

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Harmar Village Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on facility policy, observation and staff interview, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity on three of three units (Second Floor Resident R81, Third Floor Resident R31, and Memory Impaired Unit (MIU) Resident R65).</p> <p>Findings include:</p> <p>Review of facility policy Resident Rights and Facility Responsibilities dated 1/10/25, indicated it is the facility's policy to comply with all Residents Rights, and to communicate these rights to residents and their designated representatives in a language that they can understand.</p> <p>Review of the facility's Resident Handbook indicated residents have the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality.</p> <p>Review of Resident R31's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/24/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and aphasia (a language disorder that affects a person's ability to communicate). MDS Section K- Swallowing/Nutritional Status, Section K0520 indicated resident on a feeding tube-while a resident.</p> <p>Review of Resident R31's physician orders indicated that resident is NPO (nothing by mouth).</p> <p>During an observation on the Third Floor common dining room on 3/10/25, at 11:25 a.m. Resident R31 was sitting in the dining room while other residents were being served lunch and eating. Resident R31 is nonverbal, and not able to eat by mouth.</p> <p>During an interview on 3/10/25, at 11:29 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed that Resident R31 was in the dining room during mealtimes and failed to maintain her dignity when sitting around food and unable to eat.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on the MIU on 3/10/25, at 12:19 p.m. Resident R65 was observed in her room being assisted with lunch. Nurse Aide (NA) Employee E2 was standing beside Resident R65 while feeding her.</p> <p>During an interview on 3/10/25, at 12:20 p.m. NA Employee E2 confirmed that the facility failed to provide a dignified dining experience for Resident R65.</p> <p>Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE].</p> <p>Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, wound infection, and sepsis (the body's extreme response to an infection that can be life threatening). Section M - Skin Conditions, Question M0300 indicated the resident had one Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer).</p> <p>Review of a physician order dated 3/11/25, indicated to cleanse sacral (bottom of the spine) wound with soap and water, pat dry, apply absorbent dressing such as alginate or foam and cover with abd pad (gauze pad used for absorption).</p> <p>During an observation of wound care on 3/12/25, from 8:58 a.m. through 9:10 a.m., Registered Nurse (RN) Employee E7 wrote on the dressing after it was placed on Resident R81's sacrum.</p> <p>During an interview on 3/12/25, at 9:13 a.m. RN Employee E7 confirmed the facility failed to maintain Resident R81's dignity when writing on the dressings after placement on the resident.</p> <p>Pa. Code: 211.10(a)(b)(c)(d) Resident care policies.</p> <p>Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on review of facility policies, observations, resident and staff interviews, it was determined that the facility failed to determine the ability to self-administer medications for four of 21 residents (Residents R14, R42, R74, and R80).</p> <p>Findings include:</p> <p>Review of facility policy General Dose Preparation and Medication Administration dated 1/10/25, indicated that this policy is related to medication administration. Facility should take all measures required by facility policy including but not limited to the following: Facility staff should no leave medications or chemicals unattended.</p> <p>Review of Resident R14's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/25, indicated diagnoses of asthma (condition where the airways narrow and swell), osteoporosis (condition when the bones become brittle and fragile), and dysphagia (difficulty swallowing).</p> <p>Review of Resident R14's physician's order failed to include an order for self-administration of medications.</p> <p>Review of Resident R14's care plan on 1/30/25, failed to include self-administration of medication management.</p> <p>Review of Resident R14's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>During an observation on 3/10/25, at 9:12 a.m. Resident R14 had a tube of Icy Hot Maximum Strength cream (a cream used to treat pain) sitting on her overbed table. Resident R14 stated, I put it on my knee when it starts to hurt.</p> <p>During an interview on 3/10/25, at 9:13 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed that a tube of Icy Hot cream was in Resident R14's room and removed it.</p> <p>Review of Resident R42's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R42's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and hyperlipidemia (elevated levels of fats in the blood).</p> <p>Review of Resident R42's physician's order failed to include an order for self-administration of medications.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R42's care plan on 2/9/25, failed to include self-administration of medication management.</p> <p>Review of Resident R42's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>During an observation on 3/10/25, at 9:15 a.m. Resident R42 had a cup of pills, that included three oval white pills, one white oblong pill, one yellow pill, and one green pill, sitting on her dresser and a nurse was not present in the room.</p> <p>During an interview on 3/10/25, at 9:18 a.m. LPN Employee E8 stated, I gave her pills earlier this morning and did not watch her take them.</p> <p>Review of Resident R74's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R74's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/14/25, indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and seizures (a disruption of brain electrical activity that can cause changes in behavior, movement, awareness, or sensation).</p> <p>Review of Resident R74's physician's order failed to include an order for self-administration of medications.</p> <p>Review of Resident R74's care plan on 2/27/25, failed to include self-administration of medication management.</p> <p>Review of Resident R74's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>During an observation on 3/10/25, at 9:21 a.m. Resident R74 had a bottle of Flonase (a nasal spray used to treat allergies) sitting on her overbed table.</p> <p>During an interview on 3/10/25, at 9:23 a.m. LPN Employee E8 confirmed a bottle of Flonase was in Resident R74 ' s room and removed it.</p> <p>Review of Resident R80's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R80's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/14/25, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and hyperlipidemia (elevated levels of fats in the blood).</p> <p>Review of Resident R80's physician's order failed to include an order for self-administration of medications.</p> <p>Review of Resident R80's care plan on 2/22/25, failed to include self-administration of medication management.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R80's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>During an observation on 3/10/25, at 9:25 a.m. Resident R80 had a bottle of Flonase sitting on her overbed table.</p> <p>During an interview on 3/10/25, at 9:25 a.m. LPN Employee E8 confirmed a bottle of Flonase was in Resident R80's room and removed it.</p> <p>During an interview on 3/10/25, at 2:30 p.m. the Director of Nursing confirmed that the facility failed to determine the ability to self-administer medications for four of 21 residents (Residents R14, R42, R74, and R80).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p> <p>28 Pa. Code: 211.9(a)(1) Pharmacy services.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide documentation of advanced directives or was given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for two of four residents reviewed (Resident R31, and R42).</p> <p>Findings include:</p> <p>A review of the facility policy Advanced Directives Information last reviewed 1/10/25, indicated that advanced directives are written instructions about future medical care if or when you become unable to make decisions for yourself. Advanced directives will be discussed with you or your representative to determine if any advanced directives have been chosen or if you have any questions. Your medical record will identify any chosen advanced directives.</p> <p>Review of Resident R31's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/24/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and aphasia (a language disorder that affects a person ' s ability to communicate).</p> <p>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R31 was given the opportunity to formulate an Advanced Directive.</p> <p>Review of Resident R42's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R42's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and hyperlipidemia (elevated levels of fats in the blood).</p> <p>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R42 was given the opportunity to formulate an Advanced Directive.</p> <p>During an interview on 3/14/25, at 11:58 a.m. the Regional Clinical Director Employee E6 confirmed that the facility failed to provide documentation of advanced directives or was given the opportunity to formulate an advance directive for two of four residents reviewed (Resident R31, and R42).</p> <p>28 Pa. Code: 201.29(b) Resident rights.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on clinical record and interview, it was determined that the facility failed to notify the resident's responsible party of changes in condition for one of six sampled residents (Resident R71).</p> <p>Findings include:</p> <p>Review of the Resident R71 admission record indicates he was admitted on [DATE].</p> <p>Review of Resident R71 5 day MDS assessment (MDS-Minimum Data Set Assessment. Periodic assessment of resident care needs) dated 2/17/25, indicated that the resident current diagnoses were pneumonia, major depressive disorder and sepsis.</p> <p>Review of Resident R71 nurse progress dated 1/17/25 indicated family was concerned with Seroquel making the resident tired.</p> <p>Review of Resident R71 nurse progress dated 1/31/25, physician saw resident indicating dose was appropriate.</p> <p>Review of Resident R71 nurse progress dated 2/1/25 pharmacy indicated Seroquel was at appropriate dose.</p> <p>Review of Resident R71 nurse progress dated 1/17/25- 2/9/25 revealed no notification to guardian regarding Seroquel dose.</p> <p>During an interview on 3/12/25 at 11:00 a.m., the Social Worker Employee E10 confirmed the guardian was not notified in the above changes in condition as required.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>

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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on review of resident records, admission documentation and staff interview, it was determined that the facility failed to maintain admission documentation for one of two residents (Resident R100).</p> <p>Findings include:</p> <p>Review of Resident R100 was admitted [DATE] with diagnoses that include dementia(progressive decline in cognitive abilities, including memory, thinking, reasoning, and problem-solving), acute kidney failure and hypertension.</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of Resident R100's Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 10/29/24 indicated the resident was assessed as having a BIMS score of 4, which indicates severe impairment.</p> <p>Review of Resident R100's clinical record revealed no admission packet.</p> <p>During an interview with Regional Director of Clinical Services Employee E6 on 3/12/25 at 12:20 p.m. confirmed Resident R100 never had his admission paper work completed as required.</p> <p>28 Pa Code: 211.5 (f)(v.) Medical records.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop a baseline care plan for two of five residents (Resident R90, and R203).</p> <p>Findings include:</p> <p>Review of facility policy Interim/Baseline Care Plan dated 1/10/25, indicated that within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan. The baseline care plan will be sued until the comprehensive assessment and care plan is developed by the interdisciplinary team.</p> <p>Review of the clinical record indicated Resident R90 was admitted to the facility on [DATE].</p> <p>Review of Resident R90's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/30/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and lymphedema (swelling in an arm or leg caused by a lymphatic system blockage).</p> <p>Review of Resident R90's clinical record on 3/13/25, at approximately 1:00 p.m. failed to reveal that a baseline care plan had been developed.</p> <p>During an interview on 3/13/25, at 1:33 p.m. the Director of Nursing (DON) confirmed that the facility failed to develop a baseline care plan within 48 hours as required for Resident R90.</p> <p>Review of Resident R203's medical record indicated the resident was admitted to facility on 3/5/25, with diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), chronic respiratory failure (a long-term condition where lungs cannot adequately exchange oxygen and carbon dioxide), and dependence of supplemental oxygen.</p> <p>Review of Resident R203's medical record on 3/11/25, at approximately 2:00 p.m. failed to reveal that a baseline care plan was developed.</p> <p>During an interview on 3/11/25, at 2:22 p.m. the Director of Nursing confirmed that the facility failed to develop a baseline care plan within 48 hours as required for Resident R203.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update a care plan for one of three residents (Resident R50) to accurately reflect the current status of the resident and care needs.</p> <p>Findings include:</p> <p>Review of the facility policy Comprehensive Care Plan dated 1/10/25, 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.</p> <p>Review of the admission record indicated Resident R50 was admitted to the facility on [DATE].</p> <p>Review of Resident R50's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of medical records revealed that Resident R50 had a hospital stay from 12/23/24, through 12/31/24, with diagnoses of a fecal impaction (when a large, hard mass of stool gets stuck in the intestines due to chronic constipation).</p> <p>Review of Resident R50's care plan on 3/13/25, at 11:00 a.m. failed to identify the monitoring or management of fecal impaction or constipation.</p> <p>During an interview on 3/13/25, at 11:18 a.m. the Director of Nursing confirmed the facility failed to identify fecal impaction or constipation for Resident R50's care plan and the facility failed to update a care plan for one of three residents (Resident R50) to accurately reflect the current status of the resident and care needs.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, job descriptions, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services to meet the accepted standards of practice by failing to complete an admission assessment for two of four residents (Residents R90 and R203).</p> <p>Findings include:</p> <p>Review of the facility's Licensed Practical Nurse (LPN) job description indicated staff will maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of the facility's Registered Nurse (RN) job description indicated staff will maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of the clinical record indicated Resident R90 was admitted to the facility on [DATE].</p> <p>Review of Resident R90's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/30/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and lymphedema (swelling in an arm or leg caused by a lymphatic system blockage).</p> <p>Review of Resident R90's clinical record on 3/13/25, at approximately 1:00 p.m. failed to reveal that an Admission/Readmission Observation assessment had been completed when the resident was admitted on [DATE].</p> <p>Review of Resident R203's medical record indicated the resident was admitted to facility on 3/5/25, with diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), chronic respiratory failure (a long-term condition where lungs cannot adequately exchange oxygen and carbon dioxide), and dependence of supplemental oxygen.</p> <p>Review of Resident R203's medical record on 3/11/25, at approximately 2:00 p.m. failed to reveal an Admission/Readmission Observation assessment had been completed when the resident was admitted on [DATE].</p> <p>During an interview on 3/13/25, at 1:33 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide care and services to meet professional standards of practice by failing to complete an admission assessment for Resident R90 and R203.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Harmar Village Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for eight of 24 residents (Residents R1, R19, R47, R62, R81, R90, R203, and R253).</p> <p>Findings include:</p> <p>Review of facility policy Resident Weight dated 1/10/25, indicated weights will be obtained routinely in order to monitor nutritional health over time. 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. Nursing is responsible for obtaining weights. Weights will be recorded in the electronic health record.</p> <p>Review of the facility policy Diabetic Protocol dated 1/10/25, indicated the provider and staff will work together to give appropriate treatment to manage diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). The provider will follow up on any acute episodes associated with a significant blood glucose level changes and deterioration. The provider will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care plan.</p> <p>Review of facility policy Hypoglycemia indicated when acute hypoglycemia (low blood sugar level) is suspected, assess mental status (alert, uncooperative, or unconscious) and use glucometer to determine the resident's blood sugar level. A blood glucose of 70 mg/dL (milligrams per deciliter) or less may indicate the need for intervention. If there are no provider orders for specific treatment do the following:</p> <ul style="list-style-type: none"> - If the resident is conscious and treatment is indicated, give 1 tube of dextrose gel (15 grams) - After 15 minutes, repeat blood sugar and if still under 70 mg/dL, repeat glucose gel - After 15 minutes, repeat blood sugar. If above 70 mg/dL, give a snack of a protein and a carbohydrate (ex. 1/2 a sandwich with bread and a protein or crackers and a protein). Monitor until stable. <p>Once acute hypoglycemia has resolved, notify the provider and document in resident's medical record.</p> <p>Review of the facility's Registered Nurse (RN) job description indicated staff will accurately administer medication and treatment to residents per physician orders and maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Licensed Practical Nurse (LPN) job description indicated staff will accurately administer medication and treatment to residents per physician orders and maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and low back pain.</p> <p>Review of a physician order dated 12/11/23, indicated to obtain weight monthly on the 1st Tuesday of the month.</p> <p>Review of Resident R1's February 2025 Medication Administration Record (MAR) indicated the resident was not weighed on 2/4/25 as ordered. The documented reason was, CNA (Certified Nurse Aide) not available for task.</p> <p>During an interview on 3/14/24, at 10:49 a.m. Regional Director of Clinical Services Employee E6 confirmed that the facility failed to provide appropriate treatment and care by failing to obtain a weight per physician order for Resident R1.</p> <p>Review of Resident R19's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R19's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and diabetes.</p> <p>Review of Resident R19's care plan dated 2/3/25, indicated resident has a potential for alteration in blood glucose levels related to diabetes mellitus.</p> <p>Review of Resident R19's physician orders indicated to check accuchecks (blood glucose monitoring via a fingerstick) three times a day. The order failed to indicate parameters as to when to notify the physician.</p> <p>Review of Resident R19's abnormal blood glucose readings (normal reading is between 70-100 milligrams per deciliter -mg/dL were the following:</p> <p>1/12/25 - 360 mg/dL</p> <p>1/18/25 - 356 mg/dL</p> <p>2/5/25 - 380 mg/dL</p> <p>2/19/25 - 375 mg/dL</p> <p>Review of Resident R19's progress notes failed to reveal that the physician was notified of the above blood glucose readings.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/11/25, at 2:00 p.m. Director of Nursing (DON) confirmed the facility failed to notify the physician of Resident R19's abnormal blood glucose readings.</p> <p>Review of the clinical record indicated Resident R47 was admitted to the facility on [DATE].</p> <p>Review of Resident R47's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and dementia.</p> <p>Review of a physician order dated 12/8/23, indicated to obtain weight monthly on the 1st Monday of every month.</p> <p>Review of Resident R47's February 2025 MAR indicated the resident was not weighed on 2/3/25 as ordered. The documented reason was, Not obtained.</p> <p>During an interview on 3/14/24, at 10:49 a.m. Regional Director of Clinical Services Employee E6 confirmed that the facility failed to provide appropriate treatment and care by failing to obtain a weight per physician order for Resident R47.</p> <p>Review of the clinical record revealed Resident R62 was admitted to the facility on [DATE].</p> <p>Review of Resident R62's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and dementia.</p> <p>Review of a physician order dated 10/16/23, indicated to notify the physician if blood sugar is less than 60 mg/dL.</p> <p>Review of Resident R62's vitals records for February and March 2025, indicated the following blood glucose measurements:</p> <ul style="list-style-type: none"> - 2/27/25: 59 mg/dL - 3/9/25: 56 mg/dL - 3/11/25: 53 mg/dL <p>Review of Resident R62's progress notes from 2/1/25, through 3/13/25, failed to include documentation that the facility's hypoglycemia protocol was implemented for Resident R62's abnormal blood glucose readings on the dates listed above and that the physician was notified.</p> <p>Review of a nursing progress note dated 3/6/25, stated, CBG (capillary blood glucose) 61. Provided resident with orange juice and apple sauce. Resident asymptomatic (without symptoms). Will recheck in 30 minutes.</p> <p>During an interview on 3/13/25, at 10:43 a.m. Regional Director of Clinical Services Employee E6 confirmed that the facility failed to implement the facility's hypoglycemia protocol, failed to document appropriate hypoglycemia interventions, and failed to notify the physician of low blood sugar readings for Resident R62 on the dates listed above.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R81's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident 81's MDS dated [DATE], indicated diagnoses of high blood pressure, wound infection, and septicemia (the body ' s extreme response to an infection that can be life threatening) Section K0520B indicated that resident had a feeding tube while a resident.</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 7/3/24, that resident is to NPO (nothing by mouth) and is to remain on tube feeding for primary nutrition/hydration and all medications.</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 2/10/25, to provide chlorhexidine gluconate (a mouthwash that prevents the growth of bacteria in the mouth and reduces inflammation in the gums) two times per day.</p> <p>Review of Resident R81's clinical record revealed that Resident 81 did not receive chlorhexidine gluconate on 2/13/25, in the morning, or evening, 2/25/25, in the morning, 2/16/25 in the evening, 2/19/25 in the morning, 2/27/25, in the morning, and 3/5/25, in the evening.</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 3/3/25, to provide acetaminophen (a pain and fever reducer) three times per day by mouth.</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 3/3/25, to provide haloperidol lactate (medication to treat nervous, emotional, and mental conditions) every four hours by mouth.</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 3/3/25, for morphine (medication for moderate to severe pain) every two hours as needed by mouth.</p> <p>During an interview on 3/13/25, at 11:26 a.m. the DON confirmed that Resident R81 is to receive nothing by mouth, which includes medication, and that the above orders should have stated to provide the medications via the feeding tube, and not by mouth. DON also confirmed that the facility also failed to administer mouthwash as ordered.</p> <p>Review of the clinical record indicated Resident R90 was admitted to the facility on [DATE].</p> <p>Review of Resident R90's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and lymphedema (swelling in an arm or leg caused by a lymphatic system blockage).</p> <p>Review of Resident R90's Wound Management Detail Report indicated the resident was admitted on [DATE] with right and left calf venous ulcers (a wound caused by problems with blood flow in leg veins). Review of the Wound Management Detail Report revealed that the previous DON had created Resident R90's admission wound assessment on 2/6/25, ten days after the resident had been admitted to the facility.</p> <p>Review of a wound care service Initial Progress Note dated 2/5/25, stated, The patient is being seen today for the evaluation and treatment plan for a venous ulcer left posterior (back of) leg and right posterior leg.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/13/25, at 12:50 p.m. Director of Clinical Services Employee E6 confirmed that the facility failed to assess and document Resident R90's right and left posterior calf venous wounds from 1/24/25, to 2/4/25.</p> <p>Review of a physician order dated 2/6/25, indicated to exfoliate BLE (bilateral lower extremities) liberal application of moisturizer, avoid open areas twice a day.</p> <p>Review of Resident R90's February 2025 Medication Administration Record (MAR) revealed the treatment was not documented as completed on the following shifts:</p> <ul style="list-style-type: none"> - 2/7/25 4 p.m. - 2/10/25 8 a.m., the documented reason was, Providing patient care. - 2/11/25 4 p.m. - 2/13/25 4 p.m. - 2/19/25 4 p.m. - 2/20/25 8 a.m. - 2/21/25 4 p.m. <p>Review of a physician order dated 2/6/25, indicated to cleanse left posterior (back of) leg with soap and water apply Acetic Acid (a solution used to prevent and treat infections) wet to moist cover with ABD (gauze pad used for absorption) and wrap with ACE wrap (an elastic bandage used to decrease swelling) BID (twice a day) for compression.</p> <p>Review of Resident R90's February 2025 MAR revealed the treatment was not documented as completed on the following shifts:</p> <ul style="list-style-type: none"> - 2/7/25 4 p.m. - 2/9/25 4 p.m. - 2/10/25 8 a.m., the documented reason was, Providing patient care. - 2/11/25 8 am. - 2/13/25 5 p.m. - 2/19/25 4 p.m. - 2/20/25 8 a.m. - 2/21/25 4 p.m. <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 2/27/25 4 p.m.</p> <p>Review of a physician order dated 2/6/25, indicated to cleanse right leg with soap and water apply Acetic Acid wet to moist cover with ABD and wrap with ACE wrap BID for compression.</p> <p>Review of Resident R90's February 2025 MAR revealed the treatment was not documented as completed on the following shifts:</p> <p>- 2/7/25 4 p.m.</p> <p>- 2/9/25 4 p.m.</p> <p>- 2/10/25 8 a.m., the documented reason was, Providing patient care.</p> <p>- 2/11/25 4 p.m.</p> <p>- 2/13/25 4 p.m.</p> <p>- 2/19/25 4 p.m.</p> <p>- 2/20/25 8 a.m.</p> <p>- 2/21/25 4 p.m.</p> <p>- 2/25/25 8 a.m., the documented reason was, Unable to change no help.</p> <p>- 2/27/25 4 p.m.</p> <p>During an interview on 3/13/25, at 11:41 a.m. the DON confirmed that Resident R90's treatments were not documented as completed per physician orders on the dates listed above and that the facility failed to provide appropriate care and treatment.</p> <p>Review of Resident R90's clinical record on 3/13/25, at approximately 1:00 p.m. failed to reveal that an Admission/Readmission Observation assessment had been completed when the resident was admitted on [DATE].</p> <p>Review of Resident R203's medical record indicated the resident was admitted to facility on 3/5/25, with diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), chronic respiratory failure (a long-term condition where lungs cannot adequately exchange oxygen and carbon dioxide), and dependence of supplemental oxygen.</p> <p>Review of Resident R203's medical record on 3/11/25, at approximately 2:00 p.m. failed to reveal an Admission/Readmission Observation assessment had been completed when the resident was admitted on [DATE].</p> <p>During an interview on 3/13/25, at 1:33 p.m. the Director of Nursing (DON) confirmed that the facility failed to complete an admission assessment for Resident R90 and R203</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R253 was admitted to the facility on [DATE], with diagnoses of pulmonary fibrosis (thickening of the tissue around and between the air sacs in the lungs), high blood pressure, and gastroesophageal reflux disease (GERD - when stomach acid frequently flows back into the esophagus).</p> <p>Review of a physician order dated 3/7/25, indicated to administer furosemide 40 mg (milligrams) daily.</p> <p>Review of Resident R253's March 2025 Medication Administration Record (MAR) indicated the medication was not administered on the following dates:</p> <ul style="list-style-type: none"> - 3/7/25, the documented reason was refused - 3/8/25, the documented reason was refused <p>Review of a physician order dated 3/7/25, indicated to administer insulin lispro per sliding scale</p> <ul style="list-style-type: none"> - If blood sugar is less than 70, call physician - If blood sugar is 141 - 180, give 1 unit - If blood sugar is 181 - 220, give 2 units - If blood sugar is 221 - 260, give 3 units - If blood sugar is 261 - 300, give 4 units - If blood sugar is 301 - 340, give 5 units - If blood sugar is 341 - 400 give 6 units - If blood sugar is greater than 400, give 6 units and call physician <p>Review of Resident R253's March 2025 MAR indicated the medication was not administered on the following dates:</p> <ul style="list-style-type: none"> - 3/7/25 4 p.m., blood sugar was 301, requiring units of insulin. The documented reason was, refused. - 3/7/25 9 p.m., blood sugar was 325, requiring 5 units of insulin. The documented reason was, refused. <p>Review of Resident R253's progress notes from 3/7/25, from 3/12/25, failed to include documentation that the physician was made aware of Resident R253's refusal of physician ordered medications on 3/7/25, and 3/8/25.</p> <p>During an interview on 3/13/25, at 1:28 p.m. the DON confirmed that the facility failed to document notification to the physician regarding Resident R253 refusing physician ordered medications.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that residents received proper treatment and monitoring for pressure ulcers and failed to develop a plan of care timely for two of three residents (Residents R47 and R60).</p> <p>Findings include:</p> <p>Review of facility policy Pressure Injury Prevention and Treatment dated 1/10/25, indicated pressure injuries identified will be assessed initially an at least weekly thereafter, until closed.</p> <p>Review of the facility's Registered Nurse (RN) job description indicated staff will accurately administer medication and treatment to residents per physician orders and maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of the facility's Licensed Practical Nurse (LPN) job description indicated staff will accurately administer medication and treatment to residents per physician orders and maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of the clinical record indicated Resident R47 was admitted to the facility on [DATE].</p> <p>Review of Resident R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and dementia. (a group of symptoms that affects memory, thinking and interferes with daily life). Section M - Skin Conditions, Question M0300 indicated the resident had one Stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) during the 14-day lookback period.</p> <p>Review of a nursing progress note dated 1/27/25, stated, Right buttock with open area. Approximately 0.5 cm (centimeter) circumference x 0.25 cm deep. Dermaseptin (an ointment used to treat and prevent minor skin irritations) ordered for QS (every shift) and PRN (as needed).</p> <p>Review of a nursing progress note dated 2/13/25, stated, Wound scabbed over. Left OTA (open to air).</p> <p>Review of Resident R47's wound assessments, nurse progress notes, and physician notes did not include wound assessments for the weeks of 2/2/25, 2/9/25, and 2/16/25.</p> <p>During a telephonic interview on 3/14/25, at 12:10 p.m. RN Employee E23 stated, I filled out the Skin Conditions section of Resident R47's MDS. I knew to document that she had a Stage 2 from looking at the nursing progress note that stated she had an open area on her buttock.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Initial Progress Note dated 2/26/25, completed by a wound care Certified Nurse Practitioner stated, The patient is being seen today for the evaluation and treatment plan for a DTI (Deep Tissue Injury - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) to the right buttock.</p> <p>During an interview on 3/13/25, at 1:28 p.m. the Director of Nursing (DON) stated, We scheduled a telehealth visit for Resident R47 today, we don't have any more documentation to connect this. We need a professional to lay eyes on her wound today. Staff didn't get her back to bed so the wound practitioner could see her, that's why there is a documentation gap between 2/13/25 and 2/26/25. During this interview, the DON confirmed that the facility failed to make certain Resident R47 received proper monitoring for a pressure ulcer.</p> <p>Review of Resident R47's care plan revealed a plan of care including goals and interventions for Resident R47's right buttock DTI was developed on 3/13/25.</p> <p>During an interview on 3/14/25, at 10:49 a.m. Regional Director of Clinical Services Employee E6 confirmed that the facility did not develop a plan of care for Resident R47's right buttock DTI identified on 2/26/25, until 3/13/25.</p> <p>Review of the clinical record indicated Resident R60 was admitted to the facility on [DATE].</p> <p>Review of Resident R60's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/6/24, indicated diagnoses of high blood pressure, Peripheral Vascular Disease (PVD - circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and hyperlipidemia (high levels of fat in the blood).</p> <p>Review of a physician order dated 2/6/25, indicated to cleanse sacrum (bottom of the spine) with NSS (normal sterile saline) pat dry, skin prep (a liquid that forms a protective film on intact or damaged skin) to edges, apply calcium alginate (an absorbent dressing) to wound bed and cover with DD (dry dressing) twice a day.</p> <p>Review of Resident R60's February 2025 Medication Administration Record (MAR) revealed the treatment was not signed off as completed on the following shifts:</p> <ul style="list-style-type: none"> - 2/10/25 8 a.m. - 2/11/25 8 a.m. and 4 p.m. - 2/13/25 8 a.m. - 2/15/24 8 a.m. <p>Review of a physician order dated 2/16/25, indicated to cleanse sacrum with NSS pat dry, skin prep to edges, apply calcium alginate to wound bed and cover with DD twice a day. To be done after scheduled pain medications given.</p> <p>Review of Resident R60's February 2025 MAR revealed the treatment was not documented as completed on the following shifts:</p> <p>(continued on next page)</p>		

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

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 2/24/25 8 a.m.</p> <p>- 2/26/25 8 a.m.</p> <p>- 2/27/25 8 a.m.</p> <p>- 2/27/25 8 p.m., the documented reason was, Wound care nurse on duty, unknown if performed or not</p> <p>Review of Resident R60's clinical record revealed a Wound Management Detail Report was not completed for the following weeks:</p> <p>- 11/24/24 to 11/30/24</p> <p>- 2/9/25 to 2/15/25</p> <p>During an interview on 3/13/25, at 12:40 p.m. Regional Director of Clinical Services Employee E6 confirmed that the facility failed to make certain that Resident R60 received proper treatment and monitoring for a pressure ulcer.</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on reviews of facility policy, observations, and staff interviews, it was determined that the facility failed to implement effective safety measures by not supervising residents during mealtime for one of three floors (Third Floor), and failed to make certain that each resident received adequate monitoring of elopement (leaving an area without permission) devices for one of two residents (Resident R82).</p> <p>Findings include:</p> <p>Review of facility policy Resident Rights and Facility Responsibilities dated 1/10/25, indicated it is the facility's policy to comply with all Residents Rights, and to communicate these rights to residents and their designated representatives in a language that they can understand.</p> <p>During a dining room observation on 3/10/25, at 11:32 a.m. eight residents were sitting in the main dining room on the Third floor waiting for lunch.</p> <p>During a dining room observation on 3/10/25, at 11:42 a.m. staff members served residents their lunch in the main dining room and left the room.</p> <p>During an interview on 3/10/25, at 11:53 a.m. Licensed Practical Nurse (LPN) Employee E9 was sitting behind the nurse 's station on the computer. When asked, Does the common dining room need supervised when residents are eating?, LPN Employee E9 stated, Technically yes but no that doesn't happen.</p> <p>During an interview on 3/10/25, at 11:55 a.m. LPN Employee E8 stated, We are supposed to have someone in the dining room while residents eat and confirmed that no one was supervising the main dining room while residents were eating.</p> <p>During an interview on 3/10/25, at 2:30 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to implement effective safety measures by not supervising residents during mealtime for one of three floors (Third Floor).</p> <p>Review of the admission record indicated Resident R82 was admitted to the facility on [DATE].</p> <p>Review of Resident R82's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated the diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), hyperlipidemia (abnormally high levels of fats are in the bloodstream), and anxiety (a feeling of worry).</p> <p>Review of Resident R82's care plan indicated a problem identified on 2/13/24, that he experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety), and exit-seeking: 2/12/24 wandered to first floor stating he was leaving to go get a beer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R82's clinical record revealed a physician's order dated 2/13/24, for an electronic bracelet (a device that alerts staff know when a resident has left a safe area), and to check function daily , and an order dated 2/13/24, to check electronic bracelet's placement every shift.</p> <p>Review of Resident R82's clinical record failed to indicate that the facility checked the security bracelet's function on 3/10/25, and failed to check the bracelet's placement on 2/19/25 day shift, 3/5/25 evening shift, 3/7/25 day shift, 3/10/25 evening shift, and night shift, and 3/11/25 day shift and evening shift.</p> <p>During an interview on 3/13/25, at 11:36 a.m. the Director of Nursing confirmed that the facility failed to make certain each resident received adequate monitoring of elopement prevention devices for one of two residents (Resident R82).</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (e)(1) Management.</p> <p>28 Pa Code: 211.10 (c)(d) Resident care policies.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to properly monitor weight and nutrition status by failing to obtain weights for two of four residents (Residents R65 and R81).</p> <p>Findings include:</p> <p>Review of facility policy Resident Weight dated 1/10/25, indicated weights will be obtained routinely in order to monitor nutritional health over time. 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. Nursing is responsible for obtaining weights. Weights will be recorded in the electronic health record.</p> <p>Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE].</p> <p>Review of Resident R65's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and depression.</p> <p>Review of Resident R65's weight record on 3/11/25, failed to reveal any documented weights for February 2025.</p> <p>During an interview on 3/14/25, at 10:49 a.m. Regional Director of Clinical Services Employee E6 confirmed that the facility failed to properly monitor weight and nutrition status by failing to obtain and document Resident R65's weight in February 2025.</p> <p>Review of Resident R81's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident 81's MDS dated [DATE], indicated diagnoses of high blood pressure, wound infection, and septicemia (the body 's extreme response to an infection that can be life threatening). Section K0520B indicated that resident had a feeding tube while a resident.</p> <p>Review of clinical record revealed that Resident R81's last recorded weight was 184.8 pounds on 1/10/25.</p> <p>Review of clinical record revealed that Resident R81 was transferred to hospital on 2/2/25, and returned on 2/10/25.</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 2/10/25 to obtain weight at admission, then weekly for four weeks.</p> <p>Review of Resident R81's clinical record revealed a Nutritional assessment dated [DATE], that indicated that weight from hospital on 2/2/25, of 179.5 pounds was used for the assessment and tube feeding needs, and that weight requested at this facility.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R81's clinical record conducted on 3/13/25, at 9:30 a.m. failed to include that the admission weight and four weekly weights were obtained or that the nutrition assessments were able to be updated to include an accurate weight obtained by the facility.</p> <p>During an interview on 3/14/25, at 12:26 p.m. the Nursing Home Administrator confirmed that the facility failed to properly monitor weight and nutrition status for Resident R81.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for two of three residents (Residents R31, and R95).</p> <p>Findings include:</p> <p>Review of facility policy Enteral Feeding Tube dated [DATE], indicated enteral nutrition tubes will be utilized only after assessment determines that the clinical condition of the resident makes use of the feeding tube medically necessary and consent of the resident, or representative is given. Services will be provided to restore normal eating skills to the extent possible. Licensed clinicians with demonstrated competence may administer enteral feeding. If irrigation sets are used, they should be rinsed with warm water after each use and replaced every 24 hours.</p> <p>Review of Resident R31's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) 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 aphasia (a language disorder that affects a person's ability to communicate). MDS Section K- Swallowing/Nutritional Status, Section K0520 indicated resident on a feeding tube-while a resident.</p> <p>Review of current physician order indicated Peptaman 1.5 (a type of feeding that will supply a person with nutrients and minerals) to be administered continual over 16 hours. Flush tube with 60 ml (milliliters) of water every hour along with tube feed. Change enteral feeding bag daily and change irrigation set daily.</p> <p>During a tour of unit on [DATE], at 9:30 a.m. Resident R31's enteral feeding was observed hanging at bedside and failed to have a date written on the enteral feeding bag. Water flush bag failed to have a date written, and the syringe was not dated.</p> <p>Review of the clinical record indicated Resident R95 was admitted to the facility on [DATE].</p> <p>Review of Resident R95's MDS dated [DATE], indicated diagnoses of atrial fibrillation (a condition where the upper chambers of the heart (atria) beat irregularly and rapidly), parkinsonism (clinical syndrome characterized by a group of motor symptoms that mimic Parkinson's disease) and difficulty walking.</p> <p>Review of current physician order indicated Isosource 1.2 to be administered continual over 20 hours. Flush tube with 35 ml of water every hour along with tube feed.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a tour of unit on [DATE], at 9:45 p.m. Resident R95's enteral feeding was observed hanging at bedside. Fibersource HN was hanging, use be date [DATE]. Water flush bag failed to have a date written.</p> <p>During an interview on [DATE], at 10:00 a.m. Licensed Practical Nurse Employee E9 confirmed the wrong feeding was hanging, it was expired and the water flush bag was not dated.</p> <p>During an interview on [DATE], at 9:47 a.m. Licensed Practical Nurse Employee E8 confirmed she failed to see a date on the enteral feeding bag, water flush bag and the syringe.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for six of six residents (Residents R31, R42, R74, R81, R203, and R253).</p> <p>Findings include:</p> <p>Review of facility policy Oxygen Administration dated 1/10/25, indicated licensed clinicians will administer oxygen via the specified route as ordered by the provider. Change tubing, mask, cannula (a thin, flexible tube that is inserted into the nose to deliver oxygen) weekly and document. Change prefilled humidifier bottle when empty. Humidification should be added if flow rate is more than four liters per minute of oxygen.</p> <p>Review of facility policy Nebulizer (a machine that turns liquid medicine into a mist that can be inhaled into the lungs) Administration dated 1/10/25, indicated licensed clinicians may deliver medication via a nebulizer machine.</p> <p>Review of Resident R31's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/24/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and aphasia (a language disorder that affects a person ' s ability to communicate).</p> <p>Review of physician's order dated 7/14/25, indicated to administer Ipratropium-Albuterol (medication used to lung disease) inhalation via nebulizer every 12 hours as needed for shortness of breath.</p> <p>During an observation on 3/10/25, at 9:33 a.m. a nebulizer machine, tubing, and mask was on the bedside stand. The tubing and mask failed to have a date and was not stored in a bag for infection control purpose, when not in use.</p> <p>During an interview on 3/10/25, at 9:47 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed that Resident R31's nebulizer tubing and mask was not dated and stored in a bag, when not in use.</p> <p>Review of Resident R42's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R42's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and hyperlipidemia (elevated levels of fats in the blood). MDS Section O-Special treatment, Procedures, Programs Section O0100 C1 indicated that resident utilizes oxygen.</p> <p>Review of physician's order dated 12/4/23, indicated to administer Oxygen via nasal cannula continuously at two liters per minute.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of physician's order dated 1/17/24, indicated to clean oxygen concentrator and filter, change tubing weekly. Label tubing with date and initials.</p> <p>During an observation on 3/10/25, at 9:15 a.m. Resident R42 was in bed receiving oxygen and her oxygen tubing was not dated and initialed.</p> <p>During an interview on 3/10/25, at 9:18 a.m. LPN Employee E8 confirmed that Resident R42's oxygen tubing was not dated and initialed.</p> <p>Review of Resident R74's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R74's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and seizures (a disruption of brain electrical activity that can cause changes in behavior, movement, awareness, or sensation). MDS Section O- Special treatment, Procedures, Programs Section O0100 C1 indicated that resident utilizes oxygen.</p> <p>Review of physician orders dated 1/10/25, indicated to administer oxygen via nasal cannula continuously at two liters per minute. Add humidification (the process of adding moisture to the dry oxygen flow to prevent discomfort and irritation, such as dryness or bleeding, in the nose and throat) if greater than four liters per minute or for comfort, if needed.</p> <p>Review of physician orders dated 1/7/25, indicated to administer Ipratropium-Albuterol inhalation via nebulizer four times a day as needed.</p> <p>During an observation on 3/10/25, at 9:00 a.m. Resident R74 was in bed receiving oxygen. No date was present on the oxygen humidification bottle, and it was empty. The nebulizer machine, tubing, and mask was on the bedside stand. The nebulizer tubing failed to have a date and was not stored in bag, when not in use.</p> <p>During an interview on 3/10/25, at 9:06 a.m. LPN Employee E8 confirmed that Resident R74's oxygen humidification bottle was empty, not dated, and that the nebulizer tubing failed to have a date and was not stored in a bag, when not in use.</p> <p>Review of Resident R81's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, wound infection, and septicemia (the body's extreme response to an infection that can be life threatening). MDS Section O - Special treatment, Procedures, Programs Section O0100 C1 indicated that resident utilizes oxygen.</p> <p>During an observation on 3/10/25, at 10:37 a.m. Resident R81's oxygen tubing was dated 2/12/25.</p> <p>During an interview on 3/10/25, at 10:47 a.m. the Director of Nursing (DON) confirmed that the facility failed to change oxygen tubing weekly .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a medical record review on 3/11/25, at 11:00 a.m. Resident R81's physician orders failed to include an order to provide oxygen and Resident R81's care plan failed to include interventions for receiving oxygen.</p> <p>During an interview on 3/11/25, at 2:20 p.m. the DON confirmed that the facility failed to obtain a physician's order to provide oxygen for Resident R81, and failed to include oxygen therapy in Resident R81's care plan.</p> <p>Review of Resident R203's medical record indicated the resident was admitted to facility on 3/5/25, with diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), chronic respiratory failure (a long-term condition where lungs cannot adequately exchange oxygen and carbon dioxide), and dependence of supplemental oxygen.</p> <p>Review of Resident R203's medical record revealed a physician's order dated 3/5/25, to provide oxygen at 5 liters/minute.</p> <p>During an observation and interview on 3/10/25, at 1:18 p.m. Resident R203 was receiving oxygen and stated that he was not given a humidification bottle on his oxygen concentrator and that he normally uses one at home. Resident R203 stated that as a result My sinuses are killing me. No humidification bottle was attached to the oxygen concentrator per observation at this time.</p> <p>During an interview on 3/10/25, at 1:26 p.m. the DON confirmed that the facility failed to provide a humidification bottle as required to Resident R203 as required, as he received more than four liters of oxygen per minute.</p> <p>Review of the clinical record indicated Resident R253 was admitted to the facility on [DATE], with diagnoses of pulmonary fibrosis (thickening of the tissue around and between the air sacs in the lungs), high blood pressure, and gastroesophageal reflux disease (GERD - when stomach acid frequently flows back into the esophagus).</p> <p>Review of a physician order dated 3/7/25, indicated to administer oxygen via nasal cannula continuously at 5 liters/minute.</p> <p>During an observation on 3/10/25, at 9:10 a.m. Resident R253 was observed receiving oxygen via a nasal cannula at 4 liters/minute.</p> <p>During an interview on 3/10/25, at 11:48 a.m. LPN Employee E1 stated, I think something is wrong with the concentrator, she was receiving 4 liters but I turned her back up to 5 because that is what she's ordered. During this interview, LPN Employee E1 confirmed that the facility failed to provide appropriate respiratory care for Resident R253.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Harmar Village Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Freeport Road Cheswick, PA 15024	

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>41984</p> <p>Based on review of resident clinical records and staff interview, it was determined the facility failed to provide consistent and complete communication with the dialysis (treatment that helps body remove extra fluid and waste products) center for one of one resident receiving hemodialysis (Resident R66) for two of four days.</p> <p>Findings include:</p> <p>A review of Resident R66's MDS (MDS-a periodic assessment of resident care needs) dated 2/10/25, with the diagnosis of end stage renal disease (permanent condition in which the kidneys can no longer filter the blood), diabetes mellitus and hypertension.</p> <p>A review of Resident R66 physician orders last revised on 10/27/24, indicate dialysis Mondays, Wednesdays and Fridays.</p> <p>A review of Resident R66's dialysis binder indicated dialysis sheets completed on 1/3/25, 1/6/25, 1/8/25, 1/13/25, 1/15/25 and 1/17/25, incomplete 1/10/25, 1/20/25, 1/22/25, 1/27/25, 1/29/25, 2/12/25, 2/14/25, 2/17/25, 2/19/25, 2/21/25 and 2/24/25.</p> <p>During an interview on 3/13/25 Director of Nursing at 11:45 a.m., confirmed the dialysis communication forms for Resident R66 were incomplete for twelve of eighteen days.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain a physician order and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs, and the risks associated with bedrail usage for three of five residents (Residents R47, R65, and R253).</p> <p>Findings include:</p> <p>Review of facility policy Bed Rail dated 1/10/25, indicated if a bed or side rail or bar is used, the facility will evaluate the potential risks associated with the use of bed rails including entrapment, prior to bed rail installation using the Bed and Bed Rail Safety Inspection Checklist.</p> <p>Review of the clinical record indicated Resident R47 was admitted to the facility on [DATE].</p> <p>Review of Resident R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of a physician order dated 6/29/23, indicated bilateral (both sides) assistive handrails to aid in positioning.</p> <p>Review of Resident R47's clinical record revealed the last Enabler/Physical Restraint/Side Rail Review was completed on 5/8/24.</p> <p>During an observation on 3/10/25, at 9:05 a.m. two top enabler bars were present on Resident R47's bed.</p> <p>Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE].</p> <p>Review of Resident R65's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and depression.</p> <p>Review of a physician order dated 6/30/25, indicated bilateral assistive handrails to aide with positioning.</p> <p>Review of Resident R65's clinical record indicated the last Enabler/Physical Restraint/Side Rail Review was completed on 9/16/24.</p> <p>During an observation on 3/10/25, at 9:32 a.m. two top enabler bars were present on Resident R65's bed.</p> <p>Review of the clinical record indicated Resident R253 was admitted to the facility on [DATE], with diagnoses of pulmonary fibrosis, high blood pressure, and gastroesophageal reflux disease.</p> <p>(continued on next page)</p>

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

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R265's Enabler-Restraint Observation dated 3/6/25, indicated none of above were being utilized.</p> <p>During an observation on 3/10/25, at 9:12 a.m. two top enabler bars were present on Resident R265's bed.</p> <p>Review of Resident R253's active physician orders on 3/11/25, failed to reveal an order for enabler bar usage.</p> <p>During an interview on 3/14/25, at 10:45 a.m. Regional Director of Clinical Services (RDCS) Employee E6 stated, The bedrails were not captured in Resident R265's admission assessment and they have been removed from her bed because she wasn't using them.</p> <p>During an interview on 3/14/25, at 10:45 a.m. RDCS Employee E6 confirmed that the facility failed to obtain a physician order and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs, and the risks associated with bedrail usage for three of five residents as required.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (e)(1) Management.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48546</p> <p>Based on review of facility policy, resident observations, resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of six of ten residents (Residents R1, R8, R22, R60, R81, and R90).</p> <p>Findings include:</p> <p>Review of the facility's Registered Nurse (RN) job description indicated staff will accurately administer medication and treatment to residents per physician orders and maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of the facility's Licensed Practical Nurse (LPN) job description indicated staff will accurately administer medication and treatment to residents per physician orders and maintain comprehensive documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc.</p> <p>Review of Resident R1's February 2025 Medication Administration Record (MAR) revealed the resident was not weighed per physician order on 2/4/25, the documented reason was, CNA (Certified Nurse Aide) not available for task.</p> <p>Review of Resident R8's March 2025 MAR revealed the resident was not provided ordered wound care treatments on 3/6/25, the documented reason was, providing patient care, patient admission.</p> <p>Review of Resident R22's February 2025 MAR revealed the resident was not provided ordered wound care treatments on 2/21/25, the documented reason was, other patient care.</p> <p>Review of Resident R60's February 2025 MAR revealed the resident was not provided ordered wound care treatments on 2/27/25, the documented reason was, wound care nurse on duty, unknown if performed or not.</p> <p>Review of Resident R81's February 2025 MAR revealed the resident was not provided ordered wound care treatments on 2/18/25, the documented reason was, unable to get to.</p> <p>Review of Resident R90's February 2025 MAR revealed the resident was not provided ordered wound care treatments on 2/25/25, the documented reason was, unable to change no help.</p> <p>During an interview on 3/12/25, at 2:15 p.m. the Director of Nursing confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of six of ten residents.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(4) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>46167</p> <p>Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for five of five nurse aide (NA) personnel records (NA Employee E11, E12, E13, E14, and E15).</p> <p>Findings include:</p> <p>Review of personnel records indicated that NA Employees E11, E12, E13, E14, and E15 had a hire date at the facility of 7/1/23.</p> <p>Review of personnel records did not include annual performance evaluations based on the date of hire for NA Employee E11, E12, E13, E14, and E15.</p> <p>During an interview on 3/13/25, at 12:16 p.m. the Nursing Home Administrator confirmed that the facility failed to complete annual performance evaluations for five of five nurse aides as required.</p> <p>28 Pa Code: 201.20 (a)(b)(d) Staff development.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48546</p> <p>Based on review of facility policy, observation and staff interview it was determined the facility failed to dispose or reconcile discontinued medication in a timely manner for one of three nursing units (Second Floor) and one of two medication rooms (Third Floor Medication Room).</p> <p>Findings include:</p> <p>Review of facility policy Discontinued Medication Procedure dated 1/10/25, indicated when a medication is discontinued, the medication will be sent home with the patient on discharge, returned to pharmacy, or destroyed according to policy. The nurse discontinuing the medication will remove the medication from the cart and store in a secure area. Items eligible for return will be returned to the pharmacy within 48 hours or as soon as practicably possible.</p> <p>During an observation of the Second Floor nursing unit on 3/11/25, at 10:15 a.m. revealed a cardboard box stored under a desk at the nurse's station. The cardboard box contained the following medications and biologicals:</p> <ul style="list-style-type: none"> - Six bags of TPN (total parental nutrition, a nutrition solution administered intravenously via a vein) - One opened box of Lovenox (an injectable blood thinner) containing five syringes - One box of ten Lovenox syringes, unopened - Five vials of Tuberculin solution (a medication used to help diagnosis tuberculosis) - One tube of Voltaren gel (a topical medication used for pain relief), unopened - Eight boxes of DuoNeb vials (an inhaled medication used to assist with breathing effort) - One box of Albuterol vials (an inhaled medication used to assist with breathing effort) - One nicotine patch, unopened - Two sodium chloride bullet (a solution used for airway maintenance by helping to loosen and thin mucous) - Eight Zofran (a medication used to treat nausea and vomiting) tablets - 8 Neupro patches, unopened (a medication used to treat Parkinson's disease and restless legs syndrome) - One bottle of Flonase <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Two Albuterol inhalers - One bottle of Zenpep (digestive enzymes used to help break down and digest fats, starch, and proteins in food) - One box of Bisacodyl suppositories (used to treat constipation) - One tube of Nystatin cream (used to treat fungal skin infections) - 30 individual packs of Tylenol, unopened <p>During an interview on 3/11/25, at 10:15 a.m. Registered Nurse (RN) Employee E3 stated, That looks like a box of medications that we are trying to get rid of.</p> <p>During an interview on 3/11/25, at 10:50 a.m. the Regional Director of Clinical Services (RDCS) Employee E6 stated, We're having an issue determining which medications are returnable versus non-returnable to pharmacy. Night shift was given the box of medications to go through last night to determine what was returnable and what should have been destroyed. Obviously they didn't. During this interview, RDCS Employee E6 confirmed that the facility failed to dispose or reconcile discontinued medications in a timely manner on the Second Floor nursing unit.</p> <p>During an observation on 3/11/25, at 10:33 a.m. of the Third Floor Medication Room revealed the following:</p> <ul style="list-style-type: none"> - Six vials of Ampicillin (an antibiotic) 2 gm (grams) powder connected to 100 mL (milliliter) bags of sodium chloride for intravenous infusion, with a use by date of 2/21/25 - 16 vials of Ampicillin 2 gm powder connected to 100 mL bags of sodium chloride for intravenous infusion, with a use by date of 2/25/25 - Four 1000 mL bags of Lactated Ringers (an intravenous fluid used for fluid and electrolyte replenishment), with a use by date of 2/15/25 - An open box of Lovenox containing nine syringes - Tamsulosin (a medication used to treat prostate conditions) - 17 pills - Cellcept (a medication used to prevent organ rejection after a transplant) - 37 pills - Metoprolol (a medication used to treat high blood pressure) - 54 pills - Atorvastatin (a medication used to lower the amount of cholesterol in the blood) - 16 pills - Rosuvastatin (a medication used to lower the amount of cholesterol in the blood) - 42 pills - Potassium Chloride (a supplement) - 21 pills - Lasix (a medication to decrease fluid in your body) - 30 pills <p>(continued on next page)</p>		

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

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Buspirone (a medication used to treat anxiety) - 54 pills</p> <p>- One bottle of Lactulose (a medication used to treat constipation)</p> <p>During an interview on 3/11/25, at 10:39 a.m. Clinical Quality Specialist (CQS) Employee E5 confirmed the above observations and stated, Pharmacy doesn't always accept everything back, then it would have to be destroyed. These medications should have already been returned or destroyed.</p> <p>During an interview on 3/11/25, at 10:39 CQS Employee E5 confirmed that the facility failed to dispose or reconcile discontinued medications in a timely manner for the Third Floor Medication Room.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.9 (a)(1)(j.1)(k) Pharmacy services.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications on one of three nursing units (Second Floor), one of two medication rooms (Third Floor Medication Room), and two of three medication carts (Three South Medication Cart and Three East Medication Cart).</p> <p>Findings include:</p> <p>Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated [DATE], indicated the facility should ensure medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.</p> <p>During an observation of the Second Floor nursing unit on [DATE], at 10:15 a.m. revealed a cardboard box stored under a desk at the nurse's station. The cardboard box contained the following medications and biologicals:</p> <ul style="list-style-type: none"> - Six bags of TPN (total parental nutrition, a nutrition solution administered intravenously via a vein) - One opened box of Lovenox (an injectable blood thinner) containing five syringes - One box of ten Lovenox syringes, unopened - Five vials of Tuberculin solution (a medication used to help diagnosis tuberculosis) - One tube of Voltaren gel (a topical medication used for pain relief), unopened - Eight boxes of DuoNeb vials (an inhaled medication used to assist with breathing effort) - One box of Albuterol vials (an inhaled medication used to assist with breathing effort) - One nicotine patch, unopened - Two sodium chloride bullet (a solution used for airway maintenance by helping to loosen and thin mucous) <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Eight Zofran (a medication used to treat nausea and vomiting) tablets - 8 Neupro patches, unopened (a medication used to treat Parkinson's disease and restless legs syndrome) - One bottle of Flonase - Two Albuterol inhalers - One bottle of Zenpep (digestive enzymes used to help break down and digest fats, starch, and proteins in food) - One box of Bisacodyl suppositories (used to treat constipation) - One tube of Nystatin cream (used to treat fungal skin infections) - 30 individual packs of Tylenol, unopened <p>During an interview on [DATE], at 10:15 a.m. Registered Nurse (RN) Employee E3 stated, That looks like a box of medications that we are trying to get rid of.</p> <p>During an interview on [DATE], at 10:50 a.m. the Regional Director of Clinical Services (RDCS) Employee E6 stated, We're having an issue determining which medications are returnable versus non-returnable to pharmacy. Night shift was given the box of medications to go through last night to determine what was returnable and what should have been destroyed. Obviously they didn't. During this interview, RDCS Employee E6 confirmed that the facility failed to properly store medications on the Second Floor nursing unit.</p> <p>During an observation of the Third Floor Medication Room refrigerator on [DATE], at 10:27 a.m. revealed the following:</p> <ul style="list-style-type: none"> - Resident R31's Lopressor (a medication used to treat high blood pressure) suspension with a do not use after date of [DATE] - Resident R31's Gabapentin (a medication used to treat nerve pain) open with no open date noted - Resident R27's lispro insulin vial open with no open date noted - Two vials of Tuberculin solution open with no open date noted <p>During an observation of the Third Floor Medication Room supplies on [DATE], at 10:29 a.m. revealed two expired 23 gauge (the needle size) needles with the expiration date of [DATE].</p> <p>During an interview on [DATE], at 10:30 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the above observations and that the facility failed to properly store medications in the Third Floor Medication Room.</p> <p>(continued on next page)</p>		

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

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a medication cart review (Third Floor South) on [DATE], at 11:15 a.m. revealed the following:</p> <ul style="list-style-type: none"> - Amelog Solostar Lispro Insulin Pen (a medication used to lower blood sugar levels) expired [DATE] - Lantus Insulin Pen (a medication used to lower blood sugar levels) no opened or expired date - Insulin Glargine Pen (a medication used to lower blood sugar levels) no resident identification and expired <p>During an interview on [DATE], at 11:23 a.m. LPN Employee E4 confirmed the above expired insulin pens and one insulin pen failed to reveal resident information.</p> <p>During a medication cart review (Third Floor East) on [DATE], at 12:02 p.m. revealed the following:</p> <ul style="list-style-type: none"> - Insulin Glargine Pen - expired - Insulin Lispro - expired <p>During an interview on [DATE], at 12:15 p.m. LPN Employee E22 confirmed the above expired insulin pens.</p> <p>During an interview on [DATE], at 2:05 p.m. Director of Nursing confirmed that the facility failed to properly store medications on one of three nursing units (Second Floor), one of two medication rooms (Third Floor Medication Room), and two of three medication carts (Three South Medication Cart and Three East Medication Cart).</p> <p>28 Pa. Code: 211.9(a)(1)(j.1)(k) Pharmacy services.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46167</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined the facility failed to maintain clean equipment in a manner to prevent foodborne illness in the Main Kitchen.</p> <p>Findings include:</p> <p>Review of facility policy Kitchen Sanitation and Cleaning Schedules dated 1/10/25, indicated that food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule</p> <p>During an observation and interview on 3/11/25, at 1:15 p.m. Certified Dietary Manager Employee E21 confirmed that a fan that was pointed towards the clean dishes coming out of the dish machine, was covered in a gray, fuzzy substance, and that the facility failed to maintain clean equipment to prevent foodborne illness.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.6(f) Dietary services.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>46167</p> <p>Based on observation, and staff interview it was determined that the facility failed to properly contain and dispose of garbage in one of two outside dumpsters to prevent the potential for rodent and insect infestation (dumpster one).</p> <p>Findings include:</p> <p>During an observation and interview of the facility's outdoor trash receptacles on 3/11/25, at 12:45 p.m. Certified Dietary Manager Employee E21 confirmed that the lid/cover was not closed on dumpster one.</p> <p>During an observation on 3/13/25, at 8:29 a.m. the lid/cover of dumpster one was noted to be open.</p> <p>During an interview on 3/13/25, at 8:30 a.m. the Nursing Home Administrator confirmed that the facility failed to</p> <p>properly contain and dispose of garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to maintain complete and accurate documentation for three of three residents (Residents R44, R62, and R65).</p> <p>Findings include:</p> <p>Review of facility policy Comprehensive Care Planning dated /10/25, indicated a facility designee, appointed and directed by the Administrator is responsible for developing and maintaining an accurate record of residents scheduled for the Resident Care Plan Conference. The presence of all Resident Care Conferences staff/attendees and their relationship to the resident will be documented.</p> <p>Review of the clinical record indicated Resident R44 was admitted to the facility on [DATE].</p> <p>Review of Resident R44's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/25, indicated diagnoses of anemia (too little iron in the blood), hyperlipidemia (high levels of fat in the blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of Resident R44's clinical record revealed documentation that the resident had a care conference completed on 11/19/24, and the next scheduled care conference was 2/18/25. Review of the clinical record failed to reveal documentation to indicate that the scheduled care conference had been performed on 2/18/25.</p> <p>Review of the clinical record revealed Resident R62 was admitted to the facility on [DATE].</p> <p>Review of Resident R62's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and dementia.</p> <p>Review of Resident R62's clinical record revealed documentation that the resident had a care conference completed on 11/7/24, and the next scheduled care conference was 2/6/25. Review of the clinical record failed to reveal documentation to indicate that the scheduled care conference had been performed on 2/6/25.</p> <p>Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE].</p> <p>Review of Resident R65's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and depression.</p> <p>Review of Resident R65's clinical record revealed documentation that the resident had a care conference completed on 11/8/24, and the next scheduled care conference was 2/6/25. Review of the clinical record failed to reveal documentation to indicate that the scheduled care conference had been performed on 2/6/25.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/14/25, at 8:58 a.m. Social Services Employee E10 stated that care conferences occurred for Residents R44, R62, and R65 in February 2025. During this interview, Social Services Employee E10 provided a folder of paper documents containing handwritten care conference attendance and topics discussed for Residents R44, R62, and R65. Social Services Employee E10 stated, I took over as the primary Social Worker in January and I've been behind on documentation, I haven't had a chance to enter these into the medical record yet.</p> <p>During an interview eon 3/14/25, at 9:04 a.m. Social Services Employee E10 confirmed that the facility failed to maintain complete and accurate documentation for three of three residents as required.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis, and order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for three of four residents (Resident R39, R62, and R81).</p> <p>Findings include:</p> <p>Review of the facility policy Hospice Care dated 1/10/25, indicated that the facility will ensure that the resident's plan of care and a description of the services furnished by the facility to attain or maintain the residents highest practicable physical, mental, and psychological wellbeing. The facility will also obtain from hospice the instructions on how to access the hospice's 24 hour on-call system</p> <p>Review of the clinical record revealed that Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 2/28/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and hyperlipidemia (abnormally high levels of fats are in the bloodstream).</p> <p>Review of Resident R39's clinical record revealed a physician's order dated 2/17/25, to admit to hospice services.</p> <p>Review of Resident R39's comprehensive care plan failed to indicate a plan of care that included that Resident R39 was receiving hospice services.</p> <p>Review of the clinical record revealed Resident R62 was admitted to the facility on [DATE].</p> <p>Review of Resident R62's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and dementia. Review of Section O, Question O0110K1 indicated the resident received hospice care while in the facility.</p> <p>Review of a physician order dated 10/24/24, indicated to admit resident to hospice services with a diagnosis of parkinsonism.</p> <p>Review of Resident R65's comprehensive care plan on 3/12/25, failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>Review of Resident R81's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, wound infection, and septicemia (the body's extreme response to an infection that can be life threatening) .</p> <p>Review of Resident R81's clinical record revealed a physician's order dated 2/10/25, to admit to hospice services.</p> <p>Review of Resident R81's comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>During an interview on 3/13/25, at 11:15 a.m. the Director of Nursing confirmed that 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 Residents R39, R62, and R81.</p> <p>28 Pa. Code: 201.14(a) Responsibilities of licensee.</p> <p>28 Pa. Code: 201.18(b)(1)(3) Management.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R81).</p> <p>Findings include:</p> <p>Review of facility policy Clean Dry Dressing Change dated 1/10/25, indicated where sterile technique is not ordered or indicated, wounds will be dressed using clean technique which avoids direct contamination of material and supplies.</p> <p>Procedure:</p> <ul style="list-style-type: none"> - Perform hand hygiene - Introduce self to patient/resident - Confirm patient/resident ID - Explain procedure to patient/resident, offer bathroom, analgesia - Ensure privacy - Set up clean field using a barrier, towel, chux, etc - Position patient to visualize area to be dressed - Perform hand hygiene - [NAME] clean gloves - Check any dressing present, remove and wrap in gloves as you take gloves off, discard in trash bag - Assess wound (if you need to touch the area perform hand hygiene and don new clean gloves) - Perform hand hygiene - Prepare supplies on field on field including any cleansing solution - [NAME] clean gloves - Cleanse with ordered solution or normal saline soaked gauze pads - Remove gloves and discard <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Perform hand hygiene and don clean gloves - Apply new dressing(s) as ordered - Assist patient/resident back to comfortable position - Remove and discard gloves - Perform hand hygiene - Document procedure and update findings - Notify provider if necessary <p>Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE].</p> <p>Review of Resident R81's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/18/25, indicated diagnoses of high blood pressure, wound infection, and sepsis (the body ' s extreme response to an infection that can be life threatening). Section M - Skin Conditions, Question M0300 indicated the resident had one Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer).</p> <p>Review of a physician order dated 3/11/25, indicated to cleanse sacral (bottom of the spine) wound with soap and water, pat dry, apply absorbent dressing such as alginate or foam and cover with abd pad (gauze pad used for absorption).</p> <p>During a dressing change observation on 3/11/25, from 8:53 a.m. to 9:10 a.m. Registered Nurse (RN) Employee E7 removed Resident R81's previous dressing, removed her gloves and did not perform hand hygiene prior to donning a clean pair of gloves. After applying a new dressing, RN Employee E7 removed her gloves and did not perform hand hygiene prior to donning a clean pair of gloves. RN Employee E7 dated the dressing on Resident R81's sacrum with a black marker, removed her gloves, and donned a new pair of gloves without performing hand hygiene.</p> <p>During an interview on 3/11/25, at 9:13 a.m. RN Employee E7 confirmed that she did not perform hand hygiene between donning and doffing clean gloves and that the facility failed to implement infection control practices to prevent cross contamination during a dressing change observation.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.10 (d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for one of six residents (Resident R63).</p> <p>Findings include:</p> <p>Review of facility policy Resident Vaccination dated 1/10/25, indicated that residents or their responsible party will be asked about prior vaccinations at admission. Prior doses of influenza, pneumococcal, COVID-19, and other vaccines will be documented in the immunization portal in the electronic health record. Consents, refusals, or medical ineligibility will be documented.</p> <p>Review of Resident R63's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R63's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/29/25, indicated diagnoses of multiple sclerosis (a disease that affects central nervous system), seizures (a disruption of brain electrical activity that can cause changes in behavior, movement, awareness, or sensation), and gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). MDS Section O- Special treatment, Procedures, and Programs O0250 indicated Influenza vaccine was coded 5- not offered. O0300 indicated Pneumonia vaccine was coded a 0- not offered. O0350 indicated COVID vaccine was coded a 0- resident not up to date.</p> <p>During a review of Resident R63's clinical record on 3/11/25, at 1:00 p.m. indicated that the Pneumonia and Influenza vaccination was not entered and was blank.</p> <p>During a review of Resident R63's clinical record on 3/11/25, at 1:05 p.m. failed to include documentation of Pneumonia and Influenza vaccination refusal consent form, and that education was provided to Resident R63.</p> <p>During an interview on 3/11/25, at 2:05 p.m. Regional Clinical Director-Infection Preventionist Employee E6 stated the facility has no documentation that Resident R63 received his vaccinations or that he was offered after being admitted into the facility.</p> <p>During an interview on 3/11/25, at 2:10 p.m. Infection Preventionist Employee E6 confirmed that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for one of six residents (Resident R63).</p> <p>28 Pa. Code 211.5(f) Clinical records</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory disease) vaccine for two of six residents (Resident R6, and R63).</p> <p>Findings include:</p> <p>Review of facility policy Resident Vaccination dated 1/10/25, indicated that residents or their responsible party will be asked about prior vaccinations at admission. Prior doses of influenza, pneumococcal, COVID-19, and other vaccines will be documented in the immunization portal in the electronic health record. Consents, refusals, or medical ineligibility will be documented.</p> <p>Review of Resident R6's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated diagnoses of hypertension, coronary artery disease (damage or disease in the heart's major blood vessels), and cancer (uncontrolled cell growth and the ability to invade and spread to other parts of the body). MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date.</p> <p>Review of clinical records indicated that Resident R6 last received a COVID-19 vaccination on 2/17/21.</p> <p>During a review of Resident R6's clinical record on 3/11/25, at 1:05 p.m. failed to include documentation of an up-to-date COVID-19 booster vaccine was offered and that education was provided to Resident R6.</p> <p>Review of Resident R63's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R63's MDS dated [DATE], indicated diagnoses of multiple sclerosis (a disease that affects central nervous system), seizures (a disruption of brain electrical activity that can cause changes in behavior, movement, awareness, or sensation), and gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). MDS Section O- Special treatment, Procedures, and Programs O0250 indicated Influenza vaccine was coded 5- not offered. O0300 indicated Pneumonia vaccine was coded a 0- not offered. O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date.</p> <p>During a review of Resident R63's clinical record on 3/11/25, at 1:08 p.m. indicated that the COVID vaccination was not entered and was blank.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident R63's clinical record on 3/11/25, at 1:10 p.m. failed to include documentation of facility offering a COVID-19 vaccination and that education was provided to Resident R63.</p> <p>During an interview on 3/11/25, at 2:05 p.m. Regional Clinical Director-Infection Preventionist Employee E6 stated the facility has no documentation that Resident R6, and R63 was offered a COVID-19 vaccination after being admitted into the facility.</p> <p>During an interview on 3/11/25, at 2:10 p.m. Infection Preventionist Employee E6 confirmed that the facility failed to provide accurate and timely documentation related to the COVID-19 vaccine for two of six residents (Resident R6, and R63).</p> <p>28 Pa. Code 211.5(f) Clinical records</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Harmar Village Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on effective communication for four of five staff members (Employee E11, E12, E13, and E14).</p> <p>Findings include:</p> <p>Review of the Facility assessment dated [DATE], indicated that new staff are trained during orientation and existing staff are trained monthly on specific topics to ensure educational requirements are met.</p> <p>Review of facility provided documents and training records revealed the following staff members did not have documented training on effective communication.</p> <p>Nurse Aide (NA) Employee E11 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/23, and 7/1/24.</p> <p>NA Employee E12 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/23, and 7/1/24.</p> <p>NA Employee E13 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/23, and 7/1/24.</p> <p>NA Employee E14 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/23, and 7/1/24.</p> <p>During an interview on 3/14/25, at 12:31 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on effective communication for four of five staff members.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p> <p>28 Pa Code: 201.20 (a) Staff development.</p>		