STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396048	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmar Village Health & Rehab Center	715 Freeport Road Cheswick, PA 15024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview it was determined that the facility failed to provide appropriate treatment and care for one of four residents (Resident R1) Findings include: Resident R1 was admitted to the facility on [DATE]. Review of Resident R1 clinical record indicated the following diagnosis of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and bipolar (mental health condition that affects a person's mood, energy, activity, and thought and is characterized by manic (or hypomanic) and depressive episodes). Review of the clinical record physician orders indicated Resident R1 was prescribed: ziprasidone HCl - (Geodon - an antipsychotic to treat bipolar disorder) capsule; 80 mg; Amount to Administer: 80 MG; oral Further review of the clinical record indicated Resident R1 missed five doses of ziprasidone for AM and PM doses. Review of clinical progress notes did not indicate that the physician was notified of Resident R1 missing the ordered doses. During an interview on 5/9/25, at 2:35 p.m. Director of Nursing confirmed that the facility failed to provide care and services as needed with medication that was ordered for Resident R1 that was not provided and failed to notify the physician that medication was not available for Resident R1. 28 Pa. Code 201.14 (a) Responsiblity of licensee 28 Pa. Code 201.29 (a) (c.3)(1) Resident rights 28 Pa. Code 211.12 (d) (1)(3)(5) Nursing services

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and failed to identify a resident who was an elopement risk which resulted in an elopement for one of five residents (Resident R1). This failure created an immediate jeopardy situation. Findings include: Review of the facility Elopement/Unauthorized Absence Policy policy dated 8/2/24, last reviewed 3/20/25, indicated the facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner. Upon determining that a resident cannot be located a headcount will be conducted. If resident Is still missing Code Green using the resident name, room number, and unit name will be announced. Announce three times. The clinical supervisor or designs will notify the Administrator, the Director of Nursing (DON), and the attending physician. Review of the facility's admission Policy dated 3/16/23, last reviewed 3/20/25, stated the facility will admit only those individuals requiring care and services to meet their physical, psychosocial, and emotional needs and whose needs can be met by the facility. The facility will individually review and assess each prospective admission to determine if their specific needs can be adequately in the facility before acceptance. Review of Resident R1's admission record indicated she was admitted on [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and bipolar (a mental health condition that affects a person's mood, energy, activity, and thought and is characterized by manic (or hypomanic) and depressive episodes). Review of Resident R1's Hospital Discharge summary dated [DATE], revealed the resident required minimal assistance with sit to stand transfers. Orders for the next facility related to activity was as prior to hospitalization, with no restrictions. The resident was independent with a wheeled walker prior to admission. Review of Resident R1's admission assessment completed 4/25/25, at 2:37 p.m. by Licensed Practical Nurse (LPN), Employee E2 revealed the resident was ambulatory with assistance. The resident was disoriented, had a memory impairment, and disorganized thinking. The resident was assessed to be able to wheel at least 50 feet in a wheelchair with partial/moderate assistance. Resident R1's elopement risk assessment asked if the resident was ambulatory or independent in a wheelchair and LPN, Employee E2 selected No-Clinically not at risk for elopement. No further questions were asked and Resident R1 was not identified as an elopement risk. The facility failed to identify Resident R1 as an elopement risk and initiate an elopement care plan. Review of Resident R1's progress note dated 4/25/25, at 2:40 p.m. entered by LPN, Employee E2 revealed the resident was only alert to self and unable to make needs known. Resident was very confused. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident R1's progress note dated 4/25/25, at 9:56 p.m. entered by the DON stated a call was received from RN Supervisor that Resident R1 was confused and wandering. Resident R1 eloped from the unit and was found in the basement. Review of Resident R1's elopement evaluation dated 4/25/25, at 9:47 p.m. identified Resident R1 as an elopement risk. Immediate interventions included transferring the resident to the Memory Impairment Unit (MIU- secured memory care unit specifically designed to care for those with cognitive impairment or memory problems). Review of information submitted to the Department of Health on 4/26/25, stated on 4/25/25, at approximately 8:00 p.m. Resident R1 was missing, and a nurse aide notified the nurse. The resident was last seen around 7:30 p.m. drinking a chocolate milk and eating a snack on the unit. Upon admission, Resident R1 was not identified as a wandering risk and exhibited no behaviors. Staff searched all units and the outside perimeter of the facility. Resident R1 was found in the basement uninjured at approximately 8:30 p.m. Once escorted back to the unit, Resident R1 was reevaluated for a wander risk and the resident's room was changed to the memory care secured unit. The physician and family were notified. Review of Resident R1's Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed the resident had a BIMS of 1, severe cognitive impairment. During an interview on 5/7/25, at 12:03 p.m. Nurse Aide, Employee E6 stated the resident arrived to the facility in a wheelchair. Resident was confused, observed climbing in other resident's bed, and attempting to walk around room. NA, Employee E6 indicated Resident R1 was placed back into a wheelchair. During an interview on 5/7/25, at 12:09 p.m. Licensed Practical Nurse, Employee E2 stated when the resident arrived LPN, Employee E2 did not receive report from family or the hospital. The supervisor handed over a packet of information about 45 minutes before the resident arrived. It was revealed the RN Supervisor failed to assist with the admission assessment. LPN, Employee E2 completed an admission assessment and did not identify Resident R1 as an elopement risk. During an interview on 5/7/25, at 12:27 p.m. NA, Employee E8 indicated they observed Resident R1 to be very confused on 4/25/25. Resident R1 was confused, opening doors to other resident rooms, and was placed in a wheelchair due to being found in roommates bed and trying to ambulate without staff assistance. Resident R1 was not stable on her feet. Once Resident R1 was placed in the wheelchair, she was moving around the unit. NA, Employee E8 stated Resident R1 was fast in the wheelchair. Staff attempted to keep resident occupied, the resident was provided snacks. When NA, Employee E8 came back from break, NA, Employee E8 asked where Resident R1 was. The staff on the floor checked twice in the resident's room and on the unit. A code green was called and Resident R1's chocolate milk was on the floor of the elevator. The resident was found in the basement on a dolly with no brief on. During an interview on 5/7/25, at 2:43 p.m. Registered Nurse, Employee E7 confirmed on 4/25/25, she was the RN Supervisor on duty. RN, Employee E7 stated she took report from the hospital for Resident R1. RN, Employee E7 entered the medications into the clinical record, but did not assess the resident. RN, Employee E7 indicated she reviewed the information from the hospital discharge summary. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident R1's referral documents on 5/8/25, at 9:17 a.m. revealed the resident previously resided in a MIU (a secured memory care unit specifically designed to care for those with cognitive impairment or memory problems) at a personal care home. Resident R1 was not admitted to the MIU at the facility. The facility failed to implement their admission policy and ensure the facility reviewed and assessed Resident R1 to determine if their specific needs can be adequately met in the facility before acceptance. Review of Resident R1's investigation on 5/8/25, revealed Resident R1 had an increase in mobility from the initial elopement assessment. When Resident R1's mobility increased staff intervened with snacks and drinks. The facility failed to reassess Resident R1 for an elopement risk and implement a care plan to prevent Resident R1 from eloping off the unit on 4/25/25. When RN Supervisor, Employee E1 was aware Resident R1 could not be located, RN, Employee E1 failed to follow the facility's resident elopement unauthorized absence procedure and call code green prior to notifying the DON. During an interview on 5/8/25, at 9:37 a.m. admission Director, Employee E4 stated prior to accepting a resident to the facility, hospital referral documents are reviewed from central intake which is comprised of four different people. Once central intake combs through it, a decision is made to accept the resident or not. If the resident is accepted, the admission Director reads through the hospital documentation to see if a resident needs to be placed in the MIU or needs medical equipment. admission Director, Employee E4 stated They have missed it, sometimes I miss things. Admissions Director, Employee E4 confirmed the facility's elopement risk assessment does not identify residents who are at risk for eloping. admission Director, Employee E4 indicated just because a resident is not ambulatory at the time of admission, does not mean they are not at risk for eloping. During an interview on 5/8/25, at 10:11 a.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) indicated the root cause of Resident R1's elopement was staff initially thought the resident was not going anywhere, then Resident R1 became more mobile. When asked what the facility did to prevent the incident from reoccurring, the NHA stated elopement assessments were completed for those who were previously identified as a risk and verbal education was provided to all nursing staff. The facility failed to assess all residents for a risk of elopement and educate all clinical and non-clinical staff. The NHA and DON confirmed the facility failed to identify Resident R1 as an elopement risk upon admission, ensure Resident R1 received adequate supervision, and follow the facility's resident elopement unauthorized absence procedure and call code green prior to notifying the DON. During an interview on 5/8/25, at 11:13 a.m. LPN, Employee E3 stated the nurse on the unit is responsible for completing elopement assessments for new admissions. When asked how often assessments are completed, LPN, Employee E3 stated I am not certain, I am agency. LPN, Employee E3 indicated Resident R1 was found about a half hour after code green was called. Resident R1 was found in the basement and was brought to the locked unit. On 5/8/25, at 11:20 a.m. the NHA and DON were notified that Immediate Jeopardy was called due to the elopement of Resident R1 on 4/25/25, and facility staff were provided an Immediate Jeopardy template, and a corrective action plan was requested. On 5/8/25, at 2:11 p.m. the NHA provided the facility's first plan of correction. On 5/8/25, at 4:45 p.m. an immediate action plan was received and accepted which included the following interventions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-R1 was reassessed on 4/25/25 and deemed an elopement risk and moved to the secure memory care unit. Her plan of care was updated. The family and physician was updated. -To ensure residents who are newly admitted to the facility are reviewed and assessed to ensure their specific needs can be adequately met in the facility before acceptance, the admission Policy will be reviewed, and a protocol developed to address pre-admission elopement risk factors. The protocol will consist of central intake and admissions director reviewing a referral for indications of an elopement risk. If there are elopement risk factors identified, the admissions director will review with the clinical department to discuss risk factors and interventions. The central intake and Admissions Director will be educated on this process on 5/8/25, by the Regional Director of Clinical Education. -All residents will be re-assessed on 5/8/25, with an elopement risk tool that includes all risk factors. If a risk factor is identified the resident will be deemed an elopement risk and their plan of care will be updated with interventions to prevent elopement. -The admission and Elopement Policy and procedures will be reviewed and updated as needed by the Nursing Home Administrator by the end of the day on 5/8/25. -All staff will be re-educated on elopement risks and supervision by the Director of Nursing or designee on 5/8/25 via in person, phone and/or other means of communication to ensure education is done timely. All staff will sign off on understanding of education prior to the start of their next scheduled shift if they are not currently in the facility. The Registered Nurses (RN) and Licensed Practical (LPN) nursing staff will be educated on the updated elopement observation and a Registered Nurse review of the elopement tool by the Director of Nursing or designee by end of the day 5/8/25, via in person, phone and/or other means of communication to ensure education is done timely. RN and LPN staff will sign off on understanding of education prior to the start of their next scheduled shift if they are not currently in the facility. -The Director of Nursing or designee will audit all new admissions weekly for 4 weeks then monthly times 2 months to ensure the elopement observation identifies any risk factors and interventions implemented as appropriate. -An Ad Hoc QA/QAPI will be conducted by the end of the day on 5/8/25. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. -On 5/8/25, an elopement preadmit referral review tool was created to assess risk factor for elopements. If risk factors are identified, the Admissions Director will review with DON/ADON and indicate on Admissions Notification Form. Risk factors and interventions will be communicated to clinical team members. On 5/8/25, 4 of 4 central intake team members were educated and the Admissions Director were educated. During interviews completed on 5/9/25, at 9:40 a.m. 4 of 5 staff members verified they were educated on elopement preadmit referral review tool. 1 of 5 staff members who was not available for interview signed in-service sign off sheet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 5/8/25, 104/104 residents were assessed with the elopement risk tool that included a total of nine risk factors. 13 of 104 residents were identified as an elopement risk. 13 of 13 care plans reviewed on 5/9/25, revealed 13 of 13 residents were care plan individually for their risk of elopement. -On 5/8/25, the admission and elopement policies were reviewed. No changes were made to the elopement policy. The elopement preadmit protocol was added to the admission policy. -98/123 staff members confirmed they were re-educated on elopement risks and supervision. During phone interviews completed at 5/9/25, at 11:11 a.m., 3/3 staff verified they were educated on elopement risks and supervision. If a resident is unable to be located, a code green is called after the initial head count. Staff are required to sign off understanding prior to the start of their next shift. During in-person interviews completed on 5/9/25, at 11:04 a.m. 24/24 staff confirmed they were educated on elopement risks, supervision, and what to do if a resident in unable to be located. Elopement risk assessments are completed upon admission, quarterly, and as needed with change in condition. Resident is identified as an elopement risk will have interventions in place to prevent elopement. -During in-person interviews completed on 5/9/25, at 11:04 a.m. 9/9 nursing staff confirmed competency on updated elopement risk assessment. During phone interviews completed on 5/9/25, at 11:11 a.m., 3/3 nursing staff confirmed they were educated on elopement tool, elopement risks, and supervision. Staff indicated if a resident is unable to be located, a head count will be conducted. If resident is still missing a code green will be called, then the clinical supervisor will notify NHA, DON, and attending physician. -As of 5/9/25, at 9:36 a.m. the facility has not had any new admission. Facility has audit tool that ensures admission elopement assessment was completed, all risk factors were assessed, if risk factor present, intervention is put in place, and the RN will review and sign off elopement risk assessments. -Ad Hoc QA/QAPI meeting was conducted on 5/8/25. The NHA, DON, Regional Director of Clinical Services, and Medical Director designee were present. Elopement audits were completed whole house, preadmission protocol for elopement risk was created, and education for elopement, supervision and the new elopement tool was implemented. Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 5/9/25, at 11:27 a.m. During an interview on 5/9/25, at 2:54 p.m., the NHA and Regional Director of Clinical Services, Employee E5 confirmed that the facility failed to make certain each resident received adequate supervision and failed to identify and implement interventions for a resident who was an elopement risk which resulted in an elopement for one of five residents (Resident R1), resulting in Immediate Jeopardy. 28 Pa. Code 207.2(a)Administrators Responsibility. 28 Pa. Code§ 201.14(a) Responsibility of Licensee. 28 Pa. Code § 211.10(d) Resident care policies. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	28 Pa. Code § 211.12(d)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and facility documents it was determined that the facility failed to make certain controlled substances were accounted for accurately and destroyed approiately for one of four residents. Findings include: Review of facility policy Inventory Control of Controlled Substances dated 01/10/25, indicated: Facility should maintain separate individual controlled substance records on all Schedule II medications and any medication with a potential for abuse or diversion in the form of a declining inventory using the Controlled Substances Declining inventory Record Facility should insure the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift. Resident R2 was admitted to the facility on [DATE]. Review of Resident R2 MDS (minimum data set - a periodic assessment of needs) dated 2/13/25, indicated a diagnosis of PVD (a slow and progressive disorder of the blood vessels), osteoporosis (is a bone disease), and a-fib (an irregular and often very rapid heart rhythm). Review of facility submitted documentation to the state survey office indicated the following: On 3/12/25 at 5 AM, a card of 13 tablets of Oxycodone was delivered to the facility for Resident R2, and signed for by the RN supervisor Employee E9. They were then given to agency nurse Employee E8 who was to sign them into the cart. Instead of signing the medication into the controlled Drug Tracking Log, she subtracted the card, stating that the order was discontinued. Review of the facility documentation narcotic count sheet indicated that Agency Nurse Employee E? documented receiving and subtracting the oxycodone. Interview with the Director of Nursing on 5/9/25, at 2:35 p.m. indicated that ADON (Assistant Director of Nursing) Employee E9 indicated that she signed on the narcotic count sheet but did not stay to observe Agency Nurse Employee E8 put the narcotics into locked medication cart. DON confirmed that the facility realized that the medication was missing once Resident R2 asked for the medication but it could not be located. Further review of facility documentation indicated that agency Nurse Employee E8 signed for additional narcotics that were to be destroyed. During an interview on 5/9/25, at 12:55 p.m. with Regional Director of Clinical Services E5 confirmed that non destruction forms were not found/completed for narcotics and the facility was not destroying medication s with the use of two licensed staff and the facility failed to verify that narcotics were being disposed of appropriately by staff. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/25, at 2:50 p.m. Nursing Home Administrator and Director of Nursing confirmed that that the facility failed to make certain controlled substances were accounted for accurately and destroyed appropriately for one of four residents. 28 Pa. Code 211.9 (a)(j.1)(1)(2)(3)(4)(5) Pharmacy services. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.