STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395903	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Hills Healthcare and Rehabilitation Center	194 Swinderman Road Wexford, PA 15090

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to conduct care plan conferences and failed to ensure a resident or resident representative was notified in advance of care conference meetings for three of five residents (Resident R2, R31, and R43). Findings include:The facility Participation in Planning Care and Treatment policy dated 1/13/25, indicated that the resident and their family or responsible party have the right to participate in planning care and treatment or changes in care and treatment. The resident care plan shall be reviewed, evaluated, and updated quarterly and as necessary by the interdisciplinary team involved in the care of the resident. The resident and their representative shall be notified of care plan meetings and care conference and offered the opportunity to attend in person or via phone. Review of Resident R2's admission record indicated resident was admitted on [DATE]. Review of Resident R2's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 5/26/25, indicated diagnoses of depression, migraines (headache), and paraplegia (paralysis of the legs and lower body). During an interview on 7/15/25, at 9:41 a.m. Resident R2 stated: What is that? I never attended any meetings, when asked if she has participated in care plan meetings. Resident R2 stated she would like to attend if she knew when they were and that she never received an invitation for a care plan meeting. During an interview on 7/16/25, at 1:46 p.m. Assistant Director of Nursing Employee E2 stated that Resident R2 should have had a care conference December 2024, March 2025, and June 2025.The facility failed to provide documented evidence of meetings and failed to send invitations to the meeting to the resident. Review of Resident R31's admission record indicated resident was admitted on [DATE]. Review of Resident R31's MDS dated [DATE], indicated diagnoses of depression, high blood pressure, and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). During an interview on 7/17/25, at 9:38 a.m. Resident R31 stated: I haven't been to any care conferences, and I would like to go when asked if she has participated in care plan meetings. Resident R31 stated that she never received an invitation for a care plan meeting. During an interview on 7/17/25, at 11:02 a.m. Assistant Director of Nursing Employee E2 stated that Resident R31 should have had a care conference September 2024, December 2024, February 2025, and May 2025. The facility failed to provide documented evidence of meetings and failed to send invitations to the meeting to the resident. Review of Resident R43's admission record indicated resident was admitted on [DATE]. Review of Resident R43's MDS dated [DATE], indicated diagnoses of high blood pressure, 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). During an interview on 7/15/25, at 9:55 a.m. Resident R43 stated: I haven't been to any care conferences, and I would like to go when asked if she has participated in care plan meetings. Resident R31 stated that she never received an invitation for a care plan meeting. During an interview on 7/16/25, at 1:46 p.m. Assistant Director of Nursing Employee E2 stated that Resident R43 should have invited resident to her initial care plan meetings. The facility failed to send invitations to the meetings to the resident. During an interview on 7/17/25, at 1:30 p.m. Nursing Home Administrator stated that he was aware that residents have not had care conferences for a while and confirmed that the facility failed to conduct care plan conferences and failed to ensure a resident or resident representative was notified in advance of care conference meetings for three of five residents (Resident R2, R31, and R43). 28 Pa. Code 201.29 (a) Resident rights.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, 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 three of six residents sampled with hospital transfers (Residents R3, R6, and R43) and failed to obtain a physician order for discharge to home for one of six residents (Resident R56). Findings include: Review of facility policy Documentation of Resident Discharge last reviewed 1/13/25, indicated documentation in Point Click Care will be completed when resident is discharged from the facility. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident 3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/25, indicated diagnoses of acute pancreatitis (condition where the pancreas becomes inflamed), diabetes mellitus and hypertension (force of blood pushing against the artery walls is consistently too high). Review of the clinical record indicated Resident R3 was transferred to the hospital on 4/29/25, and returned to the facility on 5/2/25. Review of Resident R3's clinical record failed to include documented evidence that the resident or the resident's representative were provided with Resident R3's care plan at the time of the transfer to the hospital on 4/29/25. Review of the clinical record revealed that Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and cancer (a disease caused by an uncontrolled division of abnormal cells in a part of the body). Review of the clinical record indicated Resident R6 was transferred to the hospital on 6/7/25, and returned to the facility on 6/11/25. Review of Resident R6'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, to meet the resident's specific needs at the receiving facility. Review of the clinical record revealed that Resident R43 was admitted to the facility on [DATE]. Review of Resident R43's MDS dated [DATE], indicated diagnoses of high blood pressure, 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). Review of the clinical record indicated Resident R43 was transferred to the hospital on 6/1/25, and returned to the facility on 6/5/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R43'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, to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident CR56 was admitted to the facility on [DATE]. Review of Resident CR56's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and depression. Review of the clinical record indicated Resident CR56 was discharged home on 4/19/25. Review of Resident CR56's clinical record failed to include a written physician order for discharge as required. Interview on 7/16/25, at 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to obtain a physician order for Resident CR56's discharge as required. Interview on 7/16/25, at 2:00 p.m. the Nursing Home Administrator confirmed the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of six residents sampled with hospital transfers (Residents R3, R6, and R43) and failed to obtain a physician order for discharge to home for one of six residents (Resident R56). 28 Pa. Code: 201.29 (a)(c)(3)(2) Resident rights.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined the facility failed to conduct a significant change assessment for one of two residents reviewed (Resident R37).Findings include:According to the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS - a periodic assessment of care needs) assessments dated October 2024, the facility must conduct a comprehensive assessment of a resident within fourteen days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition. The RAI Manual indicates a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.Review of the admission record indicated Resident R37 was admitted to the facility on [DATE].Review of Resident R37's MDS dated [DATE], indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anemia (the blood doesn't have enough healthy red blood cells), and depression. Section O0110 K1. Hospice care indicated yes.Review of Resident R37's physician orders dated 4/28/25, indicated Hospice, effective date 3/21/25.Review of Resident R37's MDS assessment schedules indicated a significant change assessment was not completed within 14 days of hospice effective date of 3/21/25, as required.Interview on 7/17/25, at 1:15 p.m. the Director of Nursing confirmed the facility failed to conduct a significant change assessment for one of two residents reviewed (Resident R37).28 Pa. Code 211. 12(c)(d)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, resident and staff interviews, and observations it was determined that the facility failed to provide a resident environment free of potential accidental hazards for one of three residents (Resident R21).Findings include: Review of the facility policy Incident and Accident dated 1/13/25, indicated the facility shall make every effort to ensure that the resident's environment remains as free of accidental hazards as is possible. Review of the admission record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/7/25, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), renal insufficiency (poor function of the kidneys), and high blood pressure. Review of Resident R21's clinical record on 7/15/25, at 9:00 a.m. failed to include an assessment, identify the risks (burns and fires), ongoing evaluation, and physician's orders for the personal hot plate warmer for coffee cups. Review of Resident R21's current care plan indicated resident presents as needing twenty four hours of care and supervision. Self-care performance deficit related to limited mobility. Observation on 7/15/25, at 10:00 a.m. Resident R21 was sitting up on bed. The bedside stand had a small square hot plate device with a coffee cup on it. Interview with Resident R21 on 7/15/25, at 10:01 a.m. indicated the device was a coffee cup warmer used to keep her coffee hot. Interview on 7/15/25, at 1:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed the presence of the hot plate and indicated Resident R21 keeps on ordering things despite the safety rules and confirmed the facility failed to provide a resident environment free of potential accidental hazards for one of three residents (Resident R21). 28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.28 Pa. Code: 201.18 (b)(1)(d)(e)(1) Management.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for one of two residents reviewed (Resident R19).Findings include: Review of facility policy Colostomy Care and Management dated 1/13/25, indicated the facility will ensure the safe, effective, and person-centered care and management of residents with colostomies. Use appropriate pouching system based on stoma (opening in the abdomen), output type, and skin sensitivity. Stoma type, pouching and wafer system including size shall be documented in the medical record. Review of the clinical record revealed that Resident R19 was admitted to the facility on [DATE]. Review of Resident R19's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/10/25, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and colostomy (surgery to divert the colon into an artificial opening in the abdominal wall for waste elimination). Review of Resident R19's physician orders dated 5/20/25, indicated to change colostomy skin barrier appliance (wafer) every three days and as needed. The order failed to include size and type of colostomy appliance to be used. Review of Resident R19's current care plan dated 5/12/25, failed to include size and type of colostomy appliance being used. During an Interview on 7/16/25, at 2:25 p. m. the Director of Nursing confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for one of two residents reviewed (Resident R19). 28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews (MRR) were completed by the facility for one of three residents (Resident R2).Findings include: The facility policy Pharmacy Services reviewed 1/13/25, indicated the facility will provide routine and emergency drugs and biologicals to the residents, or obtain them under an agreement and will be provided in a timely manner. Drug regimen review to include: - - A licensed pharmacist will review the drug regimen of each resident at least once a month.- - The pharmacist will report any irregularities to the attending physician and the Director of Nursing. Review of Resident R2's admission record indicated resident was admitted on [DATE]. Review of Resident R2's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 5/26/25, indicated diagnoses of depression, migraines (headache), and paraplegia (paralysis of the legs and lower body). Review of Resident R2's clinical record on 7/16/25, at 11:04 a.m. indicated the following: December 2024- facility failed to provide the completed MRRApril 2025 - facility failed to provide the completed MRRMay 2025 - facility failed to provide the completed MRRJune 2025 - facility failed to provide the completed MRR During an interview on 7/17/25, at 10:00 a.m. Director of Nursing stated that the facility has received the encrypted emails from pharmacy however has failed to have all the recommendations reviewed and completed by the physician. During an interview on 7/17/25, at 10:10 a.m. the Director of Nursing confirmed that the facility failed to ensure Medication Regimen Reviews (MRR) were completed by the facility for one of three residents (Resident R2). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.9 (k) Pharmacy services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in one of three medications carts (C and D Hall Medication Cart) and failed to store drugs and biologicals in a safe, secure, and orderly manner for one of two medication rooms (C and D Hall Medication Room).Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in one of three medications carts (C and D Hall Medication Cart), failed to store drugs and biologicals in a safe, secure, and orderly manner for one of two medication rooms (C and D Hall Medication Room) and failed to maintain documentation of medication refrigerator temperatures in one of two medication rooms (C and D Hall medication refrigerator). Findings include: Review of the facility policy Storage of Medications last reviewed 1/13/25, indicated that medications and biologicals are stored safely, securely, and properly. Medication storage areas are kept clean, well lit, and free of clutter. During an observation on 7/15/25, at 10:03 a.m. the C and D Hall medication cart contained the following: Resident R4's Novolog insulin pen (insulin pen- a device used to inject insulin) not labeled with the date opened and not stored in bag. Resident R4's Basaglar insulin pen not labeled with the date opened and not stored in bag. Resident R17's Aspart insulin pen not stored in a bag. Resident R21's Lantus insulin pen opened and not stored in a bag. Resident R47's Lispro insulin pen not labeled with the date opened and not stored in bag. Resident R17's inhaler spacer (a plastic tube that is attached to the end of an inhaler that allows the user to take multiple breaths of the medication dose) not stored in bag. During an interview completed on 07/15/25, at 10:14 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the above observations and that the facility failed to store medications and biologicals properly and securely in one of three medications carts (C and D Hall Medication Cart). During an observation completed on 7/15/25, at 11:09 a.m. the C and D Hall medication storage room it was revealed that two refrigerators were present both failed to have a temperature monitoring log. A shelf contained: Two winter coats A tan tote bag During an interview completed on 7/15/25, at 11:13 a.m. LPN Employee E4 confirmed the refrigerators failed to have temperature monitoring logs and stated, these coats belong to a discharged resident, the family was to come in and pick them up, this is my tote bag.28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211. 9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observation, and staff interviews, it was determined that the facility failed to provide food in a form to meet individuals' needs in one of four residents ordered an NPO (nothing by mouth) diet (Resident R6). Findings include: Review of the facility policy Nothing by Mouth reviewed 1/13/25, indicated the facility will ensure the safety and well-being of residents who are at risk for aspiration or other swallowing-related complications by strictly enforcing NPO orders as directed by the physician. No food, liquid, or medication shall be administered by mouth to any resident who is under an active NPO status unless otherwise recommended by the Speech-Language Pathologist or ordered by the physician. All staff must strictly adhere to NPO orders. No staff member may provide anything by mouth unless it is explicitly ordered by the physician. Review of the clinical record revealed that Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 6/14/25, indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and cancer (a disease caused by an uncontrolled division of abnormal cells in a part of the body). Section K0520 indicated that Resident R6 received nutrition through a feeding tube while she was a resident. Review of Resident R6's physician's orders dated 6/6/25, indicated that resident was ordered an NPO diet and may have holiday free diet (a special day when a resident can eat different kinds of food). During an observation on 7/15/25, at 10:30 a.m. Resident R6 was observed resting in bed with a large Styrofoam cup full of ice chips with a spoon on her bedside table. During an interview on 7/15/25, at 10:49 a.m. Registered Nurse (RN) Employee E1 confirmed that Resident R6 was not allowed anything by mouth and that a cup of ice chips was left at her bedside. During an interview on 7/17/25, at 9:50 a.m. Director of Nursing (DON) confirmed that Resident R6 should not have had an order for a holiday free diet since resident was NPO. During an interview on 7/17/25, at 9:52 a.m. the DON confirmed that the facility failed to provide food in a form to meet individuals' needs in one of four residents ordered an NPO diet (Resident R6). 28 Pa.Code: 201.18(b)(3) Management 28 Pa. Code: 211.10(c) Resident Care Policies

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews it was determined that the facility failed to provide residents food products based on their preferences for one out of five residents (Resident R57). During an interview on 7/15/25, at 11:30 am Resident R57 voiced a concern that she is a vegetarian, doesn't drink milk. She feels her dietary needs are not being met.Review of the admission record indicated Resident R57 was admitted to the facility on [DATE].Review of Resident R57's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/4/25, indicated the diagnoses of fracture of right femur, falls and neuropathy (damage or disease affecting nerves, typically in the peripheral nervous system, which lies outside the brain and spinal cord). Review of nutritional assessment dated [DATE] indicated resident is a vegetarian, no milk has a surgical incision indicating that she requires 64 gm of protein a day.Lunch on 7/15/25 per menu consisted of ham, sweet potatoes, greens beans and pears. Resident R57 tray consisted of buttered noodles, green beans and pears. During an interview of 7/16/25, at 1:30 pm District Manager E3 confirmed Resident R57's tray did not meet her protein needs as required.Pa Code: 201.14(a) Responsibility of licensee.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to maintain sanitary conditions and practice proper infection control which created the potential for cross contamination and food borne illness (Main Kitchen) the facility failed to properly monitor refrigerator temperatures on one of two nursing units (C & D Hall unit) and failed to properly monitor residents in room personal refrigerator temperatures for three of three residents (Resident R20, R23, R50) which created the potential for food borne illness. Review of facility policy Environment dated 1/13/25 indicates all food preparation areas, and dining areas will be maintained in a clean and sanitary condition. Review of the facility policy Resident's Private Refrigerators last reviewed 1/13/25, indicated residents’ private refrigerators will be cleaned to maintain proper infection control. Monitor temperature daily and document on log. Findings include: During an observation of the main designated kitchen on 7/15/25, at 9:05 a.m. the following was observed: - fan on side of dishwasher, brown debris During an observation of lunch tray line in the main designated kitchen on 7/15/25, at 12:22 p.m. the following was observed: - Dietary Aide Employee E5 was on tray line handling food trays with no facial hair covering. During an interview on 7/17/25, at 1:00 p.m. District Manager Employee E3 confirmed that the facility failed to maintain sanitary conditions and which created the potential for food borne illness and cross contamination in the Main Kitchen. During an observation on 7/15/25 at 10:59 a.m. the C and D Hall unit refrigerator temperature log revealed missing temperatures for the following dates: 6/17/25, 6/19/25, 6/23/25, 6/26/25 and 6/30/25. During an interview completed on 7/15/25, at 11:03 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the C and D Hall unit refrigerator temperature log was incomplete missing temperatures for the following dates: 6/17/25, /6/19/25, 6/23/25, 6/26/25 and 6/30/25. During an interview and observation completed on 7/15/25, at 9:38 a.m. it was revealed that a personal refrigerator was in Resident R20's room the refrigerator failed to have a temperature log. Upon asking Resident R20 concerning the refrigerator monitoring stated, “there is a thermometer inside, they check it once or twice a month. During an interview and observation completed on 7/15/25, at 9:53 a.m. it was revealed that a personal refrigerator was in Resident R50's room the refrigerator failed to have a temperature log. Upon asking Resident R50 concerning the refrigerator monitoring stated, the maintenance man checks it every couple of months. During an observation completed on 7/15/25, at 12:37 p.m. it was revealed that a personal refrigerator was in Resident R23's room the refrigerator failed to have a temperature log. During an interview completed on 7/15/25, at 10:58 a.m. upon asking LPN Employee E4 about the residents in room personal refrigerator stated, staff do go in and check, the families usually maintain, I don’t know if anyone checks the temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395903	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Hills Healthcare and Rehabilitation Center	194 Swinderman Road Wexford, PA 15090

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further interview completed on 7/15/25, at 11:03 a.m. LPN Employee E4 stated the temperature logs are kept in the narcotic count book and are checked on night shift. Observation of the narcotic count book revealed no temperature logs for July of 2025. LPN Employee E4 confirmed that refrigerator logs were not completed for July of 2025, and stated, I didn’t even know we did that.Pa Code 201.14(a) Responsibility of licensee.Pa Code 201.18(b)(3) Management.

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F 0849 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed 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 two residents (Resident R37).Findings include: Review of facility policy Hospice Care Policy dated 1/13/25, indicated the facility will coordinate and deliver hospice care services in partnership with contracted hospice providers, ensuring residents receive compassionate, appropriate, and compliant end of life care in accordance with federal and state regulations, facility policies, and the resident's plan of care. Review of the admission record indicated Resident R37 admitted to the facility on [DATE]. Review of Resident R37's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/28/25, indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anemia (the blood doesn't have enough healthy red blood cells), and depression. Section O0110 K1. Hospice care indicated yes. Review of Resident R37's physician orders dated 4/28/25, indicated Hospice, effective date 3/21/25. Review of Resident R37's care plan dated 3/20/25, indicated resident chooses to have death with dignity, advanced directive established. Routine hospice added into care. Observation on 7/17/25, at 1:25 p.m. Resident R37's hospice binder could not be located at the nurse's station. Interview on 7/17/25, at 1:30 p.m. Licensed Practical Nurse (LPN) Employee E7 indicated the binders are kept in the closets or the rack behind the desk and indicated Resident R37 did not have a hospice binder. Interview on 7/17/25, at 1:35 p.m. the Director of Nursing indicated Resident R37 is no longer on hospice services, and confirmed a discharge order was not obtained to stop hospice services, nor was the resident's care plan updated to reflect the change of stopping hospice services. Interview on 7/17/25, 2:00 p.m. the Nursing Home Administrator confirmed the facility failed 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 two residents (Resident R37). 28 Pa Code: 211.12 (d)(3)(5) Nursing services

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of three quarterly meetings (Quarter One of 2025). Findings Include: The facility Quality Assurance and Performance Improvement (QAPI) Committee Charter policy dated 1/13/25, indicated the purpose of QAPI is to utilize a method of proactive, data-driven systematic and comprehensive process to monitor performance that identifies trends and opportunities for improvement. Review of Quality assurance and Performance Improvement sign in sheets and attendance records for Quarter One of 2025, failed to reveal the Medical Director was in attendance. During an interview on 7/17/25, at 9:54 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of three quarterly meeting (Quarter One of 2025), as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R2).Findings include: Review of the facility policy Wound Care last reviewed 1/13/25, indicated to provide guidelines for the care of wounds to promote healing. Steps in the procedure include but not inclusive to loosen tape and remove dressing and discard. Wash and dry hands thoroughly. Review of the facility policy Hand Hygiene last reviewed 1/13/25, indicated the facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infection. Hand hygiene is indicated but not inclusive to completion before moving from work on a soiled body site to a clean body site, after contact with blood, body fluids, or contaminated surfaces. Review of Resident R2's clinical record indicated admission to the facility on 8/11/23. Review of Resident R2's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/26/25, indicated the diagnosis of paraplegia (complete or partial loss of function of the lower limbs), anxiety and depression. Review of Residents R2's physician orders dated 7/16/25, indicate to cleanse right buttock with normal saline, apply Medi-honey, cover with border gauze daily or as needed. During a dressing change observation on 7/16/25, at 10:44 a.m. Licensed Practical Nurse (LPN) Employee E6 removed Resident R2's soiled dressing and cleansed the wound. LPN Employee continued to apply Medi-honey medication and border gauze without completing hand hygiene. During an interview on 7/16/25, at 11:08 a.m. LPN Employee E6 confirmed the failure to completed hand hygiene after removal of soiled dressing and that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R2). 28 Pa. Code: 211.10(d) Resident Care Policies.28 Pa. Code: 211.12(d)(1)(5) Nursing Services.