

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Harmony Court Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 6969 Glenmeadow Lane Cincinnati, OH 45237	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>40471</p> <p>Based on review of facility Self-Reported Incident Reviews (SRIs), staff interview, and review of the facility policy, the facility failed to ensure allegations of misappropriation were reported in a timely manner to the Ohio Department of Health (ODH). This affected one (Residents #12) of 12 residents reviewed for misappropriation. The facility census was 110 residents.</p> <p>Findings include:</p> <p>Review of the facility SRI initiated 09/30/24 revealed the facility substantiated an allegation of misappropriation of Resident #12's narcotic medication, oxycodone per Registered Nurse (RN) #175. The facility substantiated misappropriation had occurred and RN #175 was terminated.</p> <p>Interview on 10/30/24 at 9:00 A.M. with the Director of Nursing (DON) confirmed she received a text from Licensed Practical Nurse (LPN) #225 on Friday 09/27/24 at 6:45 P.M. with a photograph of a Resident #12's controlled substance record with Registered Nurse (RN) #175's initials signing out doses of medication but on some of the lines Resident #19's name was written in the margin. The DON confirmed she attempted to call LPN #225 who sent her the image, but the nurse did not respond. The DON further confirmed the photograph was suspicious and she had concerns RN #175 had possibly misappropriated resident medication, because RN #175 had written Resident #19's name on Resident #12's record. The DON confirmed she did not follow up on the possible misappropriation concerns until Monday, 09/30/24 when the DON notified the Administrator, who opened the SRI on 09/30/24, and the facility began their investigation. The DON confirmed she did not report the suspicious information she received on 09/27/24 to her supervisor until 09/30/24.</p> <p>Interview on 10/30/24 at 10:00 A.M. with the Administrator confirmed the DON notified him on 09/30/24 of concerns regarding misappropriation per RN #175 which she had learned of on 09/27/24, and the facility did report the allegation to ODH till 09/30/24.</p> <p>Review of the facility policy titled Abuse, Neglect, Misappropriation of Resident Property, Injury of Unknown Origin dated 08/01/22 revealed the facility would report allegations of misappropriation to the state agency, ODH, within 24 hours. The policy definition of misappropriation included missing prescription medications or diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents noncompliance investigated under Complaint Number OH00159179 and Complaint Number OH00158434.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>40471</p> <p>Based on review of Self-Reported Incident Reviews (SRIs) staff interview, and review of the facility policy, the facility failed to conduct a thorough investigation of misappropriation of resident medications and failed to protect residents during the investigation. This affected one (Residents #12) of 12 residents reviewed for misappropriation and had the potential to affect all of the residents residing in the facility. The facility census was 110 residents.</p> <p>Findings include:</p> <p>Review of the facility SRI initiated 09/30/24 revealed the facility substantiated an allegation of misappropriation of Resident #12's narcotic medication, oxycodone per Registered Nurse (RN) #175. The facility substantiated misappropriation had occurred and RN #175 was terminated.</p> <p>Interview on 10/30/24 at 9:00 A.M. with the Director of Nursing (DON) confirmed she received a text from Licensed Practical Nurse (LPN) #225 on Friday 09/27/24 at 6:45 P.M. with a photograph of a Resident #12's controlled substance record with Registered Nurse (RN) #175's initials signing out doses of medication but on some of the lines Resident #19's name was written in the margin. The DON confirmed she attempted to call LPN #225 who sent her the image, but the nurse did not respond. The DON further confirmed the photograph was suspicious and she had concerns RN #175 had possibly misappropriated resident medication, because RN #175 had written Resident #19's name on Resident #12's record. The DON confirmed she did not follow up on the possible misappropriation concerns until Monday, 09/30/24 when the DON notified the Administrator, who opened the SRI on 09/30/24, and the facility began their investigation. The DON confirmed she did not report the suspicious information she received on 09/27/24 to her supervisor until 09/30/24. The DON confirmed RN #175, the alleged perpetrator, was permitted to work on 09/28/24 and 09/29/24 and was not suspended until 09/30/24. The DON further confirmed the facility's investigation was not thorough as they did not investigate other nurses for misappropriation.</p> <p>Interview on 10/30/24 at 10:00 A.M. with the Administrator confirmed the DON notified him on 09/30/24 of concerns regarding misappropriation per RN #175 which she had learned of on 09/27/24, and the facility did report the allegation to ODH till 09/30/24. The Administrator confirmed RN #175 was suspended on 09/30/24 and was terminated. The Administrator confirmed the facility's investigation focused on RN #175 and did not include the other nurses in the facility.</p> <p>Review of the facility policy titled Abuse, Neglect, Misappropriation of Resident Property, Injury of Unknown Origin dated 08/01/22 revealed for the protection of the residents an alleged perpetrator of abuse, neglect, or misappropriation should be suspended immediately pending the results of the investigation. The facility would complete an effective thorough investigation which would include interviewing all residents, employees and individuals who might have knowledge of the misappropriation.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00159179 and Complaint Number OH00158434.</p>		