STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395726	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmon House Health & Rehab Center	601 South Church Street Mount Pleasant, PA 15666

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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that non pharmacological interventions were attempted prior to the administration of a psychotropic medication for one of 43 residents reviewed (Resident 89).Findings include: The facility's policy regarding use of psychotropic medications, dated August 14, 2025, indicated that . A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 89, dated March 13, 2026, revealed that the resident was cognitively impaired, was taking an anti-anxiety medication, and had a diagnosis of anxiety. Physician's orders for Resident 89, dated November 26, 2025 included orders for the resident to be administered 0.5 milligram (mg) lorazepam as needed for anxiety. A review of the medication administration records (MAR) for Resident 89, dated March, April, and May 2026, revealed the resident was administered 0.5 mg of lorazepam on March 6, 9, 10, 11, 14, 18, April 1, 2, 6, 7, 9, 11, 20, 25, 26, 29, 30, May 4 and 5. There was no documented evidence that non-pharmacological interventions were attempted prior to the administration of lorazepam. Interview with the Director of Nursing on May 6, 2026 at 11:21 a.m. confirmed that there were no non-pharmacological interventions attempted prior to the administration of lorazepam for the dates listed above, and there should have been. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that care and services were provided according to accepted standards of practice for five of 43 residents reviewed (Residents 1, 6, 39, 78, and 91). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 1 dated February 20, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included infection of the foot and diabetic ulcer. Review of the wound care consultant's progress note for Resident 1 dated March 19, 2026, and March 26, 2026, indicated that the Resident had a wound to his left lateral foot and was to have hydrocortisone (medication used to reduce inflammation, swelling, itching, and allergic reactions) cream applied daily with dressing changes to the peri-wound (skin immediately surrounding a wound) area. Review of the Treatment Administration Record (TAR) for Resident 1 dated March 2026, revealed no documented evidence that hydrocortisone cream was applied to the peri-wound area of the resident's left lateral foot as ordered by the wound care consultant. Interview with the Director of Nursing on May 7, 2026, at 11:14 a.m. revealed that the wound care consultant's orders for hydrocortisone cream for Resident 1's peri-wound area were not completed because the provider did not give the facility's wound care nurse verbal orders for hydrocortisone, however, it is her responsibility to review wound care consultant's notes to identify changes in orders and she did not. An annual MDS assessment for Resident 39 dated March 30, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, received insulin and had diagnosis of diabetes. A pharmacy medication regimen review for Resident 39, dated April 3, 2026, indicated that the resident had a diagnosis of diabetes, but an A1C (blood test that measures average blood sugar levels) was not available in the medical record in the past six months and fingerstick monitoring (measuring blood sugar levels in real-time by testing a tiny, capillary blood sample) cannot be found in the medical record. The review revealed that the resident receives Lantus, Insulin Lispro, and Metformin (medications to treat diabetes) and recommended to monitor her A1C on the next convenient lab day and every six months if meeting treatment goals, or every three months if therapy has changed or goals are not being met. The physician addressed the recommendation and ordered to check the resident's A1C with the next lab day and every three months. Review of Resident 39's A1C, completed on April 10, 2026, revealed that the physician reviewed the laboratory results on April 13, 2026, and noted that staff were to check the resident's accu checks (fingerstick monitoring) with meals for five days. There was no documented evidence that orders were transcribed into the resident's clinical record for accu checks to be monitored as per the physician's orders noted on the laboratory results. An interview with the Director of Nursing on May 6, 2026, at 11:16 a.m. confirmed that the order to check Resident 39's accu checks were not transcribed into the resident's clinical record and were not completed as they should have been. A quarterly MDS assessment for Resident 78 dated April 21, 2026, revealed that the resident is cognitively impaired, required assistance from staff for daily care needs, and had medical diagnosis that includes heart failure and high blood pressure. Physician's orders for Resident 78 dated January 26, 2026, included orders for Resident to receive 4 units of insulin aspart subcutaneous before meals. A review of Resident 78's Medication Administration Record (MAR) for January, February, March and April 2026, revealed that 4 units of insulin aspart were held on January 27 for a 89 mg/dl; February 1 for 117 mg/dl; February 5 for a 72 mg/dl; February 7 for a 78 mg/dl; February 11 for a 76 mg/dl; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 19 for a 71 mg/dl; February 25 for a 90 mg/dl; March 4 for 85 mg/dl; March 8 for a 81 mg/dl; March 12 for a 70 mg/dl; March 16 for a 97 mg/dl; March 16 for a 97 mg/dl; March 18 for a 75 mg/dl; March 19 for a 97 mg/dl; March 20 for a 99 mg/dl; March 21 for a 90 mg/dl; March 25 for a 107 mg/dl; April 1 for a 77 mg/dl; April 8 for a 75 mg/dl; April 10 for a 85 mg/dl; April 10 for a 85 mg/dl; April 18 for a 79 mg/dl; April 20 for a 97 mg/dl; and April 20, 2026 for 107 mg/dl. Physician's orders for Resident 78 included orders for the resident to receive 15 units of Lantus insulin subcutaneous twice a day. A review of Resident 78's MAR for February, March and April 2026, revealed that 15 units of Lantus insulin was held on February 5 for a 72 mg/dl; February 9 for a 78 mg/dl; February 19 for a 71 mg/dl; March 19 for a 97 mg/dl; March 24 for a 72 mg/dl; April 6 for a 76 mg/dl; April 9 for a 72 mg/dl and on April 18, 2026 for a 79 mg/dl. Interview with the Director of Nursing on May 6, 2026, at 3:24 p.m. confirmed that the insulins aspart and Lantus were held and there were no physician orders or notifications to hold Resident 78's insulin. A quarterly MDS assessment dated [DATE], for Resident 91 revealed that the resident was cognitively intact, required assistance from staff for daily care needs, received antidepressant medications and had a diagnosis of depression and anxiety. Physician's orders for Resident 91, dated February 19, 2026, included orders for the resident to receive 50 milligrams (mg) of Zoloft (an antidepressant medication) daily. Physician's orders for the resident, dated February 19, 2026, included orders for the resident to receive 25 mg of Zoloft daily with instructions to give with the 50 mg tablet to equal 75 mg daily. A psychiatric note for Resident 91, dated April 9, 2026, at 9:38 a.m. revealed that the resident stated she was still having symptoms of anxiety and recommended increasing her Zoloft from 75 mg daily to 100 mg daily. A physician's note for Resident 91, dated April 9, 2026, at 2:46 p.m. revealed that she reviewed the resident's psych recommendations to increase her Zoloft. The physician was agreeable to increase her Zoloft and ordered to increase her Zoloft per psych recommendations. There was no documented evidence in Resident 91's clinical record that the Zoloft was increased per the psych recommendations as agreed upon by the physician. Interview with the Director of Nursing on May 7, 2026, at 11:39 a.m. confirmed that the physician did agree with the psych recommendations to increase Resident 91's Zoloft to 100 mg daily and that there was no documented evidence the order was transcribed as recommended and as agreed upon by the physician. A quarterly MDS assessment for Resident 6, dated February 23, 2026, revealed that the resident was cognitively intact, totally dependent on staff for care, and had diagnoses that included end stage renal disease and received dialysis (a life-sustaining medical treatment that filters waste products, toxins, and excess fluids from the blood when the kidneys have failed). Physician's orders for Resident 6, dated November 26, 2025 included an order for his Eliquis (blood thinner) to be held for a medical procedure on November 28, 2026. According to hospital discharge papers, dated November 29, 2026, readmission orders included an order for the resident to receive 2.5 milligrams (mg) Eliquis twice a day. The orders were signed off by a Registered Nurse, however, the Eliquis was not put in the resident's medication orders. Hospital discharge orders for Resident 6, dated January 14, 2026 revealed that the resident was ordered 2.5 mg Eliquis twice a day and that the registered nurse signed the orders. However, the Eliquis was not put in the resident's medication orders. A review of Resident 6's MAR, dated November and December 2025, as well as January, February, March, April and May 2026, the resident did not receive the Eliquis as ordered. An interview with the Director of Nursing on May 7, 2026 3:53 p.m. revealed that he phoned the resident's physician on this date and the physician stated that she did not want to order the Eliquis at that time. However, he stated that the orders for the Eliquis should have been clarified with the physician at that time. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders regarding medication administration were followed for three of 43 residents reviewed (Residents 61, 78 and 91). This deficiency was cited as past noncompliance. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) dated March 21, 2026, for Resident 61 revealed that the resident was cognitively intact, required assistance from staff for daily care needs, received insulin and had a diagnosis of diabetes. Physician's orders for Resident 61, dated October 23, 2024, included an order for the resident to receive Novolin R insulin (short-acting insulin used to control high blood sugar) subcutaneously (delivers medication into the fatty tissue layer between the skin and muscle) per sliding scale (the amount of insulin given is determined by the blood sugar level) before meals and at bedtime as follows: if blood sugar is less than 70 milligrams per deciliter (mg/dL) , call the physician; if blood sugar is 70 to 139 mg/dL, give 0 Units; if blood sugar is 140 to 180 mg/dL, give 2 Units; if blood sugar is 181 to 240 mg/dL, give 3 Units; if blood sugar is 241 to 300 mg/dL, give 4 Units; if blood sugar is 301 to 350 mg/dL, give 6 Units; if blood sugar is 351 to 400 mg/dL, give 8 Units; if blood sugar is greater than 400 mg/dL, give 10 Units; if blood sugar is greater than 400 mg/dL, call the physician. Review of Resident 61's Medication Administration Record (MAR) for February and March 2026, revealed that on February 8, 2026, the resident's blood sugar was 414 mg/dL at 4:00 p.m., and on March 17, 2026, the resident's blood sugar was 448 mg/dL at 4:00 p.m. There was no documented evidence that the physician was notified that the resident's blood sugars were greater than 400 mg/dL. Interview with Director of Nursing on May 6, 2026, at 3:23 p.m. confirmed that there was no documented evidence that the physician was notified of Resident 61's blood sugar results that were greater than 400 mg/dL on the above-mentioned dates and times. A quarterly MDS assessment for Resident 78 dated April 21, 2026, revealed that the resident is cognitively impaired, required assistance from staff for daily care needs, and had medical diagnosis that includes heart failure and high blood pressure.Physician's orders for Resident 78 included orders for the resident to receive 2.5 milligrams of Midodrine (medication used for low blood pressure) twice a day and to hold if systolic blood pressure was greater than 130 millimeters of mercury (mm Hg).Review of Resident 78's MAR for February and March 2026, revealed that revealed that 2.5 mg of midodrine was administered to the resident on February 3 when the resident's SBP was 132; on February 9 when the resident's SBP was 145; on February 13 when the resident's SBP was 142; on February 17 when the resident's SBP was 140; on February 18 when the resident's SBP was 136; on February 21 when the resident's SBP was 159; on February 26 when the resident's SBP was 132; on February 27 when the resident's SBP was 138; on February 28 when the resident's SBP was 146; on March 1 when the resident's SBP was 131; on March 4 when the resident's SBP was 144; on March 5 when the resident's SBP was 133; on March 7 when the resident's SBP was 137; on March 9 when the resident's SBP was 138. Interview with the Director of Nursing on May 6, 2026, at 3:24 p.m. confirmed that midodrine was administered to Resident 78 when it should have been held on the above-mentioned dates and times. A quarterly MDS assessment dated [DATE], for Resident 91 revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had a diagnosis of hypertension (high blood pressure). Physician's orders for Resident 91, dated August 19, 2025, included an order for the resident to receive 100 milligrams (mg) of metoprolol tartrate daily and to hold the medication if the resident's systolic blood pressure (SBP-top number) was less than 120 millimeters of mercury (mm Hg) or heart rate was less than 65 beats per minute. Review of Resident 91's MAR for January, February and March 2026, revealed that 100 mg of metoprolol tartrate was administered to the resident on January 2 when the resident's SBP was 110; on January 3 when the resident's SBP was 110; on January 4 when the resident's SBP was 110; on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 12 when the resident's SBP was 110; on January 15 when the resident's SBP was 112; on January 16 when the resident's SBP was 112; on January 17 when the resident's SBP was 112; on January 18 when the resident's SBP was 112; on January 19 when the resident's SBP was 118; on January 22 when the resident's SBP was 118; on February 9 when the resident's SBP was 118; on February 23 when the resident's SBP was 110; on March 6 when the resident's SBP was 118; on March 8 when the resident's SBP was 106/72; and on March 19 when the resident's SBP was 115. Interview with Director of Nursing on May 7, 2026, at 11:39 a.m. confirmed that metoprolol tartrate was administered to Resident 91 when it should have been held on the above-mentioned dates and times. Following identification that medications were given outside of physician ordered parameters, the facility's corrective actions included: The residents identified as being administered medication outside of parameters were assessed for adverse effects. A baseline audit was conducted to identify residents with physician ordered parameters for medication administration and to ensure residents who were ordered medications with parameters had vital signs that were within normal limits. The licensed nursing staff were educated on following medication orders with parameters and following the six rights of medication administration. The Director of Nursing/designee will continue to complete audits three times a week for four weeks, then two times a month for two months. The findings will be reviewed with the quality assurance performance improvement committee. A review of the facility's corrective actions revealed that they were in compliance with F684 on April 23, 2026. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure that a resident's drug regimen was free of unnecessary drugs for three of 43 residents reviewed (Residents 1, 43 and 50).Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 1 dated February 20, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included infection of the foot and diabetic ulcer. Physician's orders for Resident 1 dated April 25, 2026, included to administer 100 milligrams (mg) of doxycycline hyclate (an antibiotic) twice a day. Nurse's note for Resident 1 dated April 25, 2026, at 11:08 a.m. indicated that while doing wound care, it was noted the left foot wound had a foul odor. The Certified Registered Nurse Practitioner was notified, and orders were obtained to administer 100 mg of doxycycline twice a day for 10 days after a wound culture was obtained. Review of the (Medication Administration Record (MAR) for Resident 1 dated April 2026 revealed that 100 mg of doxycycline was administered to Resident 1 in the evening of April 25 through the morning of May 6 for a total of 11 days. Interview with the Director of Nursing on May 7, 2026, at 8:32 a.m. confirmed that Resident 1 was administered antibiotics for 11 days instead of 10 days per the physician's orders on the above-mentioned dates. An annual MDS assessment for Resident 2, dated April 22, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included osteoporosis with pathological fracture (a broken bone caused by an underlying disease that weakens the bone, rather than by a high-impact injury). Physician's orders for Resident 2, dated January 12, 2026, included an order for the resident to receive 20 mg of Pantoprazole (a PPI) daily. A pharmacy medication regimen review for Resident 2, dated December 8, 2025, indicated that the resident had received pantoprazole 40 mg once daily since December 27, 2024, and recommended to re-evaluate the continued need for pantoprazole and reduce the dose of pantoprazole to 20 mg daily while monitoring for recurrence of symptoms. The rationale for the recommendation indicated that long-term PPI use (e.g., greater than 8 weeks) was associated with increased risk of C. difficile infections (highly contagious bacterium that causes severe colon inflammation and watery diarrhea), bone loss and fractures. The physician accepted the recommendation on December 9, 2025, and indicated to implement the recommendation as written. A pharmacy medication regimen review for Resident 2, dated January 12, 2026, indicated that the prescriber accepted a pharmacy recommendation to reduce Pantoprazole to 20 mg daily on December 9, 2025, but the order had not yet been processed. Review of the MAR for Resident 2, dated December 2025 and January 2026, revealed that the resident had received 40 mg of Pantoprazole daily from December 9, 2025, through January 12, 2026. Interview with the Director of Nursing on May 6, 2026, at 11:16 a.m. confirmed that Resident 2 received 40 mg of pantoprazole daily from December 9, 2025, through January 12, 2026, and the order to decrease the dosage to 20 mg daily should have been processed when recommended and approved by the physician on December 9, 2025. A quarterly MDS assessment for Resident 50 dated April 2, 2026, indicated that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, and had diagnosis that included heart failure. Physician's orders for Resident 50 dated January 15, 2026, included to administer 875-125 mg of amoxicillin-pot clavulanate (an antibiotic) twice a day for a urinary tract infection. Nurse's note for Resident 50 dated January 15, 2026, at 5:06 p.m. indicated that the resident's urine culture resulted showing over 100,000 Escherichia coli (type of bacteria). The Certified Registered Nurse Practitioner was notified, and orders were obtained to administer 875-125 mg of Augmentin (brand name for amoxicillin-pot clavulanate) twice a day for seven days for a urinary tract infection. Review of the MAR for Resident 50 dated January 2026 revealed that 875-125 mg of amoxicillin-pot clavulanate was administered to Resident 50 in the evening of January 15, 2026, through the morning of January 23 for a total of eight days. Interview with the Director of Nursing on May 7, 2026, at 11:18 a.m. confirmed that Resident 50 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was administered antibiotics for eight days instead of seven days per the physician's orders on the above-mentioned dates. Physician's orders for Resident 50 dated April 14, 2026, included to administer 500 mg of cefuroxime axetil (an antibiotic) twice a day for a urinary tract infection. Nurse's note for Resident 50 dated April 14, 2026, at 7:17 p.m. indicated that the resident's urine culture resulted showing over 100,000 Escherichia coli. The physician was notified, and orders were obtained to administer 500 mg of Ceftin (brand name for cefuroxime axetil) twice a day for five days. Review of the MAR for Resident 50 dated April 2026 revealed that 500 mg of cefuroxime axetil was administered to Resident 50 in the evening of April 14, 2026, through the morning of April 20, 2026, for a total of six days. Interview with the Director of Nursing on May 5, 2026, at 3:00 p.m. confirmed that Resident 50 was administered antibiotics for six days instead of five days per the physician's orders on the above-mentioned dates. 28 Pa. Code 211.12(d)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 43 residents reviewed (Residents 1, 36, and 50). This deficiency was cited as past non-compliance.Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section H0100C Ostomy was to be checked (1) yes if the resident had a colostomy (An opening into the colon from the outside of the body). Section H0400 Bowel Continence was to be coded (9) not rated, resident had an ostomy or did not have a bowel movement for the entire seven days, if the resident had a colostomy during the seven-day look-back period. Physician's orders for Resident 1, dated August 13, 2024, included an order for resident's colostomy skin barrier appliance to be changed every seven days. Review of the Resident's bowel record dated February 2026, revealed that the resident was using a colostomy for bowel movements. Review of the quarterly MDS assessment for Resident 1, dated February 20, 2026, revealed that Section H0100C was checked to indicate the resident had an ostomy, however Section H0400 was coded (0) always continent, indicating that the was continent of bowel. Interview with the Director of Nursing on May 6, 2026, at 2:35 p.m. confirmed that Resident 1's MDS dated [DATE], was coded inaccurately. The Long-Term Care Facility Resident Assessment Instrument (RAI) Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section P0200E. Wander/elopement alarm was to be checked 2. Used daily, if the resident had a wander/elopement alarm during the seven-day look-back period. A quarterly MDS assessment for Resident 36, dated February 14, 2026, indicated that the resident is cognitively impaired, required assistance from staff for daily care needs, and had medical diagnosis that includes high blood pressure and heart failure. Physician's orders for Resident 36, dated September 9, 2025, included orders for the resident to have a wanderguard electronic bracelet for safety check functioning daily. Review of the Residents Medication Administration Record revealed that the resident had a wanderguard in place daily during the seven-day lookback period. Interview with the Nursing Home Administrator on May 5, 2026, at 2:21 p.m. confirmed that Resident 36's MDS dated [DATE], was inaccurately coded regarding alarms. The Long-Term Care Facility RAI User's Manual, dated October 2025, revealed that Section B0200 Ability to hear (with hearing aid or hearing appliances if normally used) was to be coded (0) adequate, (1) minimal difficulty. (2) moderate difficulty, or (3) highly impaired. Section B0300 Hearing Aid was to be checked (0) no or (1) yes, if a hearing aid or other appliance was used in completing Section B0200. Review of the inventory checklist for Resident 50 dated May 15, 2025, indicated that the resident had one hearing aid and batteries present upon admission and a second hearing aid was present after admission. Interview with Resident 50 on May 4, 2026, at 11:11 a.m. revealed that he had difficulty hearing and did not have hearing aids in. Nurse aid in the room was able to locate his hearing aids and assisted the resident to place them correctly in his ears. The resident reported he prefers to have his hearing aids in. A quarterly MDS assessment for Resident 50 dated April 2, 2026, revealed that Section B0200 was coded (0) adequate, indicating that the resident had adequate hearing and Section B0300 was checked (0) indicating no hearing aids were used for the assessment. Interview with the Director of Nursing on May 6, 2026, revealed that Resident 50's MDS dated [DATE], was coded inaccurately. Following identification of the inaccurate MDS coding, the facility's corrective actions included: The MDS for resident assessments completed in a seven day look back period were reviewed and corrected, if applicable including any assessments that may have been identified prior to the lookback period. A baseline audit was performed on assessment to ensure the MDS was completed and coded correctly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395726	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmon House Health & Rehab Center	601 South Church Street Mount Pleasant, PA 15666

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Education was provided to the Registered Nurse Assessment Coordinator and assessment department to ensure accurate/timely MDS coding. To prevent reoccurrence , audits are to be completed weekly for a month, then monthly for two months. Results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee. A review of the facility's corrective actions revealed that they were in compliance with F641 on April 24, 2026. 28 Pa. Code 211.5(f) Medical records

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for one of 43 residents reviewed (Resident 50). Findings include: A facility policy for Comprehensive Care Planning, dated August 14, 2025, included that the facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet resident's medical, nursing, mental and psychosocial needs identified in comprehensive assessment. These plans will be focused on resident choices and abilities with the intent of maintaining and improving resident functional abilities and quality of life. The care plan is reviewed on an ongoing basis and revised as indicated by the residents' needs, wishes, or change in condition. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 50 dated April 2, 2026, indicated that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, and had diagnosis that included heart failure. Care plan for Resident 50 dated May 16, 2025, indicated that the resident was at risk for falls and that his hearing aids were to be within reach at his bedside. Review of the inventory checklist for Resident 50 dated May 15, 2025, indicated that the resident had one hearing aid and batteries present upon admission and a second hearing aid was present after admission. Interview with Resident 50 on May 4, 2026, at 11:11 a.m. revealed that he had difficulty hearing and did not have hearing aides in. Nurse aid in the room was able to locate his hearing aids in a bag on top of his dresser and assisted the resident to place them correctly in his ears. The resident reported he prefers to have his hearing aids in. Interview with Resident 50 on May 6, 2026, at 9:24 a.m. revealed he had difficulty hearing and that he did not have his hearing aids because they were charging. There was no documented evidence that a care plan was developed to address Resident 50's care and treatment needs related to the use of hearing aids for adequate communication. An interview with the Director of Nursing on May 6, 2026, at 3:29 p.m. confirmed there was no care plan developed to address Resident 50's care and treatment needs related to impaired hearing and the use of hearing aids. An interview with the Director of Nursing on May 7, 2026, at 11:18 a.m. revealed that the resident was seen by audiology that morning and was diagnosed with mixed hearing loss. 28 Pa. Code 211.12(d)(5) Nursing Services.