| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide documentation of advanced directives or given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for eight of eight residents reviewed (Resident R8, R30, R50, R67, R75, R86, R87, and R311).<br><br>Findings include:<br><br>A review of the facility policy Advanced Directives last reviewed [DATE], indicated that the facility has policies and procedures which allow the withholding of CPR (Cardiopulmonary Resuscitation - emergency life-saving procedure that is done when breathing or a heartbeat has stopped) measures from individual residents who have an Advanced Directives stating they do not want to be resuscitated. The procedures for determining when the services may be withheld must respect the resident ' s rights of self-determination. This nursing home will inform the resident of the policies and procedures upon admission or at such times as may be appropriate.<br><br>Review of Resident R8's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R8's MDS (Minimum Data Set, periodic assessment of resident care needs) dated [DATE], indicated diagnosis of hypertension (high blood pressure in the arteries), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression.<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R8 was given the opportunity to formulate an Advanced Directive.<br><br>Review of Resident R30's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R30's MDS dated [DATE], indicated diagnosis of hypertension, multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures.<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R30 was given the opportunity to formulate an Advanced Directive.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R50's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R50's MDS dated [DATE], indicated diagnosis of hypertension, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat).<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R50 was given the opportunity to formulate an Advanced Directive.<br><br>Review of Resident R67's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R67's MDS dated [DATE], indicated diagnosis of osteoarthritis (degeneration of the joint causing pain and stiffness), depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R67 was given the opportunity to formulate an Advanced Directive.<br><br>Review of Resident R75's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R75's MDS dated [DATE], indicated diagnosis of hypertension, dementia, and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R75 was given the opportunity to formulate an Advanced Directive.<br><br>Review of Resident R86's clinical record indicated he was admitted to the facility on [DATE].<br><br>Review of Resident R86's MDS dated [DATE], indicated diagnosis of hypertension, malnutrition (lack of nutrients to the body), and dysphagia (difficulty swallowing).<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R86 was given the opportunity to formulate an Advanced Directive.<br><br>Review of Resident R87's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R87's MDS dated [DATE], indicated diagnosis of depression, diabetes, and heart failure.<br><br>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R87 was given the opportunity to formulate an Advanced Directive.<br><br>Review of Resident R311's clinical record indicated he was admitted to the facility on [DATE].<br><br>Review of Resident R311's MDS dated [DATE], indicated diagnosis of diabetes, hypertension, and osteomyelitis (inflammation of bone caused by infection).<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the clinical record failed to reveal an advanced directive or documentation that Resident R311 was given the opportunity to formulate an Advanced Directive.<br><br>During an interview on [DATE], at 9:17 a.m. Social Worker Employee E19 confirmed that advanced directives are not part of the documentation in the clinical record.<br><br>During an interview on [DATE], at 9:20 a.m. the Director of Nursing confirmed that the facility failed to provide documentation of advanced directives or given the opportunity to formulate an advance directive for eight of eight residents reviewed (Resident R8, R30, R50, R67, R75, R86, R87, and R311).<br><br>28 Pa. Code: 201.29(b)(d)(j) Resident rights. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on facility policy, clinical record review and staff interviews, it was determined the facility failed to notify the physician of a change in condition for one of six residents. (Resident R30).<br><br>Findings include:<br><br>Review of facility policy Notification of Changes dated 2/1/24, indicated the facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:<br><br>- An accident involving the resident which results in injury and has the potential for requiring physician intervention.<br><br>- A significant change in the resident ' s physical, mental, or psychosocial status<br><br>- A need to alter treatment significantly.<br><br>Review of facility policy Protocol When to Call Physician dated 2/1/24, indicated the physicians caring for residents in your facility was to respond in an appropriate and timely manner to changes in condition as determined by the nursing staff and to address any concerns voiced by staff, residents or family members.<br><br>Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE].<br><br>Review of Resident R30's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).<br><br>Review of Resident R30's progress note indicated on 4/23/24, at 8:43 p.m. that Resident R30 was noted on floor in room on the side of bed closest to window; Resident positioned faced down no injury noted at this time; range of motion tolerated per Residents toleration times four extremities. Reddend area noted on left wrist, Resident alert to self with confusion. Resident bed positioned at lowest position.<br><br>Review of Resident R30's progress note indicated on 4/23/24, at 9:05 p.m. that resident was on the floor next to bed. upon entering room resident was laying on the right side of bed on floor face down. resident was assessed for injuries and repositioned onto her back for easy transfer. no injuries noted at this time. resident had small red area to left wrist that resident stated, that's been there. Resident R30 is alert times one and continuing on hospice. Resident R30 stated she was not in any pain. no signs or symptoms of pain or discomfort. resident transferred back into bed assist times 3. pillows placed on both sides of resident to help keep her from rolling out of bed. vitals (blood pressure, pulse, respirations) within normal limits. Afebrile (no fever). Neuros initiated. Physician notified. supervisor called husband but no answer. message left. will continue to monitor.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident R30's progress note indicated on 4/23/24, at 10:47 p.m. that resident had an increase of pain and agitation this shift, resident was crying out, when asked she stated that she was in pain, and wanted help, also that she couldn't see, hospice notified, this nurse spoke with on call, hospice stated she will call supervisor and come out to assess resident and call before she comes. Supervisor notified, will continue to monitor.<br><br>Review of Resident R30's progress notes on 4/23/24, at 10:47 p.m. failed to have an assessment documented by a registered nurse with residents change in condition.<br><br>Review of Resident R30's progress note on 4/23/24, at 10:47 p.m. failed to include documentation of notifying the physician of change in condition when resident reported having increased pain and being unable to see after a fall.<br><br>During an Interview on 5/1/24, at 10:15 a.m. the Director of Nursing (DON) confirmed the facility failed to notify the physician of a change in condition for one of six residents (Resident R30).<br><br>28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee.<br><br>28 Pa. Code 201.18(b)(1)(e)(1) Management. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546<br><br>Based on review of facility policy, clinical record review, staff interview, and facility submitted documents, it was determined that the facility failed to provide services to create an environment free from neglect for one of four residents (Resident R99).<br><br>Findings include:<br><br>Review of facility policy Abuse: Protection From Abuse dated 2/1/24, indicated residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety adequate, and appropriate services, treatment of care, including but not limited to: nutrition, medication, therapies, and activities of daily living.<br><br>Review of the clinical record indicated Resident R99 was admitted to the facility on [DATE].<br><br>Review of Resident R99's Minimum Data Set assessment (MDS - a periodic assessment of care needs) dated 2/12/24, indicated diagnosis of high blood pressure, hyperglycemia (high blood sugar levels in the blood), and pain in left knee.<br><br>A review of facility submitted documents dated 3/12/24, indicated that on 3/12/24, Resident R99 submitted a complaint to the facility that he had been left sitting in a soiled brief from 8:30 a.m. to 1:30 p.m. Once a statement was obtained from the resident, the facility was able to determine that Nurse Aide (NA) Employee E3 was caring for the resident during the time of occurrence. NA Employee E3 was removed from resident care until a full investigation could be completed.<br><br>Review of investigation documents dated 3/12/23, indicated Resident R99's roommate provided the following statement, NA Employee E3 came into room around 8:30 a.m. to answer call light, only turning it off and leaving saying she would be back. Around 1:30 p.m. NA Employee E3 came back and changed him (Resident R99) and left the room. Resident R99 was cold and not dressed in his bed. At 2:30 p.m. the second shift person covered him up.<br><br>Review of investigation documents dated 3/13/24, indicated Resident R99 provided the following statement, I put my call bell on and she (NA Employee E3) came into my room at 8:30 a.m. and turned it off and stated, I'll be back. She never came back until 1:30 p.m. to change my brief. I sat in my poop 5 hours. She changed my brief and left me in my bed with only a brief on. I was cold and she never came back in after the 1:30 p.m. brief change. Another person answered my call light and covered me up. I feel I sat too long in my brief with poop in it.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of investigation documents dated 3/13/24, indicated NA Employee E3 stated that Resident R99 put his call bell on for assistance on 3/12/24, around 12:15 p.m. when lunch trays had arrived. Resident R99 requested to be changed as he had a bowel movement. NA Employee E3 did not recall Resident R99 putting on his call bell at any other time during that shift. NA Employee E3 recalled that she had checked in on Resident R99 a couple of times during her shift and he did not need assistance. The last time she checked on him was at 10:00 a.m. and his brief ws clean and dry. At 1:30 p.m. NA Employee E3 entered Resident R99's room with NA Employee E4 and changed Resident R99. He was soiled with a bowel movement and required a change of his gown and sheets. NA Employee E3 and NA Employee E4 entered another residents room and when they came out of that room there were multiple people in the hall and they were talking about the fact that Resident R99 was upset he didn ' t have a gown on or have a sheet. NA Employee E3 remembered that she had forgotten to take them back to Resident R99 after he had been changed.<br><br>During an interview on 5/3/24, at 12:12 p.m. the Assistant Director of Nursing (ADON) confirmed that the facility failed to provide services to create an environment free from neglect for one of four residents (Resident R99).<br><br>28. Pa Code 201.14(a) Responsibility of licensee.<br><br>28. Pa Code 201.18(b)(1)(e )(1) Management.<br><br>28. Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>35785<br><br>Based on review of facility policy, newly hired personnel records and staff interviews it was determined that the facility failed to conduct an FBI background check on an employee prior to working on the nursing unit for one out of five personnel records (Registered Nurse Employee E6) and failed to properly screen an employment by completing a State background check prior to hire for one out of five personnel records (Dietary Aide Employee E17).<br><br>Findings include:<br><br>The facility Abuse: Protection from Abuse policy dated 1/23/23 and 2/1/24, indicated that the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. The facility shall have processes in place to include screening, training, prevention, identification, protection, investigation, reporting and response to allegation of potential or actual abuse and neglect. Our facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals. Screening-protocols for conducting employment background checks; background checks include State Criminal and Federal Criminal (if applicable).<br><br>Review of Registered Nurse Employee E6's personnel record indicated she was hired on 1/23/24.<br><br>Review of Registered Nurse Employee E6's personnel record revealed resident has not lived in Pennsylvania for two consecutive years and indicated a home address that was out of the state.<br><br>Review of Registered Nurse Employee E6's personnel record did not reveal that a FBI background check and fingerprint check was completed prior to her start date of employment.<br><br>During an interview on 5/2/24, at 1:40 p.m. Human Resource Employee E18 stated, They do not show me proof that they did the FBI background check prior to their date of hire, we just get the results sent to us.<br><br>During an interview on 5/2/24, at 2:05 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to conduct an FBI background check on Registered Nurse Employee E6 prior to her working on the nursing unit as required.<br><br>Review of Dietary Aide Employee E17's personnel record indicated she was hired 2/16/24.<br><br>Review of Dietary Aide Employee E17's personnel record did not include a state criminal background check prior to her date of hire.<br><br>During an interview on 5/2/24, at 1:32 p.m. Human Resource Employee E18 stated, I was off on medical leave and when I came back, I noticed it wasn ' t completed so I did it.<br><br>During an interview on 5/2/24, at 2:05 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to properly screen Dietary Aide Employee E17 by completing a state criminal background check prior to hire as required.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 28 Pa Code: 201.14(a) (c)(d)(e) Responsibility of licensee<br><br>28 Pa Code 201.18(b)(1)(2)(e)(1) Management.<br><br>28 Pa Code: 201.19 Personnel policies and procedures<br><br>28 Pa Code: 201.20 (a)(b)(c)(d) Staff development<br><br>28 Pa Code: 201.29 (d) Resident Rights |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on review of facility policy, resident clinical record, reports submitted to the State, and staff interview it was determined that the facility failed to report two allegations of abuse for one of three sampled residents (Resident R67).<br><br>Findings include:<br><br>The facility Abuse:Protection from Abuse policy dated 1/23/23 and 2/1/24, indicated that the resident have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. The facility shall have processes in place to include screening, training, prevention, identification, protection, investigation, reporting and response to allegations of potential or actual abuse or neglect.<br><br>The facility Abuse Reporting and Investigation policy dated 1/23/23 and 2/1/24, indicated that the facility will thoroughly investigate all reports of suspected or alleged abuse (mental, physical, sexual, involuntary seclusion or misappropriation of resident property), neglect or exploitation. The Department of Health will be notified of the alleged event via Electronic Reporting System (ERS) per regulation. Provider Bulletin 22 (PB22) will be completed and forwarded to the Department of Health within 5 working days of the incident.<br><br>Review of Resident R67's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R67's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/3/24, indicated diagnosis of osteoarthritis (degeneration of the joint causing pain and stiffness), depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).<br><br>During an interview on 4/29/24, at 1:40 p.m. Resident R67 stated that she had arranged with a certified nurse aide that she will get ready for bed around ten o'clock p.m. per her choice this past Friday or Sunday.<br><br>During an interview on 4/29/24, at 1:45 p.m. Resident R67 stated, I'm afraid of retaliation but I'll tell you. This weekend, Friday or Sunday an aide told me that I would either have to get cleaned up now or you will have to stay wet. The aide allegedly told Resident R67, Don ' t tell us how to do our job. Resident R67 stated, It's scary. Resident stated that she was not ready for care to be provided at this time.<br><br>During an interview on 4/29/24, at 2:21 p.m. the Nursing Home Administrator (NHA) and Director of Nursing was made aware of allegation from 4/29/24.<br><br>Review of Resident R67 clinical record on 4/30/24, at 1:07 p.m. indicated that on 10/2/23, resident was upset and shaken. Resident was insulted by staff member calling her fat because her legs rub and she doesn't move. Staff member told her that she can roll over independently, but she is just too lazy too.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/30/24, at 1:12 p.m. the Director of Nursing was made aware of allegation from 10/2/23.<br><br>During an interview on 5/3/24, at 12:00 p.m. the facility failed to provide evidence to indicate the abuse allegations from 4/29/24 and 4/30/24 were reported to the local State field office.<br><br>During an interview on 5/3/24, at 2:13 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to report two allegations of abuse for one of three sampled residents (Resident R67).<br><br>28 Pa Code: 201.14 (a)(c )(e ) Responsibility of management<br><br>28 Pa Code: 201.18 (b)(1) (e)(1) Management. |

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| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on review of facility policy, clinical records, reports submitted to the state, and staff interviews, it was determined that the facility failed to conduct a thorough investigation to rule out abuse for one of three residents (Resident R67).<br><br>Findings include:<br><br>The facility Abuse: Protection from Abuse policy dated 1/23/23 and 2/1/24, indicated that the resident have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. The facility shall have processes in place to include screening, training, prevention, identification, protection, investigation, reporting and response to allegations of potential or actual abuse or neglect.<br><br>The facility Abuse Reporting and Investigation policy dated 1/23/23 and 2/1/24, indicated that the facility will thoroughly investigate all reports of suspected or alleged abuse (mental, physical, sexual, involuntary seclusion or misappropriation of resident property), neglect or exploitation. The Department of Health will be notified of the alleged event via Electronic Event Reporting System (ERS) per regulation. Provider Bulletin 22 (PB22) will be completed and forwarded to the Department of Health within 5 working days of the incident.<br><br>Review of Resident R67's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R67's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/3/24, indicated diagnosis of osteoarthritis (degeneration of the joint causing pain and stiffness), depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).<br><br>During an interview on 4/29/24, at 1:40 p.m. Resident R67 stated that she had arranged with a certified nurse aide that she will get ready for bed around ten o'clock p.m. per her choice this past Friday or Sunday.<br><br>During an interview on 4/29/24, at 1:45 p.m. Resident R67 stated, I'm afraid of retaliation but I'll tell you. This weekend, Friday or Sunday an aide told me that I would either have to get cleaned up now or you will have to stay wet. The aide allegedly told Resident R67, Don ' t tell us how to do our job. Resident R67 stated, It's scary. Resident stated that she was not ready for care to be provided at this time.<br><br>During an interview on 4/29/24, at 2:21 p.m the Administrator and Director of Nursing was made aware of allegation from 4/29/24.<br><br>Review of Resident R67 clinical record on 4/30/24, at 1:07 p.m. indicated that on 10/2/23, resident was upset and shaken. Resident was insulted by staff member calling her fat because her legs rub and she doesn't move. Staff member told her that she can roll over independently, but she is just too lazy too.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

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| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/30/24, at 1:12 p.m. the Director of Nursing was made aware of allegation from 10/2/23.<br><br>During an interview on 5/3/24, at 12:00 p.m. the Director of Nursing failed to provide investigations for reported abuse allegations from 4/29/24 and 4/30/24.<br><br>During an interview on 5/3/24, at 2:13 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to conduct a thorough investigation to rule out abuse for one of three residents (Resident R67) as required.<br><br>28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee.<br><br>28 Pa. Code 201.18(e)(1) Management. |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five out of seven residents sampled with facility-initiated transfers (Residents R30, R57, R59 R75, and R87).<br><br>The findings include:<br><br>Review of Resident R30's clinical record indicated the resident was admitted to the facility on [DATE].<br><br>Review of Resident R30's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).<br><br>Review of Resident 30's clinical record revealed that the resident was transferred to the hospital on 4/27/24 and returned to the facility on [DATE], same day.<br><br>Review of Resident R30's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.<br><br>Review of the clinical record indicated Resident R57 was admitted to the facility on [DATE].<br><br>Review of Resident R57's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension, and stroke (an event that occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts).<br><br>Review of Resident R57's clinical record revealed that the resident was transferred to the hospital on 1/6/24, and returned on 1/8/24<br><br>Review of Resident R57's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.<br><br>Review of clinical record indicated that Resident R59 was admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 59's MDS dated [DATE], indicated diagnoses of diabetes, high blood pressure, and dysphagia (difficulty swallowing).<br><br>Review of Resident 59's clinical record revealed that the resident was transferred to the hospital on 12/22/23, and returned on 12/24/23.<br><br>Review of Resident R59's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.<br><br>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].<br><br>Review of Resident R75's MDS dated [DATE], indicated diagnoses hypertension, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).<br><br>Review of Resident R75's clinical record revealed that the resident was transferred to the hospital on 3/9/24 returned to the facility on [DATE].<br><br>Review of Resident R75's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.<br><br>Review of the clinical record indicated Resident R87 was admitted to the facility on [DATE].<br><br>Review of Resident R87's MDS dated [DATE], indicated diagnoses of depression, and, heart failure (a progressive heart disease that affects pumping action of the heart muscles).<br><br>Review of Resident R87's clinical record revealed that the resident was transferred to the hospital on 10/31/23 returned to the facility on [DATE].<br><br>Review of Resident R87's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.<br><br>During an interview on 5/1/24, at 9:36 a.m. the Director of Nursing (DON) stated, they send information in a packet, but they don't specifically document what they send.<br><br>During an interview on 5/1/24, at 2:03 p.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for five out of five residents sampled with facility-initiated transfers (Residents R30, R57, R59, R75, and R87).<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident/resident representative and/or the representative of the Office of the State Long-Term Care Ombudsman of resident transfers, in writing, to include to include the following: the reason for the transfer or discharge, date of transfer, location of transfer, statement of the resident's appeal rights, and name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman for five of seven resident records reviewed (Resident R30, R57, R59, R75, and R87)<br><br>Findings Include:<br><br>Review of Title 42 Code of Federal Regulations S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br><br>(i) The reason for transfer or discharge;<br><br>(ii) The effective date of transfer or discharge;<br><br>(iii) The location to which the resident is transferred or discharged ;<br><br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br><br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br><br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br><br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>Review of Resident R30's clinical record indicated the resident was admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R30's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).<br><br>Review of Resident 30's clinical record revealed that the resident was transferred to the hospital on 4/27/24 and returned to the facility on [DATE], same day.<br><br>Review of Resident R30's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the resident/resident representative and or Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>Review of the clinical record indicated Resident R57 was admitted to the facility on [DATE].<br><br>Review of Resident R57's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension, and stroke (an event that occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts).<br><br>Review of Resident 57's clinical record revealed that the resident was transferred to the hospital on 1/6/24, and returned on 1/8/24.<br><br>Review of Resident R57's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the resident/resident representative and or Office of Long-Term Care Ombudsman for the hospitalization on [DATE]<br><br>Review of clinical record indicated that Resident R59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's MDS dated [DATE], indicated diagnoses of diabetes, high blood pressure, and dysphagia (difficulty swallowing).<br><br>Review of Resident 59's clinical record revealed that the resident was transferred to the hospital on 12/22/23, and returned on 12/24/23.<br><br>Review of Resident R59's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the resident/resident representative and or Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].<br><br>Review of Resident R75's MDS dated [DATE], indicated diagnoses hypertension, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).<br><br>Review of Resident R75's clinical record revealed that the resident was transferred to the hospital on 3/9/24 returned to the facility on [DATE].<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R75's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the resident/resident representative and or Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>Review of the clinical record indicated Resident R87 was admitted to the facility on [DATE].<br><br>Review of Resident R87's MDS dated [DATE], indicated diagnoses of depression, diabetes, and heart failure (a progressive heart disease that affects pumping action of the heart muscles).<br><br>Review of Resident R87's clinical record revealed that the resident was transferred to the hospital on 10/31/23 returned to the facility on [DATE].<br><br>Review of Resident R87's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the resident/resident representative and or Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>During an interview on 5/2/24, at 9:22 a.m. Director of Nursing confirmed that the facility failed to notify the resident/resident representative and or the representative of the Office of the State Long-Term Care Ombudsman of resident transfers in writing for five of seven residents (Resident R30, R57, R59, R75, and R87).<br><br>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on review of facility documents, clinical records, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for one of seven resident hospital transfers (Resident R57).<br><br>Findings Include:<br><br>Review of the Admission Packet which is provided to residents upon admission, it was indicated that before the facility transfers a resident to the hospital or the resident goes on therapeutic leave, the facility shall provide written notice to Resident or Resident Representative.<br><br>Review of the clinical record indicated Resident R57 was admitted to the facility on [DATE].<br><br>Review of Resident R57's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/8/24, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension (high blood pressure in the arteries) and stroke (an event that occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts).<br><br>Review of Resident R57's clinical record revealed that the resident was transferred to the hospital on 1/6/24.<br><br>Review of Resident R57's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/6/24.<br><br>During an interview on 5/2/24, at 9:22 a.m. Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for Resident R57's hospital transfer.<br><br>28 Pa. Code: 201.29(b)(d)(j) Resident rights. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on review of the Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for three of six sampled residents (Resident R3, R21, and R37).<br><br>Findings include:<br><br>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated indicated the following instructions: Section K - Swallowing/Nutritional Status: base weight on the most recent measure in the last 30 days. If the last recorded weight was taken more than 30 days prior to the Assessment Reference Date (ARD) of this assessment or previous weight is not available, weigh the resident again. Section O-Hospice care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.<br><br>The facility Resident assessment minimum data set policy dated 2/1/24, indicated that the facility will conduct initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity under the direction of a designated registered nurse. The assessment will accurately reflect the resident's status assuring that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas.<br><br>Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].<br><br>Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/11/24, indicated active diagnosis of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness. Review of Section K: Swallowing/Nutritional Status, Question K0200 Height and Weight indicated Resident R3's documented weight was 193 pounds. Review of the clinical record indicated Resident R3's last documented weight was 193 pounds on 2/2/24.<br><br>During an interview on 5/2/24, at 1:10 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E2 confirmed that Resident R3's weight from 2/2/4, was used to complete her MDS dated [DATE], due to a more recent weight not being documented in the medical record.<br><br>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].<br><br>Review of Resident R21's MDS dated [DATE], indicated diagnoses of cancer, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic pain. Section K0200 Weight indicated Resident R21's weight was 115 pounds. Review of Resident R21's clinical record indicated Resident R21's last docuemnted weight was 115 pounds on 2/1/24<br><br>(continued on next page) |

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|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/2/24, at 12:59 p.m. LPNAC Employee E2 confirmed that the facility failed to weigh Resident R21 monthly and to ensure that MDS assessments accurately reflect Resident R21's weight status.<br><br>Review of Resident R37's admission record indicated she was originally admitted on [DATE].<br><br>Review of Resident R37's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 3/1/24, indicated she had diagnoses that included schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms), dementia (loss of cognitive function, thinking, remembering, and reasoning), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and hypothyroidism (decrease in production of thyroid hormone). The assessment indicated that these diagnoses were the most recent upon review.<br><br>Review of Resident R37's care plans dated 12/11/23, indicated that Resident R37 was on hospice.<br><br>Review of Resident R37's physician order dated 12/5/23, indicated to admit to hospice.<br><br>Review of Resident R37's clinical nurse notes dated 2/1/24, 3/25/24, and 4/22/24, indicated that she was receiving hospice services.<br><br>Review of Resident R37's MDS assessment dated [DATE], Section O-Hospice care was left blank, indicating she was not receiving hospice services during the look back period.<br><br>During an interview on 5/1/24, at 10:48 a.m. the Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E2 confirmed that the facility failed to ensure that MDS assessments accurately reflected the resident's status for Resident R37 as required.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on review of facility policies and job descriptions, clinical records, and staff interviews, it was determined that the facility failed to adhere to acceptable standards of practice related to participation in interdisciplinary meetings for 12 of 12 months, and completion of Nutrition Assessments by the Registered Dietitian for two of eight residents reviewed (Residents R21 and R59).<br><br>Findings include:<br><br>The Pennsylvania Code, Title 49, Chapter 21, Professional and Vocational Standards: Responsibilities of the Licensed Dietitian/ Nutritionist Section 21.711 Professional Conduct indicated that the Licensed Dietitian/ Nutritionist shall provide information which will enable patients to make their own informed decisions regarding nutrition and dietetic therapy, including the reasonable expectations of the professional relationship.<br><br>Review of facility policy Resident Weights, dated 2/1/24, indicated that the facility will identify residents at risk for significant weight change and ensure uniform tracking and reporting of resident weights. Monthly weights will be obtained weekly times four weeks following admission/readmission and monthly thereafter. The licensed nurse will notify the Interdisciplinary Team for further assessment.<br><br>Significant weight loss is defined as:<br><br>5% or greater in one month<br><br>7.5% or greater in three months<br><br>10% or greater in six months.<br><br>Review of Registered Dietitian's Job Description revealed that the purpose of Registered Dietitian's job position is to implement, coordinate and evaluate the medical nutrition therapy for the residents, provide resident and family education, provide nutritional assessment and consultation to assist in planning, organizing and directing the food and nutritional services of the facility. Registered Dietitian must interpret and evaluate information on a patient's chart and make recommendations for appropriate medical nutrition therapy.<br><br>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].<br><br>Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/24, indicated diagnoses of cancer, dementia (a group of symptoms that affects memory , thinking and interferes with daily life), and chronic pain.<br><br>Review of Resident R21's clinical record conducted on 4/30/24, revealed that Resident R21 was weighed on 2/1/24 at 115 pounds which reflected a significant weight loss of 10.2% in six months, and that Resident R21 had not been weighed since the 2/1/24/ weight was obtained.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R21's clinical record conducted on 4/30/24, revealed that Resident R21's February weight loss was not addressed in February by the Registered Dietitian (RD) Employee E10.<br><br>Review of clinical record indicated that Resident R59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's MDS dated [DATE], indicated diagnoses of diabetes (high sugar level in the blood), high blood pressure, and dysphagia (difficulty swallowing). Section K0520:- Nutritional Approaches, Therapeutic diet was checked, indicating that While a Resident in the past seven days, this nutritional approach was performed.<br><br>Review of Resident R59's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status and therapeutic diet captured by MDS dated [DATE].<br><br>During an interview on 5/2/24, at 12:59 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E2 confirmed that the facility failed to timely assess Resident R21's significant weight loss, and failed to timely assess the nutritional status of Resident R59.<br><br>During a telephone interview on 5/3/24, at 10:39 a.m. RD Employee E10 stated that she began working at the facility one year ago when the census was 70 residents, but that the census has been climbing over the past several months and is now 104. RD Employee E10 confirmed that she is the only employee who performs clinical nutrition evaluations, and addresses weight loss at the facility. RD Employee E10 also stated that she comes into the facility on e day per week, as she has a full time job in another facility and works part-time in a third facility. RD Employee E10 confirmed that not all nutritional evaluations are completed as required in a timely manner. RD Employee E10 also stated that since she is only in the facility one time per week, she does not participate in residents' care conferences or interdisciplinary team meetings. RD Employee E10 also confirmed that she does not always perform admission evaluations in person but that she has completed them remotely without having spoken to the residents.<br><br>During an interview on 5/3/24, at 11:41 a.m. Nursing Home Administrator confirmed that the facility failed to adhere to acceptable standards of practice related to participation in interdisciplinary meetings for 12 of 12 months, and completion of Nutrition Assessments by the Registered Dietitian for two of eight residents reviewed (Residents R21, and R59).<br><br>28 Pa. Code: 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code: 211.12(d)(1) Nursing Services. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on review of facility policy, clinical record review, a resident council group interview, resident and staff interviews, it was determined that the facility failed to make certain that showers were consistently provided and failed to provide adequate hygienic care for eight out of 12 sampled residents (Resident R30, R50, R63, R67 R75, R87, R311, and R312 ).<br><br>Findings include:<br><br>The facility Flow of care policy dated 2/1/24, indicated that residents are to have two baths or showers per week unless the resident states otherwise.<br><br>Review of Resident R30's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R30's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/2/24, indicated diagnosis of hypertension (high blood pressure in the arteries), multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures.<br><br>Review of Resident R30's care plans dated 8/24/20, indicated to monitor skin during baths and showers as scheduled.<br><br>Review of Resident R30's shower documentation dated April 2024, indicated no showers were provided for April 2024.<br><br>Review of Resident R50's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R50's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/7/24, indicated diagnosis of hypertension (high blood pressure in the arteries), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat).<br><br>Review of Resident R50's shower documentation dated April 2024, indicated only two showers in April 2024 (4/9/24 and 4/23/24).<br><br>During an observation, on 4/30/24, at 1:42 p.m. Resident R50 was sitting in wheelchair with facial hair on her chin.<br><br>Review of Resident R63's admission record indicated she was admitted on [DATE].<br><br>Review of Resident R63's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/9/24, indicated she had diagnoses that included hyperlipidemia (elevated lipid levels within the blood), hypothyroidism (decrease in production of thyroid hormone), and chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination).<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R63's care plans dated 1/17/24, indicated to monitor skin during showers and baths.<br><br>Review of Resident R63's shower documentation dated April 2024, indicated only two showers in April 2024 (4/1/24 and 4/5/24).<br><br>During a resident interview on 4/29/24, at 10:18 a.m. Resident R63 stated the following: i am only getting showers once a week.<br><br>Review of Resident R67's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R67's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/3/24, indicated diagnosis of osteoarthritis (degeneration of the joint causing pain and stiffness), depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).<br><br>Review of Resident R67's care plans dated 2/15/24, indicated provide a sponge bath when a full bath or shower cannot be tolerated.<br><br>Review of Resident R67's shower documentation dated April 2024, indicated no showers were provided for April 2024.<br><br>Review of Resident R67's clinical record on 5/1/24, the facility failed to provide documentation that the resident could not tolerate a shower for April 2024.<br><br>Review of Resident R75's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R75's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/21/24, indicated diagnosis of hypertension, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).<br><br>Review or Resident R75's care plans dated 4/28/24, indicated to provide a sponge bath when a full bath or shower can not be tolerated.<br><br>Review of Resident R75's shower documentation dated April 2024, indicated no showers were provided for April 2024.<br><br>Review of Resident R75's clinical record on 5/1/24, the facility failed to provide documentation that the resident could not tolerated a shower for April 2024.<br><br>During an observation, on 4/29/24, at 11:19 a.m. Resident R75 was sitting at the side of bed with facial hair on her chin.<br><br>During an interview on 5/1/24, at 9:33 a.m. Resident R75 stated she would like her facial hair trimmed and does not like it.<br><br>Review of Resident R87's clinical record indicated she was admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R87's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/1/24, indicated diagnosis of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart failure (a progressive heart disease that affects pumping action of the heart muscles).<br><br>Review of Resident R87's care plans dated, 10/11/23 That nails should always be cut straight across, never cut corners. File rough edges with emery board.<br><br>Review of Resident R 87's shower documentation dated April 2024, indicated no shower were provided for April 2024.<br><br>During an observation, on 4/29/24, at 1:04 p.m. Resident R87 was laying in bed with facial hair on her chin, her fingernails were long with discoloration and her hair was unkempt.<br><br>During an interview on 5/1/24, at 10:03 a.m. Resident R87 stated the following, I haven't gotten a shower for a while, I haven't gotten my hair washed and look at these fingernails, they are so long.<br><br>During an interview on 5/1/24, at 10:05 a.m. Resident R87 stated she would love to get her facial hair trimmed.<br><br>Review of Resident R311's clinical record indicated he was admitted to the facility on [DATE].<br><br>Review of Resident R311's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/24/24, indicated diagnosis of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension, and osteomyelitis (inflammation of bone caused by infection).<br><br>Review or Resident R311's care plans dated 4/23/24, indicated to monitor skin during baths and showers as scheduled.<br><br>Review of Resident R311's shower documentation dated April 2014, indicated no showers have been provided since date of admission on 4/19/24.<br><br>During an interview on 4/29/24, at 11:30 a.m. Resident R311 stated the following. I haven't gotten a shower since I got here.<br><br>Review of Resident R312's clinical record indicated he was admitted to the facility on [DATE].<br><br>Review of Resident R311's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/15/24, indicated diagnosis of dysphagia (difficult swallowing), orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down) and, hyperlipidemia (an abnormally high concentration of fats or lipids in the blood).<br><br>Review of Resident 312's care plans dated 4/9/24, indicated to monitor skin during baths and showers as scheduled.<br><br>(continued on next page) |

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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R312's shower documentation dated April 2014, indicated no showers have been provided since date of admission on 4/9/24.<br><br>During a resident council group interview on 4/30/24, at 1:00 p.m. two out of eight residents voiced concerns with receiving shower twice a week.<br><br>During an interview on 5/2/24, at 9:32 a.m. Licensed Practical Nurse (LPN) Employee E5 stated: there are shower logs in the shower rooms and the showers are documented in the computer.<br><br>During observations on 5/2/24, at 9:35 a.m. observations of the shower rooms on the 400 hall and the 200 hall found no shower logs in the shower rooms.<br><br>During an interview on 5/2/24, at 2:11 p.m. the Director of Nursing (DON) confirmed that the facility failed to make certain that showers were consistently provided and failed to provide adequate hygienic care for eight out of 12 sampled residents (Resident R30, R50, R63, R67 R75, R87, R311, and R312 ) as required.<br><br>28 Pa. Code 211.12(d)(5) Nursing services. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on facility policy, clinical record review, resident observation, and staff interviews, it was determined that the facility failed to follow physician's orders for one of two residents (Resident R311).<br><br>Findings include:<br><br>Review of facility policy, Medication and Treatment Orders, dated 2/1/24 indicate each medication administered will have a corresponding and complete physician ' s order.<br><br>Review of facility policy, Treatment and services, dated 2/1/24 indicate based on the comprehensive assessment of a resident, the facility must ensure that a resident is given the appropriate treatment and services to maintain or improve his or her abilities.<br><br>Review of Resident R311's clinical record indicated he was admitted to the facility on [DATE].<br><br>Review of Resident R311's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 4/24/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension (high blood pressure in the arteries) and osteomyelitis (inflammation of bone caused by infection).<br><br>Review of Resident R311's active physician order dated 4/19/23, indicated change PICC (a type of long catheter that is inserted through a peripheral vein, often in the arm, into a larger vein in the body used when intravenous treatment is required over a long time) line dressing every day shift, every seven days for catheter care.<br><br>Review of Resident R311's care plan, dated 4/23/24 indicated dressing change per physician order.<br><br>During an observation on 5/1/24, at 10:57 a.m. Resident R311's PICC line dressing was dated 4/23/24.<br><br>Review of Resident R311's clinical record on 5/1/24, at 12:20 p.m. failed to provide documentation from a licensed nurse that the treatment was completed and signed on the Treatment Administration Record (TAR) on 4/30/24.<br><br>During an interview on 5/1/24, at 12:38 p.m. Licensed Practical Nurse (LPN) Employee E8, confirmed the PICC line dressing was dated 4/23/24 on Resident R311's arm.<br><br>During an interview on 5/1/24, 12:47 p.m. Director of Nursing confirmed the facility failed to follow physician ' s orders for one of two residents (Resident R311).<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 201.18(a)(b)(3) Management.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546<br><br>Based on review of facility policies, clinical records, facility documents and staff interview, it was determined that the facility failed to ensure that residents received neurological assessment after an incident involving a fall for four of nine residents (Residents R8, R12, R30, and Resident R87).<br><br>Findings include:<br><br>Review of facility policy Falls Protocol dated 2/1/24, indicated residents experiencing an actual fall will have an immediate assessment by nursing and medical attention will be obtained as needed. Falls that involve a possible head injury will have neurological checks performed and documented.<br><br>Review of facility policy Neurological Checks dated 2/1/24, indicated neurological checks shall be performed following an unwitnessed fall or known head injury. Neurological checks should be performed periodically for at least 72 hours. Neurological checks shall be documented on the designated record.<br><br>Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].<br><br>Review of Resident R8's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/11/24, indicated diagnoses of hypertension (high blood pressure in the arteries), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression.<br><br>Review of a nursing progress note dated 2/26/24, indicated Resident R8 was observed sitting on the floor beside her bed. She was unclear if she hit her head. Assisted back to bed. Neuro checks initiated.<br><br>Review of the clinical record failed to reveal a neurological assessment was performed for 72 hours following Resident R8's unwitnessed fall on 2/26/24.<br><br>During an interview on 5/3/24, at 10:51 a.m. the Assistant Director of Nursing (ADON) confirmed that the facility did not perform a neurological assessment for 72 hours after Resident R8's unwitnessed fall on 2/26/24.<br><br>Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE].<br><br>Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/8/24, indicated diagnosis of high blood pressure, muscle weakness, and dependence on supplemental oxygen.<br><br>Review of a nursing progress note dated 4/7/24, indicated Resident R12 was found on the floor by a staff member. Four staff members were required to move Resident R12 away from the bed. Resident R12 was assessed and placed into a chair using a mechanical lift.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the clinical record failed to reveal a neurological assessment was performed for 72 hours following Resident R12's unwitnessed fall on 4/7/24.<br><br>During an interview on 5/3/24, at 10:51 a.m. the Assistant Director of Nursing (ADON) confirmed that the facility did not perform a neurological assessment for 72 hours after Resident R12's unwitnessed fall on 4/7/24.<br><br>Review of a nursing progress note dated 4/23/24, indicated Resident R12 was found face down on the floor on a fall mat. Neuro checks were initiated and family and the physician were made aware of the fall.<br><br>Review of the clinical record failed to reveal a neurological assessment was performed for 72 hours following Resident R12's unwitnessed fall on 4/23/24.<br><br>During an interview on 5/3/24, at 10:51 a.m. the ADON confirmed that the facility did not perform a neurological assessment for 72 hours after Resident R12's unwitnessed fall on 4/23/24.<br><br>Review of the clinical record indicated Resident R30 was admitted to facility on 2/26/24.<br><br>Review of Resident R30's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/2/24, indicated diagnosis of hypertension (high blood pressure in the arteries), multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures.<br><br>Review of a nursing progress note dated 4/27/24, indicated Resident R30 was observed face down on the floor beside her bed. Resident was turned on her back. Nursing noticed a laceration above her eye. Resident was assisted back into bed. Resident was sent to emergency room and returned with stitches on her eye brow.<br><br>Review of the clinical record failed to reveal a neurological assessment was performed for 72 hours following Resident R30's unwitnessed fall on 4/27/24.<br><br>During an interview on 5/3/24, at 10:51 a.m. the ADON confirmed that the facility did not perform neurological assessment for 72 hours after Resident R30's unwitnessed fall on 4/27/24.<br><br>Review of clinical record indicated Resident R87 was admitted to the facility on [DATE].<br><br>Review of Resident R87's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/1/24, indicated diagnosis of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart failure (a progressive heart disease that affects pumping action of the heart muscles).<br><br>Review of a nursing progress note dated 3/1/24, indicated Resident R87 was found sitting on the bathroom floor. Resident stated I slipped. Resident unable to describe how fall happened. Resident assessed. No injuries noted. Resident assisted back to bed and placed call bell within reach.<br><br>Review of the clinical record failed to reveal a neurological assessment was performed for 72 hours following Resident R87's unwitnessed fall on 3/1/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/3/24, at 10:51 a.m. the ADON confirmed that the facility did not perform a neurological assessment for 72 hours after Resident 87's unwitnessed fall on 3/1/24.<br><br>During an interview on 5/3/24, at 10:51 a.m. the ADON confirmed that the facility failed to ensure that residents received neurological assessment after an incident involving a fall for four of nine residents (Resident R8, R12, R30, and R87).<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 201.18(e)(1) Management.<br><br>28 Pa. Code: 207.2(a) Administrator's responsibility.<br><br>28 Pa. Code: 211.10(d) Resident care policies. |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based a review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that weights were monitored for two of nine residents (Resident R21, and R50), failed to timely assess the nutritional status for two of four residents (Resident R21, and R59), and failed to provide nutritional supplements as ordered for weight loss for one of two residents ( Resident R50).<br><br>Findings include:<br><br>Review of facility policy Resident Weights, dated 2/1/24, indicated that the facility will identify residents at risk for significant weight change and ensure uniform tracking and reporting of resident weights. Monthly weights will be obtained weekly times four weeks following admission/readmission and monthly thereafter. The licensed nurse will notify the Interdisciplinary Team for further assessment.<br><br>Review of facility policy Nutriton Management, dated 2/1/24, indicated that based on a resident's comprehensive assessment, the facility will ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible and receives a therapeutic diet when there is a nutritional problem. Suggested parameters for evaluating significance f unplanned weight loss are:<br><br>Significant weight loss is defined as:<br><br>5% or greater in one month<br><br>7.5% or greater in three months<br><br>10% or greater in six months.<br><br>In evaluating weight loss, the dietitian will consider the resident's usual weight through adult life, and the potential for weight loss to any medical conditions.<br><br>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].<br><br>Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/24, indicated diagnoses of cancer, dementia (a group of symptoms that affects memory , thinking and interferes with daily life), and chronic pain.<br><br>Review of Resident R21's clinical record conducted on 4/30/24, revealed that Resident R21 was weighed on 2/1/24 at 115 pounds which reflected a significant weight loss of 10.2% in six months, and that Resident R21 had not been weighed since the 2/1/24/ weight was obtained.<br><br>Review of Resident R21's clinical record conducted on 4/30/24, revealed that Resident R21's February weight loss was not addressed in February by the Registered Dietitian (RD) Employee E10.<br><br>(continued on next page) |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R50's clinical record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R50's MDS dated [DATE], indicated diagnosis of hypertension (high blood pressure), dementia, and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat).<br><br>Review of Resident R50 's care plan initiated on 3/28/24, indicated to monitor weights.<br><br>Review of Resident R50's progress note dated 10/28/23, at 20:58 indicate a weight of 150.5# was recorded for resident for the month of October. This alerts as a -7.5% change [ Comparison Weight 7/12/2023, 163.7 Lbs, -8.1% , -13.2 Lbs ]. Will recommend to begin 60cc TwoCal HN (thickened) BID at med pass. This will provide 240 kcal and 10gm protein a day.<br><br>Review of Resident R50's care plan initiated on 11/3/23, indicated to provide nutritional supplement as ordered.<br><br>Review of Resident R50's physician orders dated 3/2/24, reveal to weigh resident every month on the day sift.<br><br>Review of Resident R50's physician orders dated 11/19/23, reveal to give resident Two Cal (a nutritional supplement) three times a day with medication pass.<br><br>Review of Resident R50's clinical record on 5/2/24, at 10:53 a.m. indicated on residents medication administration record (MAR) that Two Cal supplement was unavailable on 4/2/24, 4/4/24, 4/24/24, and 4/27/24.<br><br>Review of Resident R50's clinical record on 5/2/24, at 10:55 a.m. indicated that resident was last weighed on 2/9/24.<br><br>During an phone interview on 5/3/24, at 10:39 a.m. Registered Dietician, Employee E10 stated that she was not made aware of the facililty not having TwoCal and would have made a recommendation to substitute with another supplement.<br><br>Review of clinical record indicated that Resident R59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's MDS dated [DATE], indicated diagnoses of diabetes (high sugar level in the blood), high blood pressure, and dysphagia (difficulty swallowing). Section K0520:- Nutritional Approaches, Therapeutic diet was checked, indicating that While a Resident in the past seven days, this nutritional approach was performed.<br><br>Review of Resident R59's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status and therapeutic diet captured by MDS dated [DATE].<br><br>During an interview on 5/2/24, at 12:59 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E2 confirmed that the facility failed to weigh Resident R21 monthly and to timely assess, and address Resident R21's weight loss, and failed to timely assess the nutritional status of Resident R59.<br><br>(continued on next page) |

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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

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| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a telephone interview on 5/3/24, at 10:50 a.m. RD Employee E10 confirmed that the facility failed to obtain weights monthly as per policy, that not all nutritional evaluations are completed as required in a timely manner, and failed to provide nutritional supplements as ordered for weight loss for one of two residents ( Resident R50).<br><br>28 Pa. Code: 201.18(b)(1)(e)(1) Management.<br><br>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on review of facility policy, observations, interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care and maintain respiratory equipment for three out of four sampled residents (Resident R3, R12, and R66).<br><br>Findings include:<br><br>The facility Oxygen administration policy dated 2/1/24, indicated that humidifiers should be labeled and dated with the time changed. At regular intervals, check and clean oxygen equipment, masks, tubing and nasal cannula.<br><br>Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].<br><br>Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/11/24, indicated active diagnosis of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness.<br><br>Review of a physician order dated 1/2/24, indicated to administer supplemental oxygen continuously at 2 liters per minute via a nasal cannula (a lightweight tube placed in the nostrils to deliver oxygen).<br><br>Review of a physician order dated 1/2/24, indicated to administer Ipratropium-Albuterol (a medication used to make breathing easier) 0.5-2.5 milligrams, inhale orally every six hours as needed for wheezing and/or shortness of breath.<br><br>Review of a physician order dated 4/16/24, indicated to change oxygen tubing, change humidification bottle, and cleanse oxygen filter every night shift every Saturday.<br><br>During an observation on 4/29/24, at 10:11 a.m. Resident R3 was observed receiving oxygen at 3 liters per minute via a nasal cannula. A nebulizer machine was located on Resident R3's bedside table. No date was present on the nebulizer tubing and the aerosol face mask was stored inside of an open box of gauze dressings.<br><br>During an interview on 4/29/24, at 10:39 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed there was no date on Resident R3's nebulizer tubing and the aerosol mask was improperly stored in an open box of gauze dressings.<br><br>Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE].<br><br>Review of Resident R12's MDS dated [DATE], indicated diagnosis of high blood pressure, muscle weakness, and dependence on supplemental oxygen.<br><br>Review of a physician order dated 10/1/22, indicated to administer oxygen at 2 liters via a nasal cannula as needed for shortness of breath or oxygen saturation less than 90%.<br><br>(continued on next page) |

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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

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| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a physician order dated 6/4/23, indicated to change oxygen tubing, change humidification bottle, and cleanse oxygen filter every night shift every Saturday.<br><br>During an observation on 4/29/24, at 10:16 a.m. Resident R12 was observed receiving oxygen at 3 liters per minute via a nasal cannula. The humidifier bottle connected to the oxygen concentrator was empty and dated 4/14/24.<br><br>During an interview on 4/29/24, at 10:40 a.m. LPN Employee E1 confirmed that Resident R12's humidifier bottle was empty and dated 4/14/24.<br><br>Review of Resident R66's admission record indicated she was admitted on [DATE].<br><br>Review of Resident R66's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/7/24, indicated she had diagnoses that included chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), peripheral vascular disease (a progressive narrowing of the blood vessels impacting blood flow to the limbs), dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning).<br><br>Review of Resident R66's care plan dated 12/6/23, indicated that she is receiving oxygen therapy, change oxygen tubing, change humidification bottle and provide maintenance for oxygen equipment.<br><br>Review of Resident R66's physican order dated 5/17/22, indicated to administer oxygen at 2-Liters via nasal cannula every shift for Shortness of breath (SOB).<br><br>Review of Resident R66's physician order dated 4/16/24, indicated to change oxygen tubing, Change humidification bottle, cleanse oxygen filter, inspect easy foam wraps (replace if soiled of missing) every night shift every Saturday for Maintenance of oxygen equipment.<br><br>During observations on 4/29/24, at 10:19 a.m. Resident R66 was observed sitting in her room. Her oxygen nasal canula tube was above the bridge of her nose. The humidifier water bottle connected to Oxygen concentrator was observed dated 4/14/24.<br><br>During an interview on 4/29/24, at 10:20 a.m. Nurse aide (NA) Employee E7 was brought into Resident R66 room and stated: Resident R66's water container is empty and dated 4/14/24. Its not connected to the Oxygen concentrator. Resident R66 oxygen line is dated 4/21/24. Nurses date the oxygen at night and her oxygen is not on her nose.<br><br>During an interview on 4/29/24, at 2:05 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide appropriate respiratory care and maintain respiratory equipment for Residents R3, R12, and R66 as required.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

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|---|---|
| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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|---|---|
| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on review of facility policy, resident clinical records and staff interview it was determined that the facility failed to obtain laboratory results and promptly report those results as per order for one out of two sampled residents (Resident R17).<br><br>Findings include:<br><br>The facility Laboratory services policy dated 8/2016, and last reviewed 2/1/24, indicated that laboratory studies will be obtained only when ordered by a physician. The facility will notify the physician of the results promptly and laboratory findings will be filed in the resident record. The facility will have a system to reconcile physician orders, lab orders, and results received.<br><br>Review of Resident R17's admission record indicated she was admitted on [DATE].<br><br>Review of Resident R17's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 4/10/24, indicated she had diagnoses that included major depressive disorder (a state of consistent sadness and loss of interest interfering in daily life activities), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and hematuria (blood in urine).<br><br>Review of Resident R17's care plans dated 4/16/24, indicated to obtain and monitor laboratory results as ordered and report results to a physician.<br><br>Review of Resident R17's physician orders dated 4/27/24, indicated to obtain a complete blood count (CBC) one time for infection prevention.<br><br>Review of Resident R17's physician orders dated 4/27/24, indicated to obtain an urinalysis (a urine test) one time for urinary tract infection.<br><br>Review of Resident R17's CBC lab results dated 4/27/24, indicated a high white blood cell count of 10.40.<br><br>Review of Resident R17's physician orders dated 4/27/24, indicated to administer Macrobid (antibiotic) 100mg twice a day by mouth for seven days. Resident R 17 diagnosis was a urinary tract infection.<br><br>Review of Resident R17's urinalysis results dated 4/29/24, indicated that superficial bacteria does not show a urinary tract infection.<br><br>Review of Resident R17's physician notes and clinical nurse notes did not indicate a notification to the doctor about the results of the 4/29/24 urinalysis showing Resident R17 did not have an active urinary tract infection.<br><br>(continued on next page) |

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|---|---|
| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident R17's April 2024 and May 2024 Medication Administration Record (MAR) indicated that she received Macrobid 100mg on 4/28/24, 4/29/24, 4/30/24, 5/1/24, and 5/2/24.<br><br>During an interview on 5/2/24, at 12:19 p.m. Registered Nurse (RN) Employee E6 confirmed that the facility failed to obtain laboratory results and promptly report those results as per order for Resident R17 as required.<br><br>28 Pa. Code 211.12(d)(3)(5) Nursing services. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>46167<br><br>Based on staff interviews, and review of the Food Service Director's Job description, it was determined that the facility failed to employ a full-time qualified Food Service Director for six of six months (November and December 2023, and January through April 2024).<br><br>Finding include:<br><br>Review of the facility's Food Service Director's Job Description indicated that the Food Service Director:<br><br>Must be a graduate of an accredited course in dietetic training approved by the American Dietetic Association.<br><br>Must be registered as a Food Service Director in Pennsylvania.<br><br>Must provide documentation of registry/certificate upon application for the position.<br><br>During an interview conducted at initial tour on 4/29/24, at 9:28 a.m. Food Service Director (FSD) Employee E9, stated that he was not a Certified Dietary Manager (CDM) and did not have any formal education or certificates in food service management. FSD Employee E9 stated that he has been a cook in the facility, but was promoted to FSD about six months ago. FSD Employee E9 also clarified that he is not currently enrolled in any classes to become a CDM.<br><br>During an additional interview on 4/29/24, at 9:40 a.m. FSD Employee E9 stated that the facility does employ a Registered Dietitian (RD), but that RD Employee E10 comes into the facility on ly one day per week.<br><br>During an interview on 4/29/24, at 1:45 p.m. Nursing Home Administrator (NHA) confirmed that Food Service Director Employee E23 did not possess the appropriate qualifications as required.<br><br>28 Pa. Code: 211.6(c)(d) Dietary services. |

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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

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|---|---|
| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on review of clinical records, facility policies, facility documents, and staff interviews, it was determined that the facility failed to have sufficient dietary staff to perform essential clinical duties for six out of 12 months (November and December 2023, and January through April 2024).<br><br>Findings include:<br><br>Review of facility policy Resident Weights, dated 2/1/24, indicated that the facility will identify residents at risk for significant weight change and ensure uniform tracking and reporting of resident weights. Monthly weights will be obtained weekly times four weeks following admission/readmission and monthly thereafter. The licensed nurse will notify the Interdisciplinary Team for further assessment.<br><br>Significant weight loss is defined as:<br><br>5% or greater in one month<br><br>7.5% or greater in three months<br><br>10% or greater in six months.<br><br>Review of Registered Dietitian's Job Description revealed that the purpose of Registered Dietitian's job position is to implement, coordinate and evaluate the medical nutrition therapy for the residents, provide resident and family education, provide nutritional assessment and consultation to assist in planning, organizing and directing the food and nutritional services of the facility. Registered Dietitian must interpret and evaluate information on a patient's chart and make recommendations for appropriate medical nutrition therapy.<br><br>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].<br><br>Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/24, indicated diagnoses of cancer, dementia (a group of symptoms that affects memory , thinking and interferes with daily life), and chronic pain.<br><br>Review of Resident R21's clinical record conducted on 4/30/24, revealed that Resident R21 was weighed on 2/1/24 at 115 pounds which reflected a significant weight loss of 10.2% in six months, and that Resident R21 had not been weighed since the 2/1/24/ weight was obtained.<br><br>Review of Resident R21's clinical record conducted on 4/30/24, revealed that Resident R21's February weight loss was not addressed in February by the Registered Dietitian (RD) Employee E10.<br><br>Review of clinical record indicated that Resident R59 was admitted to the facility on [DATE].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395758 | A. Building<br>B. Wing | 05/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 59's MDS dated [DATE], indicated diagnoses of diabetes (high sugar level in the blood), high blood pressure, and dysphagia (difficulty swallowing). Section K0520:- Nutritional Approaches, Therapeutic diet was checked, indicating that While a Resident in the past seven days, this nutritional approach was performed.<br><br>Review of Resident R59's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status and therapeutic diet captured by MDS dated [DATE].<br><br>During an interview on 5/2/24, at 12:59 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E2 confirmed that the facility failed to address Resident R21's weight loss, and failed to timely assess the nutritional status of Resident R59.<br><br>During a telephone interview on 5/3/24, at 10:39 a.m. RD Employee E10 stated that she began working at the facility one year ago when the census was 70 residents, but that the census has been climbing over the past several months and is now 104. RD Employee E10 confirmed that she is the only employee who performs clinical nutrition evaluations at the facility. RD Employee E10 also stated that she comes into the facility on e day per week, as she has a full time job in another facility and works part-time in a third facility. RD Employee E10 confirmed that not all nutritional evaluations are completed as required in a timely manner. RD Employee E10 also stated that since she is only in the facility one time per week she does not participate in residents' care conferences or interdisciplinary team meetings. RD Employee E10 also stated on 5/3/24, at 11:00 a.m. that she does not have enough time to address the current census in one day per week.<br><br>During an interview on 5/3/24, at 11:41 a.m. Nursing Home Administrator confirmed that the facility failed to have sufficient dietary staff to perform essential clinical duties for six out of 12 months.<br><br>28 Pa. Code: 211.6 (c) Dietary services. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>46167<br><br>Based on observations, facility menu, resident interviews, and staff interviews it was determined that the facility failed to follow the displayed menu for one of four observed meals (lunch meal 4/30/24).<br><br>Findings include:<br><br>During an interview on 4/29/24, at 12:19 p.m. Resident R59 stated that she often does not receive food items that are on her meal ticket or menu.<br><br>Review of lunch menu for 4/30/24 revealed that the vegetable was to be broccoli cuts, and that the alternative vegetables were peas, green beans, and carrots.<br><br>During an observation in the Main Dining Room on 4/30/24, at 12:46 a.m., no residents were served broccoli, but had Winter Blend vegetables (cauliflower, carrots and broccoli) instead.<br><br>Review of Resident R9, R17, R21, R58, and R210's meal tickets all indicated that they were to have received broccoli cuts, but received Winter Blend instead.<br><br>During an interview on 4/30/24, at 1:00 p.m. Food Service Director (FSD) Employee E9 stated that he was aware that broccoli was on the menu but that he did not receive it in the food delivery so he served the Winter Blend instead. When FSD Employee E9 was asked if he had approval from the Registered Dietitian to change the menu or alert residents of the change in the menu, he replied no.<br><br>During an interview on 4/30/24, at 1:01 p.m., FSD Employee E9 confirmed that facility failed to properly display and update the menu being served for the lunch meal on 4/30/24.<br><br>Pa Code: 211.6(a) Dietary services. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on a review of facility policy, observation, resident interview, and staff interview, it was determined that the facility failed to serve food products that appeared palatable for one of four meals observed (lunch meal on 4/29/24).<br><br>Findings include:<br><br>Review of facility policy Meal Service Line, dated 2/1/24, indicated that the facility will serve food that will be prepared by methods that conserve nutritive value, flavor, and appearance, and will be placed on trays in an attractive manner.<br><br>During an observation on 4/29/24, at 12:19 p.m. Resident R59 had her lunch tray in front of her, but was not eating.<br><br>During an observation on 4/29/24, at 12:19 p.m., Resident R59's meal ticket stated that she was to have received fried chicken, however, there was no fried chicken on her tray and there was a very dry, hard, and stringy appearing piece of meat.<br><br>During an interview on 4/29/24, at 12:20 p.m. Resident R59 was asked what her entree was and she replied, I think it's left over roast beef from yesterday.<br><br>During an interview in Resident R59's room on 4/29/24, at 12:47 p.m. Food Service Director (FSD) Employee E9 confirmed that Resident R59 was served leftovers from yesterday's lunch of [NAME] pot roast, and confirmed that the meat appeared to be very dry and unappetizing. FSD confirmed that the facility failed to provide food products that appeared palatable for the lunch meal on 4/29/24.<br><br>Pa Code 211.6(b)(c)(d) Dietary Services. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>46167<br><br>Based on review of facility policy, facility documents, resident interviews, meal tray observations and staff interviews, it was determined that the facility failed to provide menu selections according to the resident's preference for five out of nine residents (Resident R21, R58, R59, R88, and R210).<br><br>Findings include:<br><br>Review of the facility policy Meal Service Line last reviewed on 2/1/24, indicated that the cook will be stationed at the steam table to place foods from the wells onto the plate in accordance with the menu and resident diet order. Dining Services staff will check the tray for accuracy, cover the plate, and place the tray onto the food cart to be delivered to the floor or unit. The meal service line will be supervised and checked for quality assurance by the Dining Service Manager, Assistant Manager, Supervisor, or Dietitian.<br><br>Review of facility Grievance Log dated 3/12/24, revealed that a resident voiced concern as no one had discussed food preferences with the resident.<br><br>Review of 3/12/24, Resident Council Meeting Minutes revealed that a resident voiced concern regarding dietary preferences being honored.<br><br>Review of 4/9/24, Resident Council Meeting Minutes revealed that a resident voiced concern over not receiving milk on her tray. Another resident voiced concern that the doctor changed her diet to low carbohydrate, but continues to receive a regular diet.<br><br>During an interview on 4/29/24, at 12:19 p.m. Resident R59 stated that she often does not receive food items that are on her meal ticket or menu. Resident R59 stated that she asks for additional protein foods on her tray and that this is not always honored.<br><br>During an observation on 4/29/24, at 12:19 p.m., Resident R59's meal ticket stated that she was to receive fried chicken, however, there was no fried chicken on her tray and there was a very dry, hard, and stringy appearing piece of meat.<br><br>During an interview on 4/29/24, at 12:50 p.m Food Service Director (FSD) Employee E9 stated that the registered dietitian visits the residents for food preferences after admission.<br><br>During a lunch meal observation on 4/30/24, the following was noted:<br><br>During an interview on 4/30/24, at 12:15 p.m. Resident R88 stated Nobody asks what we like. You just get stuff.<br><br>During an observation on 4/30/24, at 12:19 p.m. Resident R21 had breaded chicken and buttered noodles on her meal ticket, but did not have either one of them on her tray. Resident R21 had lasagna on her tray instead.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 4/30/24, at 12:23 p.m. Resident R58 had ice cream on her meal ticket, but she had not received it on her tray.<br><br>During an interview with Nurse Aide Employee E19 confirmed that Resident R21 and R58 did not receive the foods listed on their meal tickets as stated above.<br><br>During an interview on 4/30/24, at 12:32 p.m. Resident R210 stated I get stuff I don't like but I just don't eat it.<br><br>During an interview on 5/3/24, at 10:46 a.m. Registered Dietitian (RD) Employee E10 stated that the FSD Employee E9 is to visit residents for food preferences. When RD Employee E10 was told the FSD Employee E9 stated that RD Employee E10 is to do the visits for food preferences, RD Employee E10 stated that she only comes into the facility on ce a week and not able to visit residents in a timely manner after their admission to obtain food preferences.<br><br>During an interview on 5/3/24, at 11:35 a.m. Resident R210 stated that she had never been asked about food preferences since her admission on 4/13/24, and also added They say I am allergic to fish. But that's not true. I eat fish all the time. Resident R 210 clarified that no one from Dietary Services had ever asked her about any food allergies or preferences.<br><br>During an interview on 5/3/24, at 11:40 a.m. Nursing Home Administrator confirmed that the facility failed to provide menu selections in accordance with resident's preferences.<br><br>28 Pa Code: 211.6(a)(c ) Dietary service. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on a review of facility menu, facility documents, observations, staff interviews, and resident interview, it was determined that the facility failed to comply with food safety regulations by failing to monitoring the proper cooling of foods for two days (4/27/24, and 4/28/24), and properly store utensils for one of two ice machines (Main Dining Room) creating the potential for food borne illness.<br><br>Findings include:<br><br>Review of the facility policy Food Temperature Recording Policy dated 2/1/24, indicated that temperatures of un-served/production foods will be taken after meal service/production and followed for six hours (if needed) after service/production for appropiate cooling. All temperature's will be recorded on the Cooling Log. Temperatures of un-served/production foods will be taken prior to the close of the Dining Services department for appropriate cooling and will be recorded on the Cooling Log. If the desired temperature of the un-served/production food is not achieved prior to the close of the dietary department, the food will be discarded.<br><br>Review of the facility menu revealed that for Week One Sunday (4/28/24), the main entree for lunch was [NAME] Pot Roast, and Week One Monday (4/29/24) the alternate main entree for lunch was roast beef.<br><br>During an observation and interview on 4/29/24, at 9:40 a.m. in the Main Dining Room, the ice machine had a scoop that was sitting on top of the ice machine. Food Service Director (FSD) Employee E9 confirmed that the facility failed to prevent any physical contamination and or cross contamination of ice by having an ice scoop on top of the machine.<br><br>During an observation on 4/29/24, at 12:19 p.m. Resident R59 had her lunch tray in front of her, but was not eating.<br><br>During an observation on 4/29/24, at 12:19 p.m., Resident R59's meal ticket stated that she was to receive fried chicken, however, there was no fried chicken on her tray and there was a very dry, hard, and stringy appearing piece of meat.<br><br>During an interview on 4/29/24, at 12:20 p.m. Resident R59 was asked what her entree was and she replied I think it's left over roast beef from yesterday.<br><br>During an interview in Resident R59's room on 4/29/24, at 12:47 p.m. FSD Employee E9 confirmed that Resident R59 was served leftovers from yesterday's lunch of [NAME] pot roast, and confirmed that the meat appeared to be very dry and unappetizing.<br><br>During an additional interview on 4/29/24, at 1:08 p.m. FSD Employee E9 stated that [NAME] pot roast was on the menu for lunch on Sunday 4/28/24, but that it was made a day ahead on Saturday 4/27/24, then cooled, and reheated for lunch on Sunday 4/28/24. This was cooled again on 4/28/24, then reheated and reserved for lunch on Monday 4/29/24 as an alternate now called roast beef.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 4/29/24, at 1:10 p.m. FSD Employee E9 was asked to produce Cooling Logs to ensure that the meat had undergone proper cooling and temperature monitoring throughout its two separate occasions of cooling.<br><br>Review of the facility's Food and Leftover Cooling Log for April 2024 failed to ensure that any documentation for proper cooling was completed for the meat on 4/27/24, or 4/28/24 prior to being served to residents.<br><br>During an interview on 4/29/24, at 1:10 p.m. FSD Employee E9 confirmed that the facility failed to provide evidence that the meat temperature was properly monitored and cooled for two days creating the potential for food bore illness.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee<br><br>28 Pa. Code: 201.18(b)(1) Management.<br><br>28 Pa. Code: 211.6(c) Dietary services. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>46167<br><br>Based on facility policy, observation, and staff interview it was determined that the facility failed to properly contain and dispose of garbage in one of one outside dumpsters to prevent the potential for rodent and insect infestation.<br><br>Findings include:<br><br>Review of facility policy Garbage and Rubbish Disposal Policy, date 2/1/24, indicated that outside dumpsters provided by the garbage pick-up services must be kept closed and free of litter around the dumpster area.<br><br>During an observation of the facility's outdoor trash receptacle on 4/29/23, at 9:32 a.m. revealed the lids/covers were not closed on the dumpster.<br><br>During an interview on 4/29/24, at 9:32 a.m. Food Service Director Employee E9 confirmed that the facility failed to properly contain and dispose of garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation.<br><br>28 Pa. Code 201.18(b)(3) Management.<br><br>28 Pa. Code 207.2(a) Administrator's responsibility. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to maintain and complete accurate documentation for two of nine residents (Resident R3 and R12).<br><br>Findings include:<br><br>Review of facility policy Documentation dated 2/1/24, indicated nursing documentation will provide accurate reflection of a resident condition that will meet federal and state requirements.<br><br>Review of Title 42 Code of Federal Regulations (CFR) S483.709(i) Medical records. In accordance with accepted professional standards and practice, the facility must maintain medical records that are complete, accurately documented, readily accessible, and systematically organized.<br><br>Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].<br><br>Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/11/24, indicated active diagnosis of high blood pressure, dementia, and muscle weakness.<br><br>Review of a physician order dated 1/2/24, indicated to weigh patient every day shift every month starting on the 2nd day of the month.<br><br>Review of a physician order dated 1/18/24, indicated to weigh resident every day shift every Thursday. This order was discontinued on 2/11/24.<br><br>Review of Resident R3's clinical record failed to reveal that a weight was documented in the electronic medical record on 1/25/24, 2/1/24, 2/8/24, 3/2/24, and 4/2/24.<br><br>During an interview on 5/3/24, at 12:09 p.m. the Assistant Director of Nursing (ADON) provided facility documentation to indicate that Resident R3's ordered weights were documented on paper sheets dated 1/2/24, 2/2/24, 2/9/24, 3/2/24, and 4/2/24. During this interview the ADON confirmed that these weights had not be transferred to the electronic medical record and were not readily accessible for review.<br><br>Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE].<br><br>Review of Resident R12's Minimum Data Set MDS dated [DATE], indicated diagnosis of high blood pressure, muscle weakness, and dependence on supplemental oxygen.<br><br>Review of a physician order dated 12/18/24, indicated to weigh resident every day shift every Thursday. This order was discontinued on 2/23/24.<br><br>Review of Resident R12's clinical record failed to reveal that a weight was documented in the electronic medical record on 2/1/24, 2/8/24, and 2/15/24. Further review of R12's clinical record failed to reveal a weight documented in the electronic medical record for February and March 2024.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/3/24, at 12:09 p.m. the ADON provided facility documentation to indicate that Resident R12's ordered weights were documented on paper sheets dated 2/2/24, 2/9/24, 2/16/24, and 3/2/24. During this interview the ADON confirmed that these weights had not be transferred to the electronic medical record and were not readily accessible for review.<br><br>During an interview on 5/3/24, at 10:39 a.m. Registered Dietitian (RD) Employee E10 stated, I come in to the facility on ce a week, usually on Thursdays. I do a lot of my charting remotely from home. I rely on weights being documented in the electronic medical record for my charting.<br><br>During an interview on 5/3/24, at 12:09 p.m. the ADON confirmed that the facility failed to maintain and complete accurate documentation for two of nine residents (Resident R3 and R12).<br><br>28 Pa. Code 211.5(f) Clinical Records.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785<br><br>Based on a review of facility policy, resident clinical records, and staff interviews, it was determined the facility failed to obtain a physician order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for one of four residents (Resident R30).<br><br>Findings include:<br><br>Review of the facility's Hospice Care Policy dated, 2/1/24, indicated hospice care will be offered to residents, as ordered by the attending physician, to provide additional supportive care for residents with end-stage terminal illnesses. Social services or designee will obtain a physician ' s order and contact Hospice Agency. All hospice services are provided under contractual arrangements.<br><br>Review of Resident R30's clinical record indicated the resident was admitted to the facility on [DATE].<br><br>Review of Resident R30's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), multiple sclerosis (a disease that affects central nervous system), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).<br><br>Review of Resident R30's documentation from the resident's hospice provider dated 3/13/24, indicated the resident was admitted to their services on 3/13/24.<br><br>Review of Resident R30's care plan initiated 5/1/24, indicated the resident is receiving hospice care related to end stage illness.<br><br>Review of Resident R30's clinical record failed to include a completed hospice contract between the facility and hospice provider.<br><br>Review of Resident R30's physician orders dated 4/27/24, included a hospice phone number for hospice services.<br><br>Review of Resident R30's physician orders dated 3/13/24 through 5/1/24 failed to include a physician order for hospice services.<br><br>During an interview on 5/1/24, at 10:40 a.m. Director of Nursing stated, I don ' t see an order but I will get one put in.<br><br>During an observation on 5/1/24, at 12:30 p.m. Nursing Home Administrator provided a contract which failed to identify resident name, what kind of contract and which hospice provider was contracted to provide services to Resident R30.<br><br>(continued on next page) |

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|---|---|
| Grove at Harmony, The | 191 Evergreen Mill Road<br>Harmony, PA 16037 |

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 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/1/24, at 10:42 a.m. Director of Nursing confirmed the facility failed to obtain a physician order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for one of four residents (Resident R30).<br><br>28 Pa. Code 211.2(a) Physician services<br><br>28 Pa. Code 211.11(d) Resident care plan |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>35785<br><br>Based on review of facility in-service documentation, personnel records, and staff interviews it was determined that the facility failed to implement and maintain an effective training program for six out of eight personnel records (LPN Employee E11, LPN Employee E12, Nurse aide Employee E7, Nurse aide Employee E13, Nurse aide Employee E14, and Nurse aide Employee E15).<br><br>Findings include:<br><br>The facility Monthly mandatory education schedule last reviewed 2/1/24, indicated that staff will be provided annual inservice training based on the following:<br><br>January training (abuse, neglect, elder care justice act)<br><br>February training (infection control, bloodborne pathogens, COVID-19).<br><br>March training (psychosocial needs, dementia, trauma informed care, substance abuse).<br><br>April training (customer service).<br><br>May training (resident rights, HIPAA/confidential information, cultural diversity).<br><br>June training (falls, restraints, accident, incidents)<br><br>July training (fire and safety, disasters, hazards, active shooter).<br><br>August training (restorative care, dietary and nutrition, hydration).<br><br>September (abuse, neglect, elder care justice act).<br><br>October (compliance and ethics).<br><br>November (quality assurance performance improvement).<br><br>December (infection control, bloodborne pathogens, COVID-19).<br><br>Review of Licensed Practical Nurse (LPN) Employee E11's personnel record indicated she was hired on 9/25/95. The record indicated she last received in-service training on 3/2023. Review of Licensed Practical Nurse (LPN) Employee E11's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year.<br><br>(continued on next page) |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Licensed Practical Nurse (LPN) Employee E12's personnel record indicated she was hired on 10/3/17. The record indicated she last received in-service training on 2/2023. Review of Licensed Practical Nurse (LPN) Employee E12's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year.<br><br>Review of Nurse aide (NA) Employee E7's personnel record indicated she was hired on 12/18/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E7's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year.<br><br>Review of Nurse aide (NA) Employee E13's personnel record indicated she was hired on 10/28/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E13's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year.<br><br>Review of Nurse aide (NA) Employee E14's personnel record indicated she was hired on 11/25/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E14's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year.<br><br>Review of Nurse aide (NA) Employee E15's personnel record indicated she was hired on 6/4/03. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E15's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year.<br><br>During an interview on 5/3/24, at 11:40 a.m. Licensed Practical Nurse (LPN) Infection Control Preventionist and staff educator Employee E16 confirmed that the facility failed to implement and maintain an effective training program for six personnel record as required.<br><br>28 Pa. Code 201.19(7) Personnel policies and procedures<br><br>28 Pa. Code 201.20(a)(d) Staff development |

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| F 0942<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.<br><br>35785<br><br>Based on review of facility in-service documentation, personnel records, and staff interviews it was determined that the facility failed to ensure that nurse aide staff received annual inservice training on resident rights for four out of four personnel records (Nurse aide Employee E7, Nurse aide Employee E13, Nurse aide Employee E14, and Nurse aide Employee E15).<br><br>Findings include:<br><br>The certified nursing assistant job description, last reviewed on 2/1/24, indicated that Nurse aides must complete 12 hours of in-service training annually tracked from date of hire. Nurse aides attend mandatory inservice trainings that includes resident rights.<br><br>Review of Nurse aide (NA) Employee E7's personnel record indicated she was hired on 12/18/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E7's personnel record did not include annual inservice training on resident rights.<br><br>Review of Nurse aide (NA) Employee E13's personnel record indicated she was hired on 10/28/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E13's personnel record did not include annual inservice training on resident rights.<br><br>Review of Nurse aide (NA) Employee E14's personnel record indicated she was hired on 11/25/91. The record indicated she last received inservice training on 2/2023. Review of Nurse aide (NA) Employee E14's personnel record did not include annual inservice training on resident rights.<br><br>Review of Nurse aide (NA) Employee E15's personnel record indicated she was hired on 6/4/03. The record indicated she last received inservice training on 2/2023. Review of Nurse aide (NA) Employee E15's personnel record did not include annual inservice training on resident rights.<br><br>During an interview on 5/3/24, at 11:40 a.m. Licensed Practical Nurse (LPN) Infection Control Preventionist and staff educator Employee E16 confirmed that the facility failed to ensure that nurse aide staff received annual inservice training on resident rights for four personnel records as required.<br><br>28 Pa. Code 201.19(7) Personnel policies and procedures<br><br>28 Pa. Code 201.20(a)(d) Staff development |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>35785<br><br>Based on review of facility in-service documentation, personnel records, and staff interviews it was determined that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of inservice education training each year for four out of four personnel records (Nurse aide Employee E7, Nurse aide Employee E13, Nurse aide Employee E14, and Nurse aide Employee E15).<br><br>Findings include:<br><br>The certified nursing assistant job description, last reviewed on 2/1/24, indicated that Nurse aides must complete 12 hours of in-service training annually tracked from date of hire.<br><br>Review of Nurse aide (NA) Employee E7's personnel record indicated she was hired on 12/18/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E7's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year. Review of Nurse aide (NA) Employee E7's personnel record did not indicate that 12 hours of inservice training was completed.<br><br>Review of Nurse aide (NA) Employee E13's personnel record indicated she was hired on 10/28/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E13's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year. Review of Nurse aide (NA) Employee E13's personnel record did not indicate that 12 hours of inservice training was completed.<br><br>Review of Nurse aide (NA) Employee E14's personnel record indicated she was hired on 11/25/91. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E14's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year. Review of Nurse aide (NA) Employee E14's personnel record did not indicate that 12 hours of inservice training was completed.<br><br>Review of Nurse aide (NA) Employee E15's personnel record indicated she was hired on 6/4/03. The record indicated she last received in-service training on 2/2023. Review of Nurse aide (NA) Employee E15's personnel record did not include annual inservice training on resident rights, resident confidential information, quality assurance performance improvement (QAPI), falls/incident accident, restorative care, cultural competence, and compliance and ethics in the past year. Review of Nurse aide (NA) Employee E15's personnel record did not indicate that 12 hours of inservice training was completed.<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/3/24, at 11:40 a.m. Licensed Practical Nurse (LPN) Infection Control Preventionist and staff educator Employee E16 confirmed that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of inservice education training each year for four personnel records as required.<br><br>28 Pa. Code 201.19(7) Personnel policies and procedures<br><br>28 Pa. Code 201.20(a)(d) Staff development |