STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396048	A. BLDG: 00 B. WING:	12/17/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HARMAR VILLAGE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **077802**	**715 FREEPORT ROAD** **CHESWICK, PA 15024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an abbreviated survey in response to an annoymous complaint completed on December 17, 2024, it was determined that Harmar Village Health & Rehab Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0636 SS=E		F 0636		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0636 SS=E	Continued from page 1 483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	R1, R2 and R3 previously dated late assessments were unable to be recreated. R1, R2 and R3 assessments have been completed to be current. A house audit will be completed by 12/25/24, to ensure active residents have a recent Activity Assessment. Assessments due will be reviewed in clinical meeting and followed up on per policy as appropriate. The new Activity Director was provided education on the Activity Assessments completion and policy by the Nursing Home Administrator/designee. The Registered Nurse Assessment Coordinator/designee, moving forward, will perform an audit of new admissions/due Activity Assessments 3 times per week times 4 weeks then weekly x 2 weeks to ensure compliance. Any noted discrepancies will be addressed as appropriate, and results of auditing will be reviewed at the facility Quality Assurance Meeting.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/20/2024**

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F 0636 SS=E	Continued from page 2 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 0636		

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F 0636 SS=E	Continued from page 3 Based on clinical record review, and staff interview, it was determined that the facility failed to complete admission activites evaluation for three of three residents as required. (Residents R1, R2 and R3) Findings include: During a review of clinical record indicated that Resident R3 was admitted 11/12/24. During a review of clinical record clinical assessment summary indicated Resident R3 Admission Activities Evaluation due date was 11/16/24, and it was not completed and overdue. During a review of clinical record indicated that Resident R1 was admitted 11/27/24. During a review of clinical record clinical assessment summary indicated Resident R1 Admission Activities Evaluation due date was 11/31/24, and it was not completed and overdue.	F 0636		

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F 0636 SS=E	Continued from page 4 During a review of clinical record indicated that Resident R2 was admitted 11/29/24. During a review of clinical record clinical assessment summary indicated Resident R2 Admission Activities Evaluation due date was 12/2/24, and it was not completed and overdue. During an interview on 12/17/24, at 1:00 p.m., Nursing Home Administrator confirmed the that Admission Activities Evaluation's were not completed as required. 28 Pa. Code: 211.10(d) Resident care policies.	F 0636		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 5 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	The care plan for R3 was revised on 12/17/2024 revised to reflect care interventions. The order for the device was discontinued prior to the observation. The interdisciplinary team will be re-in serviced by the RDCS/designee on Care Plan Timing and Revision F0657 by 12/26/2024. The Registered Nurse Assessment Coordinator/designee will conduct audits of care plan revisions needing made to the comprehensive care plans via the 24 hour report 3 x per week for 4 weeks then weekly times 2 weeks. Any noted discrepancies will be addressed as appropriate, and results of auditing will be reviewed at the facility Quality Assurance Meeting.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/20/2024**

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F 0657 SS=D	Continued from page 6 Based on clinical records and staff interview, it was determined that the facility failed to revise a care plan for one of three residents (Resident R3) to accurately reflect the current status of the resident. Findings include: Review of clinical record indicated Resident R3 was admitted to the facility on 11/12/24, with diagnoses that included encephalopathy(disease in which the functioning of the brain is affected by some agent or condition), hypothyroidism and anemia. Review of Resident R3's Minimum Data Set (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 11/18/24, indicated the diagnoses remain current. Review of Resident R3's Resident Care Plan Summary Report (report nurse aides used to know what kind of care to provide) dated 11/18/24, indicated equip resident with a device that alarms when wanders. Check for proper functioning of	F 0657		

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F 0657 SS=D	Continued from page 7 device every day and placement q shift. Review of Resident R3's physician orders dated 11/13/24 indicated no order for device. During an interview on 12/17/24, at 1:30 p.m. Director of Nursing confirmed the facility failed to revise care plan for Resident R3 as required. 28 Pa. Code: 211.11(d) Resident Care Plan.	F 0657		

Certified End Page

HARMAR VILLAGE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 077802

SURVEY EXIT DATE: 12/17/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY