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	11/15/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 notify a medical provider of a change in condition for two of seven residents (Resident R6 and R7).Findings include: Review of the facility, Resident Change in Condition Policy dated 10/23/25, indicated, The licensed nurse will recognize and intervene in the event of a change in resident condition. The Physician/ Provider and the Family/Responsible Party will be notified as soon as the nurse has identified the change in condition, and the resident is stable. Review of the facility policy, Resident Weight Policy dated 10/23/25, indicated each resident's weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission, and monthly or more often if risk is identified, or as ordered. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 9/4/25, included diagnoses of high blood pressure and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of a physician's order dated 11/4/25, indicated Administer oxygen via nasal canula continuously at 2 liters per minute. Check SPO2. Review of the plan of care dated 11/7/25, revealed that Resident R6 did not have a plan of care developed for the use of heart failure prior to 11/7/25. Review of the plan of care for respiratory failure with hypoxia (low levels of oxygen in the body tissues) dated 9/10/25, revealed that staff should monitor and report signs of respiratory distress. Review of a progress note dated 11/7/25, at 12:56 a.m. indicated, This writer was informed during shift change that resident's O2 (oxygen) saturation has not been greater than 77% t/o (throughout) the previous shift with continuous oxygen at 2L NC (two liters via nasal canula). At 2320 (11:20 p.m.) resident was assessed by this writer. Oxygen was turned up to 4L. At that time resident had her bipap (bilevel positive airway pressure, a noninvasive ventilation device that assists with breathing) oxygen being bled in. SpO2 (blood oxygen level) was between 75-77%. Respiratory rate was normal, 20. Resident states her breathing was fast earlier today. Resident tachycardiac (elevated heart rate) 102. BP (blood pressure) difficult to hear, 100/60's. [Physician] informed of the same. Per [Physician] send resident to the hospital. At 2350 (11:50 p.m.) EMS (emergency medical services) at bedside working on resident. Review of progress notes failed to reveal a notification to the provider of Resident R6's low oxygen level by the previous shift nurse. Review of hospital discharge paperwork dated 11/13/25, indicated Resident R6 was admitted to the hospital from [DATE], through 11/13/25, with an admitting diagnosis of difficulty breathing, and a discharge diagnosis of heart failure. Review of the clinical record indicated Resident R7 was initially admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident R7's MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and heart failure. Review of Section O: Special Treatments, Procedures, and Programs, revealed that Resident R6 utilized oxygen therapy. Review of the plan of care for nutrition/hydration initiated 8/4/25, indicated for staff to monitor weight per protocol. Further review of the care plan failed to reveal goals and interventions related a heart failure diagnosis. Review of a physician's order dated 7/26/25, indicated for staff to obtain weight upon admission, then weekly x4. Review of Resident R7's weight record indicated that on 10/9/25, Resident R7's weight was 130.4 pounds, and on 11/5/25, was 144 pounds. Review of progress notes failed to reveal a notification to a provider of a fifteen-pound weight gain in four weeks. During an interview on 11/13/25, at approximately 2:00 p.m. Medical Records Employee E5 confirmed that she was up to date on scanning and uploading any paper notifications that may have been completed. Review of the electronic medical record confirmed that documentation of a paper notification to a provider of the weight gain was not uploaded. Review of a progress note dated 11/8/25, at 2:21 p.m. indicated that Resident R7 and family had complaints of increased abdominal distention, shortness of breath, and +3 lower leg edema (a moderate grade of pitting edema, characterized by a noticeably deep pit, around 5-6 mm, that takes between 15 and 60 seconds to fully disappear after pressure is applied). A one-time order for Lasix (a diuretic medication) 20 mg was received. Review of a progress note dated 11/12/25, at 8:45 p.m. indicated, Resident was observed while lying in her bed. Resident reports feeling very tired and SOB (short of breath). Resident is on 4L NC (nasal canula). Resident's abdomen is distended and firm but she denies nausea. she has +3 B/L LE edema. Resident's LLL and RLL (right and left lower lobe) and RML (right middle lobe) are diminished and have rhonchi (breath sounds caused by partial obstruction of the small breathing tubes in the

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined the facility failed to implement policies and procedures to protect residents from neglect that resulted in the actual harm of choking and subsequent death for one of five residents (Resident R1).Findings include: Review of facility Pennsylvania Resident Abuse Policy dated 10/23/25, revealed neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set assessment (MDS, periodic assessment of resident care needs) dated 10/8/25, included diagnoses of Dementia (group of symptoms that affects memory, thinking and interferes with daily life), and Chronic Obstructive Pulmonary Disease (COPD, group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R1's clinical record including diagnosis list revealed Dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of Resident R1's plan of care for increased nutrition/hydration risk initiated 9/22/23, including the intervention of, Continue to adhere to STRICT aspiration precautions. Further review of the plan of care failed to reveal goals and interventions developed for dysphagia or the need to have crushed medications. Review of Resident R1's physician's order dated 8/20/25, revealed, Give meds crushed in pudding or applesauce until cleared by speech. Review of Resident R1's progress notes dated 11/6/25, Resident CTB (cease to breath) after going into respiratory failure post aspiration coughing event. Crash cart brought into the room and RN supervisors notified. Resident identified as a DNR (do not resuscitate) finger sweep, suction, Heimlich maneuver was not successful and patient CTB at 1800 (6:00 p.m.). Death was pronounced by [RN Employee E3] and [RN Supervisor Employee E2]. During an interview on 11/13/25, at approximately 11:45 a.m. Licensed Practical Nurse (LPN) Employee E1 revealed Resident R1 had asked if (he/she) could take (his/her) medications whole, as (his/her) diet order had recently changed. Employee E1 confirmed that he provided Resident R1's medications uncrushed. Employee E1 revealed Resident R1 began coughing. Licensed Employee E1 revealed Resident R1 began experiencing respiratory distress and additional staff responded. LPN Employee E1 revealed he removed Resident R1's upper denture and completed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) which brought forth food matter. During an interview on 11/13/25, at approximately 3:35 p.m. RN Supervisor Employee E2 stated when LPN Employee E1 performed a finger sweep whole pills were removed from Resident R1's mouth/throat. During review of facility documents on 11/15/25, revealed, LPN Employee E1 was given a disciplinary action for neglecting to provide medication in the form ordered by the physician. During an interview on 11/15/25, at approximately 12:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to implement policies and procedures to protect Resident R1 from neglect that resulted in the actual harm of aspiration and respiratory failure. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to implement policies and procedures to report possible neglect one of five residents (Resident R1).Findings include: Review of facility Pennsylvania Resident Abuse Policy dated 10/23/25, indicated all allegations of neglect must reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than two hours after the allegation is made. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE] Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 10/8/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of the facility diagnosis list included dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of the plan of care for increased nutrition/hydration risk initiated 9/22/23, included the approach of, Continue to adhere to STRICT aspiration precautions. Further review of the plan of care failed to reveal goals and interventions developed specifically for dysphagia or the need to have crushed medications. Review of a physician's order dated 8/20/25, indicated, Give meds crushed in pudding or applesauce until cleared by speech. Review of a progress note dated 11/6/25, at Resident CTB (cease to breath) after going into respiratory failure post aspiration coughing event. Crash cart brought into the room and RN supervisors notified. Resident identified as a DNR (do not resuscitate) finger sweep, suction, Heimlich maneuver was not successful and patient CTB at 1800 (6:00 p. m.). Death was pronounced by [RN Employee E3] and [RN Supervisor Employee E2]. During an interview on 11/13/25, at approximately 11:20 a.m. the Director of Nursing was asked to provide the investigation documents for Resident R1's choking incident. The Director of Nursing stated an investigation was not completed. Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible neglect to Resident R1. During an interview on 11/13/25, at approximately 11:45 a.m. LPN Employee E1 stated that Resident R1 had asked if she could take her medications whole, as her diet order had recently changed. LPN Employee E1 confirmed that he provided Resident R1 her medications uncrushed. LPN Employee E1 stated that Resident R1 began coughing. LPN Employee E1 stated that Resident R1 began experiencing respiratory distress and additional staff responded. LPN Employee E1 stated that he removed Resident R1's upper denture and completed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) which brought forth food matter. During an interview on 11/13/25, at approximately 3:35 p.m. RN Supervisor Employee E2 stated that when LPN Employee E1 performed a finger sweep whole pills were removed from Resident R1's mouth/throat. During an interview on 11/15/25, at approximately 12:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to implement policies and procedures to report possible neglect one of five residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211. 10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to implement policies and procedures to investigate a choking incident to rule out possible neglect one of five residents (Resident R1).Review of facility Pennsylvania Resident Abuse Policy dated 10/23/25, indicated it is that facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE] Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 10/8/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of the facility diagnosis list included dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of the plan of care for increased nutrition/hydration risk initiated 9/22/23, included the approach of, Continue to adhere to STRICT aspiration precautions. Further review of the plan of care failed to reveal goals and interventions developed specifically for dysphagia or the need to have crushed medications. Review of a physician's order dated 8/20/25, indicated, Give meds crushed in pudding or applesauce until cleared by speech. Review of a progress note dated 11/6/25, at Resident CTB (cease to breath) after going into respiratory failure post aspiration coughing event. Crash cart brought into the room and RN supervisors notified. Resident identified as a DNR (do not resuscitate) finger sweep, suction, Heimlich maneuver was not successful and patient CTB at 1800 (6:00 p. m.). Death was pronounced by [RN Employee E3] and [RN Supervisor Employee E2]. During an interview on 11/13/25, at approximately 11:20 a.m. the Director of Nursing was asked to provide the investigation documents for Resident R1's choking incident. The Director of Nursing stated an investigation was not completed. During an interview on 11/13/25, at approximately 11:45 a.m. LPN Employee E1 stated that Resident R1 had asked if she could take her medications whole, as her diet order had recently changed. LPN Employee E1 confirmed that he provided Resident R1 her medications uncrushed. LPN Employee E1 stated that Resident R1 began coughing. LPN Employee E1 stated that Resident R1 began experiencing respiratory distress and additional staff responded. LPN Employee E1 stated that he removed Resident R1's upper denture and completed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) which brought forth food matter. During an interview on 11/13/25, at approximately 3:35 p.m. RN Supervisor Employee E2 stated that when LPN Employee E1 performed a finger sweep whole pills were removed from Resident R1's mouth/throat. During an interview on 11/15/25, at approximately 12:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to investigate a choking incident to rule out possible neglect for one of five residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201. 18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop a person-centered care plan related to the need for crushed medications for one of five residents (Resident R1).Findings include: Review of the facility policy Comprehensive Care Plan dated 10/23/25, indicated an interdisciplinary plan of care will be established for every resident and updated in accordance with State, and Federal requirements and on an as needed basis. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE] Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 10/8/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of the facility diagnosis list included dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of the plan of care for increased nutrition/hydration risk initiated 9/22/23, included the approach of, Continue to adhere to STRICT aspiration precautions. Further review of the plan of care failed to reveal goals and interventions developed specifically for dysphagia or the need to have crushed medications. Review of a physician's order dated 8/20/25, indicated, Give meds crushed in pudding or applesauce until cleared by speech. Review of a progress note dated 11/6/25, at Resident CTB (cease to breath) after going into respiratory failure post aspiration coughing event. Crash cart brought into the room and RN supervisors notified. Resident identified as a DNR (do not resuscitate) finger sweep, suction, Heimlich maneuver was not successful and patient CTB at 1800 (6:00 p.m.). Death was pronounced by [RN Employee E3] and [RN Supervisor Employee E2]. During an interview on 11/13/25, at approximately 11:45 a.m. LPN Employee E1 stated that Resident R1 had asked if she could take her medications whole, as her diet order had recently changed. LPN Employee E1 confirmed that he provided Resident R1 her medications uncrushed. LPN Employee E1 stated that Resident R1 began coughing. LPN Employee E1 stated that Resident R1 began experiencing respiratory distress and additional staff responded. LPN Employee E1 stated that he removed Resident R1's upper denture and completed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) which brought forth food matter.During an interview on 11/15/25, at approximately 12:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to develop a person-centered care plan related to the need for crushed medications for one of five residents. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, and resident and staff interview, it was determined that the facility failed to procure physician's orders for the need to have crushed medications for 29 of 33 residents (Resident R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, and R36). Findings include: Review of the Facility assessment dated [DATE], indicated the facility will provide speech therapy services. During an interview on 11/13/25, at 2:25 p. m. Speech Therapist Employee E7 stated that the speech department adjusts diet consistency orders but does not address the need for a physician's order for crushed medications. When asked how nursing staff are aware of the need for a resident to have medications crushed, Speech Therapist Employee E7 stated, I would assume the staff know. During a review of current residents on 11/14/25, it was noted that four residents (Residents R2, R3, R4, and R5) had physician orders for crushed medications. During a review on 11/15/25, at approximately 10:30 a.m. of a speech therapy audit completed by Speech Therapist Employee E7 on 11/14/25, it was noted that 29 additional facility residents were documented as needing their medications crushed (Resident R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, and R36). During an interview on 11/15/25, at approximately 12:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to procure physician's orders for the need to have crushed medications for 29 of 33 residents. 28 Pa. Code 211.2(d)(10) Medical Director.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review facility policy, clinical records, and staff interviews, it was determined that the facility failed to assure that the Director of Nursing displayed the appropriate competencies and skills to recognize, report, and investigate possible neglect leading to death for one of five residents (Resident R1).Findings include: Review of facility job description for the Director of Nursing indicated, As the Director of Nursing it is your responsibility to organize, develop, manage, and direct the overall operations of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern the community. The Director of Nursing is to work directly with the Administrator and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. Follows all the health, sanitary and infection control policies and maintains established standards of practice set forth by the community's administration and Nursing Policies and Procedures. Included in the Essential Functions of the position was, Responsible for the reporting of any known or suspected allegations of abuse, neglect, and/or misappropriation in accordance with state guidelines. During observations on 11/13/25 of the Second Floor and Third Floor nursing station, posted at each station was a document that indicated the Director of Nursing as the Abuse Coordinator. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE] Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 10/8/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of the facility diagnosis list included dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of the plan of care for increased nutrition/hydration risk initiated 9/22/23, included the approach of, Continue to adhere to STRICT aspiration precautions. Further review of the plan of care failed to reveal goals and interventions developed specifically for dysphagia or the need to have crushed medications. Review of a physician's order dated 8/20/25, indicated, Give meds crushed in pudding or applesauce until cleared by speech. Review of a progress note dated 11/6/25, at Resident CTB (cease to breath) after going into respiratory failure post aspiration coughing event. Crash cart brought into the room and RN supervisors notified. Resident identified as a DNR (do not resuscitate) finger sweep, suction, Heimlich maneuver was not successful and patient CTB at 1800 (6:00 p. m.). Death was pronounced by [RN Employee E3] and [RN Supervisor Employee E2]. During an interview on 11/13/25, at approximately 11:20 a.m. the Director of Nursing was asked to provide the investigation documents for Resident R1's choking incident. The Director of Nursing stated an investigation was not completed. Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible neglect to Resident R1. During an interview on 11/13/25, at approximately 11:45 a.m. LPN Employee E1 stated that Resident R1 had asked if she could take her medications whole, as her diet order had recently changed. LPN Employee E1 confirmed that he provided Resident R1 her medications uncrushed. LPN Employee E1 stated that Resident R1 began coughing. LPN Employee E1 stated that Resident R1 began experiencing respiratory distress and additional staff responded. LPN Employee E1 stated that he removed Resident R1's upper denture and completed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) which brought forth food matter. During an interview on 11/13/25, at approximately 3:35 p.m. RN Supervisor Employee E2 stated that when LPN Employee E1 performed a finger sweep whole pills were removed from Resident R1's mouth/throat. During an interview on 11/15/25, at approximately 12:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to assure that the Director of Nursing displayed the appropriate competencies and skills to recognize, report, and investigate possible neglect leading to death for one of five residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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	396048	A. Building B. Wing	11/15/2025

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

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to accurately document the need to crush medications for 29 of 33 residents (Resident R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, and R36) and failed to ensure that residents are free of significant medication errors which resulted in an immediate jeopardy situation for one of five residents (Resident R1).Findings include: Facility policy, General Dose Preparation and Medication Administration revealed staff will Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. Review of Resident R1's clinical record indicated Resident R1 was admitted to the facility on [DATE] Review of the Minimum Data Set assessment (MDS, periodic assessment of resident care needs dated 10/8/25, included diagnoses of Dementia (group of symptoms that affects memory, thinking and interferes with daily life), and Chronic Obstructive Pulmonary Disease (COPD, group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R1's diagnosis list included Dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of Resident R1's plan of care for increased nutrition/hydration risk initiated 9/22/23, included the approach of, Continue to adhere to STRICT aspiration precautions. Further review of Resident R1's plan of care failed to reveal goals and interventions developed for dysphagia or the need to have crushed medications. Review of Resident R1's physician's order dated 8/20/25, revealed, Give meds crushed in pudding or applesauce until cleared by speech. During an interview on 11/13/25, at 2:25 p.m. Speech Therapist Employee E7 stated that the speech department adjusts diet consistency orders but does not address the need for a physician's order for crushed medications. When asked how nursing staff are aware of the need for a resident to have medications crushed, Speech Therapist Employee E7 stated, I would assume the staff know. Review of Resident R1's progress note dated 11/6/25, at 6:00 p.m. revealed Registered Nurse (RN) Employee E3 documented, This nurse was called to residents' room by RN supervisor to assist with resident in respiratory distress. This nurse performed Heimlich maneuver and suctioning with Yankauer (rigid, one-piece suction tip used in medical procedures to remove secretions, blood, and other fluids from the mouth, throat, or surgical sites) suctioning, which both were unsuccessful. Resident cyanotic (blue fingernails due to lack of oxygen in the blood) and unresponsive, unable to perform CPR due to resident's code status. Auscultated apical pulse for one full minute, absent heart sounds, verified with RN Supervisor Employee E1. Review of Resident R1's progress note dated 11/6/25, at 6:10 p.m. revealed RN Supervisor Employee E2 documented, At approximately 1745 (5:45 p.m.), Licensed Practical Nurse (LPN) Employee E1 called RN Supervisor to resident bedside as [he/she] was in respiratory distress. Resident was cyanotic, exhibiting agonal breathing (irregular, labored breaths). Nonrebreather placed on resident's face, while Heimlich was performed. LPN Employee E1 attempted to clear the resident's airway, but this measure was unsuccessful. At 1800 patient had no spontaneous respirations, no palpable carotid or femoral pulses, no apical heart sounds auscultated after 1 minute of continuous listening and no response to verbal or painful stimuli. RN Supervisor Employee E2 pronounced resident's death at 1800 (6:00 p.m.). Review of Resident R1's progress note dated 11/6/25, revealed Resident CTB (cease to breath) after going into respiratory failure post aspiration coughing event. Crash cart brought into the room and RN supervisors notified. Resident identified as a DNR (do not resuscitate) finger sweep, suction, Heimlich maneuver was not successful and patient CTB at 1800 (6:00 p.m.) Death was pronounced by [RN Employee E3] and RN Supervisor Employee E2. During an interview on 11/13/25, at approximately 11:45 a.m. LPN Employee E1 stated, Resident R1 had asked if [he/she] could take [his/her] medications whole, as [his/her] diet order had recently changed. LPN Employee E1 confirmed that he provided Resident R1's medications uncrushed. LPN Employee E1 stated that Resident R1 began coughing. LPN, Employee E1 stated that Resident R1 began experiencing respiratory distress and additional staff responded. LPN Employee E1 stated that he removed Resident R1's upper denture and completed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) which brought forth food matter. During an interview on 11/13/25, at approximately 3:25 p.m. RN Employee E3 stated that on 11/6/25, LPN Employee E1 came out of Resident R1's for the suction machine and crash cart. RN Supervisor Employee E2 entered the room. RN Supervisor came out of the room and said he (LPN Employee E1) needed the oxygen key that

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to protect residents from significant medication errors. This failure resulted in a resident with an active order to have medications crushed receive their medications whole, leading the resident ceasing to breathe after going into respiratory failure post-aspiration coughing event, which created an Immediate Jeopardy situation for one of five residents (Resident R1). Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, The primary purpose of your job is to lead, direct, and manage the overall operations of the community in accordance with policies and procedures and current federal, state and local standards, guidelines and regulations that govern the community. As the Administrator, it is your responsibility to organize, develop, and direct resources to maintain the highest degree of quality care is maintained for each resident at all times. Review of the facility-provided Director of Nursing (DON) job description indicated, As the Director of Nursing it is your responsibility to organize, develop, manage, and direct the overall operations of the Nursing Service Department in accordance with policies and procedures and current federal, state and local standards, guidelines and regulations that govern the community. The Director of Nursing is to work directly with the Administrator and the Medical Director to ensure the highest degree of quality care is maintained for each resident at all times. Follows all health, sanitary, and infection control policies and maintains established standards of practice set forth by the community's administration and Nursing Policies and Procedures. Based on findings identified in this report, the facility failed to prevent the failed protect residents significant medication errors. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 11/15/25, at approximately 12:30 p.m. the NHA and DON confirmed that they failed to effectively manage the facility to protect residents from significant medication errors. This failure resulted in a resident with an active order to have medications crushed receive their medications whole, leading the resident ceasing to breathe after going into respiratory failure post-aspiration coughing event, which created an Immediate Jeopardy situation for one of five residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201. 18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 documents, clinical records, and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for of 14 of 104 residents (R2, R8, R14, R16, R17, R21, R32, R33, R37, R39, R40, R41, R43, and R44).During an interview on [DATE], at approximately 12:30 p.m. when asked how they ascertain if a resident required their medications to be crushed, Licensed Practical Nurse (LPN) Employee E8 stated she reviews the physician's orders. LPN Employee E8 displayed the physician's order screen in the electronic charting system, and indicated an order that stated, May crush medications unless contraindicated. Additionally, LPN Employee E8 stated that there were report sheets at the nurse's station that indicate if residents required their medications crushed. LPN Employee E7 was unable to provide a report sheet for her unit. Review of additional resident charts on [DATE], at approximately 1:00 p.m. revealed that May crush medications unless contraindicated is a standing order present on every resident chart, not indicative if a resident specifically required crushed medications. During an interview on [DATE], at approximately 12:40 p.m. when asked how they ascertain if a resident required their medications to be crushed, LPN Employee E9 stated that when you administer the medications for a resident that required them to be crushed, an administration order is required to be clicked off in the electronic medical record. During a review on [DATE], at approximately 1:00 p.m., of residents with physician orders who require their medications to be crushed revealed four residents with a physician order for crushed medications:Resident R2: No administration order present in the electronic medical record. Resident R3: No administration order present in the electronic medical record. Resident R4: Administration order present in the electronic medical record. Resident R5: Administration order present in the electronic medical record. During a review on [DATE], at approximately 3:15 p.m. when asked how they ascertain if a resident required their medications to be crushed, LPN Employee E10 stated that it is on the report sheet how they take their medications. LPN Employee E10 stated that he would also look at the resident's diet order. During a review on [DATE], at approximately 3:03 p.m. when asked how they ascertain if a resident required their medications to be crushed, LPN Employee E11 stated, I would look at the information here and at that time displayed the report sheets. LPN Employee E11 stated that they would ask the patient if the patient was with it enough to say. During a review on [DATE], at approximately 3:10 p.m. when asked how they ascertain if a resident required their medications to be crushed, Registered Nurse Employee E12 stated they receive that information in report from the previous nurse, that it is on the MAR (medication administration record), or they would go under the bar (referring to the banner that displays at the top of the screen on the electronic charting system). During a review on [DATE], at approximately 3:14 p. m. when asked how they ascertain if a resident required their medications to be crushed, LPN Employee E13 stated there would be an order in the computer and a paper posted above the resident's bed. During a review on [DATE], at approximately 3:17 p.m. when asked how they ascertain if a resident required their medications to be crushed, LPN Employee E14 stated On the paper as long as this is updated. You can check in the computer, for some of them it's listed. Review of the nursing unit report sheets revealed the following inaccuracies: Resident R1's information was included on the report sheet. Resident R1 had ceased to breathe on [DATE]. Resident R2's name was written in on the report sheet, with no designation on how medications were administered. Resident R2 was transferred to that bed location on [DATE]. Review of Resident R2's physician's order revealed Resident R2 required crushed medications. Resident R8 was not listed on the report sheet, with Resident R48's information still present in the bed location. Resident R47 had ceased to breathe on [DATE]. The code status for Resident R47 DNR/DNI (do not resuscitate / do not intubate) remained printed on the report sheet. Resident R8 was a full code (directive given by a patient that instructs healthcare providers to use all possible life-saving measures, including cardiopulmonary resuscitation (CPR), if their heart and lungs stop working). Resident R14's name was written in on the report sheet, with no designation on how medications were administered. Resident R14 was admitted on [DATE]. Review of Resident R14's physician's order revealed Resident R14 required crushed medications. Resident R16's name was written in on the report sheet, with no designation on how medications were administered. Resident R16 was admitted on [DATE]. Resident R17 was documented on the report sheet as a full code. Review of Resident R17's physician order dated [DATE], indicated DNR/DNI. Review of the banner information at the top of Resident R17's electronic chart indicated DNR/DNI. Resident R32's bed location did

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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 0908 Level of Harm - Actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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F 0908 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews it was determined the facility failed to ensure equipment was in safe operating condition for two of two crash carts (carts maintained with equipment used in emergencies) which caused the actual harm of a delay in emergency care for one of five residents (Resident R1).Findings include: Review of the facility Emergency Equipment Check Policy dated 10/23/25, revealed, Emergency equipment/cart(s) will be checked daily and items which are outdated or opened will be replaced. The cart will be restocked promptly after any use. Check contents against community-specific emergency cart contents checklist. Replace missing items and items that have been opened. Initial/sign community specific emergency cart check sheet. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE] Review of the Minimum Data Set assessment (MDS, periodic assessment of resident care needs) dated 10/8/25, included diagnoses of Dementia (group of symptoms that affects memory, thinking and interferes with daily life), and Chronic Obstructive Pulmonary Disease (COPD, group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R1's diagnosis list included Dysphagia (difficulty swallowing) with a diagnosis date of 9/18/24. Review of Resident R1's plan of care for increased nutrition/hydration risk initiated 9/22/23, included intervention of, Continue to adhere to STRICT aspiration precautions. Further review of the plan of care failed to reveal goals and interventions developed for Dysphagia or the need to have crushed medications. Review of Resident R1's physician's order dated 8/20/25, indicated, Give meds crushed in pudding or applesauce until cleared by speech. Review of Resident R1's progress note dated 11/6/25, at 6:10 p.m. revealed, At approximately 1745 (5:45 p. m.), Licensed Practical Nurse (LPN) Employee E1 called RN (Registered Nurse) Supervisor to resident bedside as [he/she] was in respiratory distress. Resident was cyanotic (fingernails are blue due to lack of oxygen in blood), exhibiting agonal (irregular, labored) breathing. Nonrebreather placed on resident's face, while Heimlich was performed. LPN Employee E1 attempted to clear the resident's airway, but this measure was unsuccessful. At 1800 patient had no spontaneous respirations, no palpable carotid or femoral pulses, no apical heart sounds auscultated after 1 minute of continuous listening and no response to verbal or painful stimuli. RN Supervisor Employee E2 pronounced resident's death at 1800 (6:00 p.m.). During an interview on 11/13/25, at approximately 3:25 p.m. RN Employee E3 revealed on 11/6/25, LPN Employee E1 came out of Resident R1's for the suction machine and crash cart. RN Supervisor Employee E2 entered the room. RN Supervisor came out of the room and said he (LPN Employee E1) needed the oxygen key that was on her key ring. RN Employee E3 stated she did not have an oxygen key on her key ring. I started running around searching for a key. RN Employee E3 confirmed it was approximately three to four minutes before an oxygen key was found to access the oxygen tank on the crash cart. During an interview on 11/13/25, at approximately 3:35 p.m. RN Supervisor Employee E2 stated that she was told LPN Employee E1 needed her in Resident R1's room. Resident R1 was visibly in respiratory distress and [his/her] color was not great. RN Supervisor Employee E2 stated LPN Employee E1 got the crash cart, and she began doing vitals on [him/her] with [resident] oxygen level about 60%. RN Supervisor Employee E2 stated that when they attempted to put the non-rebreather mask (an oxygen mask that delivers high concentrations of oxygen in emergencies) they were unable to access the oxygen tank as there was not an oxygen key. RN Supervisor, Employee E2 stated Resident R1 had an oxygen concentrator in [his/her] room, and she used that, but the oxygen concentrator only goes up to five liters. I mean, it helped a little bit, but then it was just clear that [resident] needed way more oxygen. So, I'm running around looking for the key, we're looking, and we can't find a key. Finally, somebody from the Second Floor brings one up. RN Supervisor Employee E2 stated that when LPN Employee E1 performed a finger sweep (first-aid technique to remove a visible foreign object from a person's mouth during a choking emergency) whole pills were removed from Resident R1's mouth/throat. RN Supervisor Employee E2 confirmed Resident R1's oxygen saturation had risen slightly on the concentrator and that if there had been high-level oxygen replacement had been available, it may have provided additional time to clear Resident R1's airway. During an observation on 11/13/25, at approximately 3:50 p.m. of the Third Floor Emergency Cart Daily Checklist for November 2025 revealed:11/1/25: No documentation a check was completed.11/2/25: Documented that no items were available on the cart. 11/3/25: No documentation a check was completed.11/4/25: No documentation a check was completed. 11/5/25: Documented that no items were available on the cart.11/6/25: No documentation a check was