspicuous and public place was for the month of August 2025.

Plan of Correction

Accept [REDACTED] - 10/08/2025)

Corrected immediately upon identification. Facility ED/Designee placed copies of the September 2025 Activity calendar on each unit, and in each of the facility elevators. Moving forward the ED/Designee will incorporate audits for the posting of the most up to date activity calendar into the existing monthly audits being conducted for postings. This audit began 10/1/2025. New Activity Director and AL activity staff will be educated no later than 10/10/2025 on the requirements of 2800.221c.

Licensee's Proposed Overall Completion Date: 10/23/2025

Implemented [REDACTED] - 10/24/2025)

227d Support plan – med/dental

5. Requirements

2800.

227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

On [REDACTED] a lap belt was present on resident [REDACTED] wheelchair; however, this device was not indicated on resident [REDACTED]'s most recent support plan dated [REDACTED]. Also, at the time of inspection, bilateral bedside mobility devices were present on resident [REDACTED]'s bed; however, resident [REDACTED]'s most recent support plan does not include the specific need for the device, the intended use and any risks associated with the use or resident [REDACTED] ability to use the device safely for the purpose it was intended

REPEAT VIOLATION: [REDACTED], et. al.

Plan of Correction

Accept [REDACTED] - 10/08/2025)

The support plan for Resident [REDACTED] has been updated by the Resident Care Coordinator on 9/17/2025 to include the

*227d Support plan – med/dental (continued)*

*wheelchair lap belt and bilateral bedside mobility devices.*

*A baseline support plan audit has been completed by the Resident Care Coordinator/designee to ensure that support plan reflects the use of bedside mobility devices and wheelchair devices as appropriately utilized. This audit to be completed no later than 10/10/2025.*

*The Executive Director/designee will educate licensed nurses on regulation 2800.227d and their responsibility to review/update support plan with changes in care needs. This education will be completed by 10/10/2025 and documentation will be kept in accordance with 2800.65L.*

*The Executive Director/designee will review five support plans weekly, starting 10/6/2025, to ensure that the final support plan is reflective of the resident's care and services. This audit will be performed weekly for 3 months and continue monthly ongoing in addition to the quarterly reviews. Support plans will continue to be reviewed and updated quarterly in addition to the monthly sample that is reviewed.*

**Licensee's Proposed Overall Completion Date: 10/23/2025**

**Implemented [REDACTED] - 10/24/2025)**