

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  05/14/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on medical record review, review of facility Self-Reported Incidents (SRIs), staff interview, and review of the facility policy, the facility failed to ensure residents were free from verbal abuse by the staff. This affected one (Resident #104) of three residents reviewed for abuse. The facility census was 112 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #104 revealed an admission date of 02/13/25 with diagnoses including hemiplegia and hemiparesis following cerebral infarction, anxiety disorder, bipolar disorder, post-traumatic stress disorder, and aphasia.</p> <p>Review of the facility SRI for Resident #104 initiated 04/19/25 revealed the facility substantiated an allegation of abuse per Licensed Practical Nurse (LPN) #500 towards Resident #104. On 04/19/25 at approximately 5:30 P.M. Resident #104 and another nurse witnessed LPN #500 using profane language and speaking in a verbally abusive manner towards the resident. The facility reported LPN #500's actions to the Ohio Board of Nursing (OBN) and terminated the nurse.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #104 dated 04/24/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.)</p> <p>Interview on 05/14/25 at 11:03 A.M. with the Administrator and Assistant Director of Nursing (ADON) #357 confirmed the facility investigated an allegation of verbal abuse per LPN #500 towards Resident #104. Interview confirmed the facility substantiated verbal abuse had occurred, and they terminated LPN #500 and reported the nurse to the OBN.</p> <p>Review of the facility policy titled Abuse, Neglect, Misappropriation of Resident Property, and Injury of Unknown Origin dated August 2024 revealed the facility had a zero-tolerance policy for resident abuse which included verbal abuse.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00165135.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on medical record review, review of facility Self-Reported Incidents (SRIs), staff interview, and review of the facility policy, the facility failed to prevent resident elopements. This affected one (Resident #45) of three residents reviewed for elopements. The facility census was 112 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed an admission date of 11/20/23 with diagnoses including atherosclerotic heart disease, Alzheimer's disease, psychotic disorder with delusions and hallucinations, and Parkinson's disease.</p> <p>Review of the elopement risk assessment for Resident #45 dated 01/23/25 revealed the resident was at risk for elopement due to a history of wandering with a pattern, goal-directed wandering, and wandering that might affect the resident's safety and the privacy of others.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #45 dated 03/28/25 revealed the resident was moderately cognitively impaired, was independently mobile with a walker, and required supervision with activities of daily living (ADLs).</p> <p>Review of the care plan for Resident #45 updated 04/28/25 revealed the resident was at risk for elopement related to disorientation, voicing the desire to leave, and piling his belongings on his walker seat. Interventions included the following: attempt to redirect the resident from wandering with diversional activities, encourage structured activities and calls and visits from family,</p> <p>Review of a progress note for Resident #45 dated 05/01/25 revealed a nurse from another unit notified the nurse the resident had gotten out the back door. The nurse went to the back door where the door alarm was sounding and found the resident sitting on his walker. The nurse directed Resident #45 back into the building and placed the resident on one-on-one supervision.</p> <p>Review of the elopement risk assessment for Resident #45 dated 05/01/25 revealed the resident was at risk for elopement due to prior elopements, a history of wandering with a pattern, goal-directed wandering, and wandering that might affect the resident's safety and the privacy of others.</p> <p>Review of the facility SRI dated 05/01/25 revealed Resident #45 exited an alarmed door on the secured unit without staff knowledge. When Resident #45 exited the facility, the door alarm sounded but it was not sufficiently loud enough for the two aides working the unit to hear. The aides on the unit were notified of Resident #45's elopement when an aide from another unit came over to tell them the police had called the facility advising there was a resident outside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/13/25 at 3:15 P.M. with Certified Nursing Assistant (CNA) #151 confirmed she and another aide were on the unit and the nurse was not present when Resident #45 eloped from the facility on 05/01/25. CNA #151 confirmed both she and the other aide were in the nursing station and did not hear the door alarm sounding when Resident #45 exited the building. CNA #151 confirmed staff from another unit told them the police had called the facility stating Resident #45 was outside. CNA #151 confirmed she had not been aware Resident #45 was an elopement risk, or she would have provided closer supervision.</p> <p>Observation on 05/13/25 at 5:25 P.M. revealed the door alarm to the secured unit from which Resident #45 eloped did not sound loudly when activated and could not be heard from the nurses' station.</p> <p>Interview on 05/14/25 at 9:20 A.M. with Maintenance Director (MD) #385 confirmed he knew a resident had eloped on 05/01/25 but he had received no requests to make the alarm louder.</p> <p>Interview on 05/14/25 at 10:05 A.M. with Licensed Practical Nurse (LPN) #241 confirmed she was not working on Resident #45's unit when the resident eloped. LPN #241 further confirmed she was working another unit when she received a call from the police that there was a resident outside the building. LPN #241 then went to Resident #45's unit to notify the aides who had not been able to hear the door alarm when the resident exited.</p> <p>Interview on 05/14/25 at 11:03 A.M. with the Administrator and Assistant Director of Nursing (ADON) #357 confirmed Resident #45 was at risk for elopement and eloped from an alarmed door on the secured unit without staff knowledge in the morning of 05/01/25. At the time of Resident #45's elopement the two aides working the unit did not hear the alarm as it didn't sound loudly enough to be heard from the nurses' station where the two aides were sitting. The nurse for the unit had not arrived to work. The Administrator and ADON #357 confirmed the staff was not aware Resident #45 had eloped until the police observed the resident outside and called the facility.</p> <p>Review of the facility policy titled Elopement Prevention and Management Unsafe Wandering and Exit Seeking Behavior revised May 2024 revealed elopement from the facility was defined as when a cognitively impaired resident left the physical structure of the facility unattended and without staff knowledge. Residents would be assessed for elopement risk and interventions would be developed to meet their individualized needs based on the assessment. The facility would ensure door alarm and wander control system were in proper working order.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00165418.</p>		