

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/20/2024
NAME OF PROVIDER OR SUPPLIER  Harmony Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  164 Office Park Drive Xenia, OH 45385	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988</b></p> <p>Based on observation, record review, review of the facility policy, and resident and staff interview the facility failed to ensure the residents had access to their call light. This affected one (Resident #200) of two residents reviewed for call light accessibility and functioning. The facility census was 71.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #200 revealed an admitted [DATE]. Diagnoses included right hip fracture, seizure disorder, left below the knee amputation, traumatic brain injury, and vascular dementia.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #200 had intact cognition. Resident #200 required partial/moderate assistance from staff with oral hygiene and substantial/maximal assistance to dependent on staff for toileting, bathing/shower, upper body dressing, and lower body dressing.</p> <p>Review of the plan of care dated 06/14/22 revealed Resident #200 was at increased for risk for falls with interventions to have commonly used articles within easy reach: water, call light, remote control, and telephone.</p> <p>Interview and observation on 05/16/24 at 8:50 A.M. with Resident #200 in his room stated he was unable to find his television remote and could not call for help because he did not have his call light. No observation of call light within reach of Resident #200. During the interview with Resident #200, Registered Nurse (RN) #31 entered the room. Resident #200 told RN #31 that he was unable to locate his remote and his call light. RN #31 located the call light behind Resident #200's bed approximately five foot up the wall was a light bar and located on top of the light bar was Resident #200 call light. RN #31 removed the call light from above the light bar and gave it to Resident #200.</p> <p>Interview with RN #31 on 05/16/24 at 8:55 A.M. verified call lights were to be within reach of residents, including Resident #200. RN #31 verified Resident #200's call light was not within reach and was unable to call for assistance to find his remote.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Call Lights, revision date 01/2020, revealed the call light is used by a resident to notify staff of the nursing facility that the resident has a need that they would like addressed. Staff will ensure that the resident is in a safe and comfortable position and that the call light is within reach of the resident before leaving the resident's room.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153796.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>47988</p> <p>Based on observations and staff interviews, the facility failed to provide a safe environment for the residents when a window air-conditioning unit in the dining room had exposed wires and coils. This had the potential to affect 41 residents (#102, #107, #109, #110, #112, #116, #118, #119, #120, #122, #125, #126, #127, #128, #129, #130, #131, #134, #135, #136, #138, #139, #142, #143, #144, #145, #146, #147, #149, #151, #152, #153, #154, #156, #158, #159, #161, #162, #163, #164, and #167) who the facility identified who were cognitively impaired and mobile. The facility census was 71.</p> <p>Findings include:</p> <p>Observations on 05/15/24 at 10:20 A.M. in the dining room, was a window air conditioning unit plugged into electrical outlet. The air conditioning unit had exposed coils, wires, and a thick layer of dust with debris and cobwebs covering the exposed internal components of the unit. On the wall in the dining room was a thermostat with no dial with a typed note Do not change setting on the thermostat, and fan, doing so can cause the system to overheat and could cause a fire. For residents rooms the settings must stay on 'cool'. Do not turn the thermostat up, our air conditioner unit is now on, and the system is based on water and not cooled air.</p> <p>Interview on 05/15/24 at 10:25 A.M. with Housekeeping Staff #40 verified the air conditioning unit located in the window of the dining room was plugged into the electrical outlet with the cover that had been broken for a long time. Housekeeping Staff stated, don't touch because she was unsure of the hazard risk because of the layer of dust, grass, and cobwebs on the coils and wires. Housekeeping Staff #40 was unsure when it was cleaned or when it was maintained last.</p> <p>Interview with the Administrator on 05/16/24 at 1:15 P.M. verified the typed letter hanging above thermostat in dining room indicating not to change the thermostat and fan, because of overheating and cause a fire. The Administrator stated she was unsure when or why this letter was placed and removed the letter from the wall. The Administrator stated there was no facility policy regarding the air conditioning system functioning and thermostat controls.</p> <p>Interview with Maintenance Staff #42 on 05/16/24 at 2:30 P.M. verified the air conditioning unit located in the dining room was non-functioning, missing a plastic surround which exposed electrical wires and coils. He verified the unit posed an electrical risk if exposed wires/coils were touched because the unit was plugged into the electrical outlet. He verified that all air conditioning units were to be maintained though the maintenance department but was unsure when that unit was last functioning or maintained.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153796.</p>		