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:	03/14/2025

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**

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F 0000	INITIAL COMMENT Based on an Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance survey and an Abbreviated survey completed on March 14, 2025, it was determined that Harmar Village Health and 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 0550 SS=E		F 0550		

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 0550 SS=E	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Residents #81, #31 and #65 had no negative outcomes. There were no other concerns expressed during survey related to dignity regarding dressing changes, residents in dining room that are NPO or CNA's standing and feeding residents. To prevent this from recurring the DON / designee educated nursing staff on the regulatory requirements of F550 and dignity with emphasis on not writing on dressings after placed on resident, not placing residents that are NPO in the dining room during mealtime or feeding residents while standing up. To monitor and maintain ongoing compliance the DON / designee will audit 3 meal services and 3 dressing changes weekly x4 then monthly x2. Negative findings will be addressed, and ad hoc education will be completed as necessary. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0550 SS=E	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550		

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F 0550 SS=E	Continued from page 3 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). Findings include: 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. 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. Review of Resident R31's clinical record indicated	F 0550		

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F 0550 SS=E	Continued from page 4 the resident was admitted to the facility on 9/13/13. 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. Review of Resident R31's physician orders indicated that resident is NPO (nothing by mouth). 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. During an interview on 3/10/25, at 11:29 a.m.	F 0550		

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F 0550 SS=E	Continued from page 5 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. 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. 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. Review of the clinical record indicated Resident R81 was admitted to the facility on 2/10/25. Review of Resident R81's MDS 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	F 0550		

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F 0550 SS=E	Continued from page 6 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). 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). 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. 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.	F 0550		

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F 0550 SS=E	Continued from page 7 Pa. Code: 211.10(a)(b)(c)(d) Resident care policies. Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0550		
F 0554 SS=D		F 0554		

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F 0554 SS=D	Continued from page 8 483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 0554	Residents #14, #42 #74 and #80 had not negative outcomes. Items left at bedside were secured and medications were administered to Resident #42. To identify other potential areas of concern, the DON/Designee completed a whole house audit of resident room to ensure medications were not left at bedside. The DON/designee will complete a house audit of residents with a BIMS of 13 or greater to see if any request to self-med administer. If so, the self-med assessment will be completed as appropriate. There were no negative findings. To prevent this from recurring the DON / designee educated licensed nursing staff on the regulatory requirements of F554 regarding self-administration and also educated on the medication administration policy. To monitor and maintain ongoing compliance the DON / designee will complete 3 room audits weekly x4 then monthly x2 to ensure no medications are left at bedside. Negative findings will be addressed, and ad hoc education will	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0554 SS=D	Continued from page 9	F 0554	be completed as necessary. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	

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F 0554 SS=D	Continued from page 10 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). Findings include: 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. Review of Resident R14's clinical record indicated the resident was admitted to the facility on 1/29/25. 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	F 0554		

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F 0554 SS=D	Continued from page 11 (condition when the bones become brittle and fragile), and dysphagia (difficulty swallowing). Review of Resident R14's physician's order failed to include an order for self-administration of medications. Review of Resident R14's care plan on 1/30/25, failed to include self-administration of medication management. Review of Resident R14's clinical record indicated the absence of a Self-Administration of Medication assessment. 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". During an interview on 3/10/25, at 9:13 a.m. Licensed Practical Nurse (LPN) Employee E8	F 0554		

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F 0554 SS=D	Continued from page 12 confirmed that a tube of Icy Hot cream was in Resident R14's room and removed it. Review of Resident R42's clinical record indicated the resident was admitted to the facility on 5/13/17. Review of Resident R42's MDS dated 2/2/25, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and hyperlipidemia (elevated levels of fats in the blood). Review of Resident R42's physician's order failed to include an order for self-administration of medications. Review of Resident R42's care plan on 2/9/25, failed to include self-administration of medication management. Review of Resident R42's clinical record indicated the absence of a Self-Administration of Medication assessment.	F 0554		

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F 0554 SS=D	Continued from page 13 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. 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". Review of Resident R74's clinical record indicated the resident was admitted to the facility on 5/20/24. 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). Review of Resident R74's physician's order failed to	F 0554		

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F 0554 SS=D	Continued from page 14 include an order for self-administration of medications. Review of Resident R74's care plan on 2/27/25, failed to include self-administration of medication management. Review of Resident R74's clinical record indicated the absence of a Self-Administration of Medication assessment. 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. 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. Review of Resident R80's clinical record indicated the resident was admitted to the facility on 11/10/23.	F 0554		

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F 0554 SS=D	Continued from page 15 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). Review of Resident R80's physician's order failed to include an order for self-administration of medications. Review of Resident R80's care plan on 2/22/25, failed to include self-administration of medication management. Review of Resident R80's clinical record indicated the absence of a Self-Administration of Medication assessment. During an observation on 3/10/25, at 9:25 a.m. Resident R80 had a bottle of Flonase sitting on her overbed table.	F 0554		

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F 0554 SS=D	Continued from page 16 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. 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). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services. 28 Pa. Code: 211.9(a)(1) Pharmacy services.	F 0554		
F 0578 SS=E		F 0578		

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:	03/14/2025

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**

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F 0578 SS=E	Continued from page 17 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	The resident and/or resident representative for Resident #31 and #42 were provided an opportunity to develop an advance directive. Moving forward, SSD/designee will verify residents and/or resident representatives have been provided an opportunity to develop an advance directive upon admission and at each quarterly care conference. To prevent this from recurring, the RDCS/designee educated licensed nursing on the regulatory requirements of F578 regarding ensuring residents and/or resident representatives are provided an opportunity to develop an advance directive. To monitor and maintain ongoing compliance the DON/designee will audit 3 residents weekly x4 then monthly x 2 to ensure residents and /or families are provided an opportunity to develop an advance directive. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0578 SS=E	Continued from page 18 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	Improvement (QAPI) committee for further review and recommendations	

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F 0578 SS=E	Continued from page 19 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). Findings include: 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. Review of Resident R31's clinical record indicated	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0578 SS=E	Continued from page 20 the resident was admitted to the facility on 9/13/13. 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). 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. Review of Resident R42's clinical record indicated the resident was admitted to the facility on 5/13/17. Review of Resident R42's MDS dated 2/2/25, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and hyperlipidemia (elevated levels of fats in the blood).	F 0578		

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F 0578 SS=E	Continued from page 21 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. 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). 28 Pa. Code: 201.29(b) Resident rights.	F 0578		
F 0580 SS=D		F 0580		

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F 0580 SS=D	Continued from page 22 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Moving forward the facility will ensure that proper notification to Resident family/RP are completed with changes. Unable to make corrective action for R 71, he no longer resides in facility. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee reviewed progress notes to ensure that notification of changes were complete with resident family and/or Responsible Party. Negative findings will be addressed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed nursing staff on the regulatory requirements of F580. To monitor and maintain ongoing compliance the DON/designee will audit progress notes weekly x4 then monthly x 2 to ensure notifications are made. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI)	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0580 SS=D	Continued from page 23 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	committee for further review and recommendations.	

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F 0580 SS=D	Continued from page 24 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). Findings include: Review of the Resident R71 admission record indicates he was admitted on 1/12/25. 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. Review of Resident R71 nurse progress dated 1/17/25 indicated family was concerned with Seroquel making the resident tired. Review of Resident R71 nurse progress dated 1/31/25, physician saw resident indicating dose was appropriate.	F 0580		

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F 0580 SS=D	Continued from page 25 Review of Resident R71 nurse progress dated 2/1/25 pharmacy indicated Seroquel was at appropiate dose. Review of Resident R71 nurse progress dated 1/17/25- 2/9/25 revealed no notification to guardian regarding Seroquel dose. 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. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0580		
F 0620 SS=D		F 0620		

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F 0620 SS=D	Continued from page 26 483.15(a)(1)-(7) Admissions Policy §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. §483.15(a)(4) In the case of a person eligible for Medicaid, a	F 0620	R 100 has discharged. Unable to correct. To identify other residents that have the potential to be affected, the admissions director/designee completed a 15 day look back of new admission to ensure each resident has admission paperwork as required. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated staff on the regulatory requirements of F620 and ensuring new admissions have paperwork as required. To monitor and maintain ongoing compliance the DON/designee will audit new admissions/readmission weekly x4 weeks then monthly x 2 to ensure they have paperwork as required. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0620 SS=D	Continued from page 27 nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. §483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.	F 0620		

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F 0620 SS=D	Continued from page 28 §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by:	F 0620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0620 SS=D	Continued from page 29 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). Findings include: Review of Resident R100 was admitted 10/23/24 with diagnoses that include dementia(progressive decline in cognitive abilities, including memory, thinking, reasoning, and problem-solving), acute kidney failure and hypertension. 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: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment	F 0620		

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F 0620 SS=D	Continued from page 30 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. Review of Resident R100's clinical record revealed no admission packet. 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. 28 Pa Code: 211.5 (f)(v.) Medical records.	F 0620		
F 0622 SS=E		F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0622 SS=E	Continued from page 31 483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident	F 0622	The facility cannot retroactively correct for Resident #26, #31, #44 and #95. Moving forward the facility will communicate necessary information to the receiving health care provider. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed nursing staff on the regulatory requirements of F620. To monitor and maintain ongoing compliance the DON/designee will audit residents transferred to hospital for Continuation of Care document and bed hold policy2x weekly x4 weeks, then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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:	03/14/2025

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F 0622 SS=E	Continued from page 32 while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 0622		

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F 0622 SS=E	Continued from page 33 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 0622		

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F 0622 SS=E	Continued from page 34 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of five residents sampled with facility-initiated transfers (Residents R26, R31, R44, and R95). Review of facility policy "Transfers" dated 1/10/25, indicated forms that need to be sent out with facility-initiated transfers to hospital: Discharge/Transfer Form, copy of care plan goals, and Bed Hold Notice. Review of the clinical record revealed that Resident R26 was admitted to the facility on 6/4/18. Review of Resident 26's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/11/25, indicated diagnoses of anxiety disorder (mental illnesses that involve persistent and uncontrollable feelings of fear), hyperlipidemia (abnormally high levels of fats are in the	F 0622		

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F 0622 SS=E	Continued from page 35 bloodstream), and dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory). Review of the clinical record indicated Resident R26 was transferred to the hospital on 2/9/25. Review of Resident R26's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R31's clinical record indicated the resident was admitted to the facility on 9/13/13. Review of Resident R31's MDS dated 2/24/25, indicated diagnoses of high blood pressure, diabetes	F 0622		

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F 0622 SS=E	Continued from page 36 (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). Review of the clinical record indicated Resident R31 was transferred to the hospital on 1/10/25. Review of Resident R31's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R44 was admitted to the facility on 7/28/15. Review of Resident R44's MDS dated 2/6/25,	F 0622		

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F 0622 SS=E	Continued from page 37 indicated diagnoses of anemia (too little iron in the blood), hyperlipidemia, and dementia. Review of the clinical record indicated Resident R44 was transferred to the hospital on 1/25/25. Review of Resident R44's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R95 was admitted to the facility on 2/12/25. Review of Resident R95's MDS dated 3/5/25, indicated diagnoses of atrial fibrillation (a condition where the upper chambers of the heart (atria) beat	F 0622		

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F 0622 SS=E	Continued from page 38 irregularly and rapidly), parkinsonism(clinical syndrome characterized by a group of motor symptoms that mimic Parkinson's disease) and difficulty walking. Review of the clinical record indicated Resident R95 was transferred to the hospital on 2/24/25. Review of Resident R95s clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 3/13/25, at 1:25 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving	F 0622		

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F 0622 SS=E	Continued from page 39 health care provider for four of five residents as required. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.	F 0622		
F 0625 SS=E		F 0625		

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F 0625 SS=E	Continued from page 40 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	The facility cannot retroactively correct for Resident #26, #31, #44 and #95. Moving forward the facility will communicate necessary information to the receiving health care provider. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed nursing staff on the regulatory requirements of F625. To monitor and maintain ongoing compliance the SSD/designee will confirm bed hold policy was sent for residents transferred to hospital 2x weekly x4 weeks, then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0625 SS=E	Continued from page 41	F 0625		

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F 0625 SS=E	Continued from page 42 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for four of four resident hospital transfers (Residents R31, R44, R74, and R95). Review of facility policy "Transfers" dated 1/10/25, indicated forms that need to be sent out with facility-initiated transfers to hospital: Discharge/Transfer Form, copy of care plan goals, and Bed Hold Notice. Review of Resident R31's clinical record indicated the resident was admitted to the facility on 9/13/13. 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),	F 0625		

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F 0625 SS=E	Continued from page 43 and aphasia (a language disorder that affects a person's ability to communicate). Review of the clinical record indicated Resident R31 was transferred to the hospital on 1/10/25, and returned to the facility on 1/11/25. Review of Resident R31's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/10/25. Review of the clinical record indicated Resident R44 was admitted to the facility on 7/28/15. Review of Resident R44's MDS dated 2/6/25, indicated diagnoses of anemia (too little iron in the blood), hyperlipidemia (high levels of fat in the blood), and dementia. Review of the clinical record indicated Resident R44 was transferred to the hospital on 1/25/25, and	F 0625		

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F 0625 SS=E	Continued from page 44 returned to the facility on 1/27/25. Review of Resident R44's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/25/25. Review of Resident R74's clinical record indicated the resident was admitted to the facility on 5/20/24. Review of Resident R74's MDS 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). Review of the clinical record indicated Resident R74 was transferred to the hospital on 12/31/24, and returned 1/7/25.	F 0625		

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F 0625 SS=E	Continued from page 45 Review of Resident R74's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/31/24. Review of the clinical record indicated Resident R95 was admitted to the facility on 2/12/25. Review of Resident R95's MDS dated 3/5/25, 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. Review of the clinical record indicated Resident R95 was transferred to the hospital on 2/24/25, and returned 3/5/25. Review of Resident R95's clinical record failed to include documented evidence that the resident or the	F 0625		

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F 0625 SS=E	Continued from page 46 resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/24/25. During an interview on 3/13/25, at 1:25 p.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for four of four resident hospital transfers as required. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.	F 0625		
F 0655 SS=D		F 0655		

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F 0655 SS=D	Continued from page 47 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	The facility is unable to complete baseline care plans for R90 and R203. A comprehensive care plan was developed for R90 and R203. Moving forward the facility will ensure a baseline care plan is developed. To identify other residents that have the potential to be affected, the RNAC/designee reviewed new admissions for 2 weeks to ensure a baseline care plan was developed. Negative findings will be addressed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed staff and RNAC on the regulatory requirements of F655. To monitor and maintain ongoing compliance the RNAC/designee will audit new admission baseline care plans 2x weekly x4 weeks then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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: _____	03/14/2025

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F 0655 SS=D	Continued from page 48 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655		

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F 0655 SS=D	Continued from page 49 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). Findings include: 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. Review of the clinical record indicated Resident R90 was admitted to the facility on 1/24/25. Review of Resident R90's Minimum Data Set	F 0655		

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F 0655 SS=D	Continued from page 50 (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). 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. 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. 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	F 0655		

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F 0655 SS=D	Continued from page 51 dependence of supplemental oxygen. 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. 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. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0655		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 52 483.21(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 careplan for Resident #50 was updated and revised to reflect current status. Moving forward the facility will ensure careplans are updated and revised timely to reflect current status. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee reviewed all residents with a diagnosis or history of constipation and fecal impaction to ensure care plans are updated and revised timely. Corrections will be made as needed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated IDT on the regulatory requirements of F657. To monitor and maintain ongoing compliance the DON/designee will audit orders for any new constipation medications weekly x2 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0657 SS=D	Continued from page 53	F 0657	recommendations.	

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F 0657 SS=D	Continued from page 54 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. Findings include: 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. Review of the admission record indicated Resident R50 was admitted to the facility on 9/23/24. 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).	F 0657		

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F 0657 SS=D	Continued from page 55 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). 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. 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. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0657		

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F 0658 SS=D	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	The facility cannot retroactively correct the admission readmission observation for Resident #90 and #203. A chart review was completed to ensure their needs were care planned. Moving forward the facility will ensure admission readmission observations are completed as required. New admissions and readmissions have the potential to be affected. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated staff on the requirements to complete and admission assessment/observation. To monitor and maintain ongoing compliance the DON/designee will audit new admissions/readmissions for admission observation completeness weekly x2 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0658 SS=D	Continued from page 57 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). Findings include: 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. 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.	F 0658		

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F 0658 SS=D	Continued from page 58 Review of the clinical record indicated Resident R90 was admitted to the facility on 1/24/25. 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). 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 1/24/25. 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	F 0658		

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F 0658 SS=D	Continued from page 59 exchange oxygen and carbon dioxide), and dependence of supplemental oxygen. 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 3/5/25. 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. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0658		

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F 0660 SS=D	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.	F 0660	Unable to correct R46. Moving forward the facility will ensure discharge planning is completed that focuses on resident goals. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee reviewed pending discharges to ensure discharge documentation is completed as required. Corrections will be made as needed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed nursing staff on the regulatory requirements of F660. To monitor and maintain ongoing compliance the DON/designee will audit discharge documentation weekly x4 hen monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0660 SS=D	Continued from page 61 (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.	F 0660		

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F 0660 SS=D	Continued from page 62 This REQUIREMENT is not met as evidenced by:	F 0660		

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(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 0660 SS=D	Continued from page 63 Based on review of clinical record review and interview with staff, it was determined that the facility failed to provide discharge planning that focuses on the resident's discharge goals and preparation of resident to be active partners in the discharge planning process that focuses on the resident's discharge planning and process for one of three residents (R46). Findings include: Review of Resident R46's admission record indicated R46 was admitted 2/7/25. Review of R46's Minimum Data Set (MDS-a periodic assessment of care needs) dated 2/13/25, indicated diagnoses of muscle wasting, anemia and failure to thrive. Review of R46s physician orders dated 3/9/25, indicated resident to discharge to home with home health.	F 0660		

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	396048	A. BLDG: __00_____ B. WING: _____	03/14/2025

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F 0660 SS=D	Continued from page 64 Review of Resident R46's progress notes dated March 2025 indicated no discharge instruction, no inventory or medication reconciliation, no indication that the R46 had been discharged. During an interview on 3/13/25, at 2:45 p.m. the Director of Nursing confirmed that the facility failed complete discharge documentation for Resident R46 as required. 28. Pa. Code 211.5(d) Medical records.	F 0660		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 65 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	The weight was obtained for R1 R19 and R47. Unable to correct assessments for R90 and R203. The provider was notified of R19's hypoglycemic issue. R62 no longer resides at the facility, unable to correct. R81 no longer resides at the facility, unable to correct. Provider was notified of R253 refusals. Moving forward, clinical morning meeting will include review of quality of care items and follow up by DON/designee. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated nursing staff on the weight policy, blood glucose policy, hypoglycemia policy, wound assessment, medication administration, documentation, admission assessment requirements and notification of physician. To monitor and maintain ongoing compliance the DON/designee will audit the facility activity report five time weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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F 0684 SS=E	Continued from page 66	F 0684	will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	

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F 0684 SS=E	Continued from page 67 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). Findings include: 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. Review of the facility policy "Diabetic Protocol" dated 1/10/25, indicated the provider and staff will work together to give appropriate treatment to	F 0684		

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F 0684 SS=E	Continued from page 68 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. 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: - 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	F 0684		

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F 0684 SS=E	Continued from page 69 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. Once acute hypoglycemia has resolved, notify the provider and document in resident's medical record. 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. 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,	F 0684		

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F 0684 SS=E	Continued from page 70 incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc. Review of the clinical record indicated Resident R1 was admitted to the facility on 10/8/20. 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. Review of a physician order dated 12/11/23, indicated to obtain weight monthly on the 1st Tuesday of the month. 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."	F 0684		

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F 0684 SS=E	Continued from page 71 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. Review of Resident R19's clinical record indicated the resident was admitted to the facility on 11/8/18. Review of Resident R19's MDS dated 2/3/25, indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and diabetes. 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. 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.	F 0684		

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F 0684 SS=E	Continued from page 72 Review of Resident R19's abnormal blood glucose readings (normal reading is between 70-100 milligrams per deciliter -mg/dL were the following: 1/12/25 - 360 mg/dL 1/18/25 - 356 mg/dL 2/5/25 - 380 mg/dL 2/19/25 - 375 mg/dL Review of Resident R19's progress notes failed to reveal that the physician was notified of the above blood glucose readings. 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. Review of the clinical record indicated Resident R47 was admitted to the facility on 3/21/21. Review of Resident R47's MDS dated 2/3/25,	F 0684		

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F 0684 SS=E	Continued from page 73 indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and dementia. Review of a physician order dated 12/8/23, indicated to obtain weight monthly on the 1st Monday of every month. 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." 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. Review of the clinical record revealed Resident R62 was admitted to the facility on 9/1/21. Review of Resident R62's MDS dated 2/25/25,	F 0684		

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F 0684 SS=E	Continued from page 74 indicated diagnoses of high blood pressure, hyperlipidemia, and dementia. Review of a physician order dated 10/16/23, indicated to notify the physician if blood sugar is less than 60 mg/dL. Review of Resident R62's vitals records for February and March 2025, indicated the following blood glucose measurements: - 2/27/25: 59 mg/dL - 3/9/25: 56 mg/dL - 3/11/25: 53 mg/dL 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. Review of a nursing progress note dated 3/6/25, stated, "CBG (capillary blood glucose) 61.	F 0684		

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F 0684 SS=E	Continued from page 75 Provided resident with orange juice and apple sauce. Resident asymptomatic (without symptoms). Will recheck in 30 minutes." 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. Review of Resident R81's clinical record indicated the resident was admitted to the facility on 3/6/24. Review of Resident 81's MDS dated 2/18/25, 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. Review of Resident R81's clinical record revealed a	F 0684		

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F 0684 SS=E	Continued from page 76 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. 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. 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. 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.	F 0684		

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F 0684 SS=E	Continued from page 77 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. 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. 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. Review of the clinical record indicated Resident R90 was admitted to the facility on 1/24/25. Review of Resident R90's MDS dated 1/30/25,	F 0684		

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F 0684 SS=E	Continued from page 78 indicated diagnoses of high blood pressure, hyperlipidemia, and lymphedema (swelling in an arm or leg caused by a lymphatic system blockage). Review of Resident R90's "Wound Management Detail Report" indicated the resident was admitted on 1/24/25 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. 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." 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	F 0684		

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F 0684 SS=E	Continued from page 79 document Resident R90's right and left posterior calf venous wounds from 1/24/25, to 2/4/25. 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. Review of Resident R90's February 2025 Medication Administration Record (MAR) revealed the treatment was not documented as completed on the following shifts: - 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. Review of a physician order dated 2/6/25, indicated to cleanse left posterior (back of) leg with soap and	F 0684		

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F 0684 SS=E	Continued from page 80 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. Review of Resident R90's February 2025 MAR revealed the treatment was not documented as completed on the following shifts: - 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. - 2/27/25 4 p.m. 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	F 0684		

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: _____	03/14/2025

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F 0684 SS=E	Continued from page 81 with ACE wrap BID for compression. Review of Resident R90's February 2025 MAR revealed the treatment was not documented as completed on the following shifts: - 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 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. - 2/25/25 8 a.m., the documented reason was, "Unable to change no help." - 2/27/25 4 p.m. 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.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 82 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 1/24/25. 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. 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 3/5/25.	F 0684		

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F 0684 SS=E	Continued from page 83 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 Review of the clinical record indicated Resident R253 was admitted to the facility on 3/6/25, 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). Review of a physician order dated 3/7/25, indicated to administer furosemide 40 mg (milligrams) daily. Review of Resident R253's March 2025 Medication Administration Record (MAR) indicated the medication was not administered on the following dates: - 3/7/25, the documented reason was "refused" - 3/8/25, the documented reason was "refused"	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 84 Review of a physician order dated 3/7/25, indicated to administer insulin lispro per sliding scale - 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 Review of Resident R253's March 2025 MAR indicated the medication was not administered on the following dates: - 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". Review of Resident R253's progress notes from	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 85 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. 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. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0684		
F 0686 SS=D		F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 86 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	R47 was assessed and added to weekly wound rounds. R60 no longer resides at the facility, unable to correct. To identify other residents that have the potential to be affected, the wound nurse/designee completed an evaluation of current residents to identify new skin impairments. An audit of current pressure ulcers was completed to ensure they were measured weekly, treatments are appropriate, and care plan is updated. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed staff on the requirements for F686. To monitor and maintain ongoing compliance the DON/designee will audit pressure ulcer documentation weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 87 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). Findings include: 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. 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. Review of the facility's Licensed Practical Nurse	F 0686		

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F 0686 SS=D	Continued from page 88 (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. Review of the clinical record indicated Resident R47 was admitted to the facility on 3/21/21. 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)	F 0686		

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F 0686 SS=D	Continued from page 89 during the 14-day lookback period. 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)." Review of a nursing progress note dated 2/13/25, stated, "Wound scabbed over. Left OTA (open to air)." 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. 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	F 0686		

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F 0686 SS=D	Continued from page 90 open area on her buttock." 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." 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.	F 0686		

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F 0686 SS=D	Continued from page 91 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. 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 2/2/6/25, until 3/13/25. Review of the clinical record indicated Resident R60 was admitted to the facility on 11/8/24. 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). Review of a physician order dated 2/6/25, indicated to cleanse sacrum (bottom of the spine) with NSS	F 0686		

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F 0686 SS=D	Continued from page 92 (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. Review of Resident R60's February 2025 Medication Administration Record (MAR) revealed the treatment was not signed off as completed on the following shifts: - 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. 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. Review of Resident R60's February 2025 MAR revealed the treatment was not documented as	F 0686		

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F 0686 SS=D	Continued from page 93 completed on the following shifts: - 2/24/25 8 a.m. - 2/26/25 8 a.m. - 2/27/25 8 a.m. - 2/27/25 8 p.m., the documented reason was, "Wound care nurse on duty, unknown if performed or not" Review of Resident R60's clinical record revealed a "Wound Management Detail Report" was not completed for the following weeks: - 11/24/24 to 11/30/24 - 2/9/25 to 2/15/25 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. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies.	F 0686		

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F 0686 SS=D	Continued from page 94 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 95 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Nursing is currently documenting checking placement and function for Resident #82's electronic bracelet. There were no other concerns identified regarding supervision during meal service during survey. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee reviewed current residents with electronic bracelets to ensure documentation occurring for checking placement and function of electronic bracelet. Corrections will be made as needed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated staff on the supervision during meal service and ensuring residents receive adequate monitoring of elopement devices (checking placement and function). To monitor and maintain ongoing compliance the DON/designee will audit meal service for supervision for meals and electronic bracelets for documentation of placement and function weekly x4 then monthly x 2. Negative findings will be addressed.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 96	F 0689	Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	

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: _____	03/14/2025

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 0689 SS=D	Continued from page 97 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). Findings include: 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. 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.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 98 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. 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". 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. 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).	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 99 Review of the admission record indicated Resident R82 was admitted to the facility on 2/8/24. 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). 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". 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	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 100 daily , and an order dated 2/13/24, to check electronic bracelet's placement every shift. 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. 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). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1) Management. 28 Pa Code: 211.10 (c)(d) Resident care policies.	F 0689		
F 0692 SS=E		F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 101 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Weights were obtained for R65. R81 no longer resides at the facility, unable to correct. Moving forward, the Director of Nursing (DON)/designee will review new admissions/readmissions to ensure admission weights and four weekly weights are obtained and that the nutrition assessments are able to be updated to include an accurate weight obtained by the facility. Negative findings will be addressed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated dietary tech and nursing staff on the weight policy and updating nutritional assessments with an accurate weight. To monitor and maintain ongoing compliance the DON/designee will audit new admissions/readmissions for weights as ordered weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI)	Completion Date: 04/14/2025 Status: APPROVED Date: 04/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 102	F 0692	committee for further review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 103 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). Findings include: 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. Review of the clinical record indicated Resident R65 was admitted to the facility on 7/24/20. Review of Resident R65's Minimum Data Set	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 104 (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. Review of Resident R65's weight record on 3/11/25, failed to reveal any documented weights for February 2025. 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. Review of Resident R81's clinical record indicated the resident was admitted to the facility on 3/6/24. Review of Resident 81's MDS dated 2/18/25, 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	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 105 feeding tube while a resident. Review of clinical record revealed that Resident R81's last recorded weight was 184.8 pounds on 1/10/25. Review of clinical record revealed that Resident R81 was transferred to hospital on 2/2/25, and returned on 2/10/25. 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. Review of Resident R81's clinical record revealed a Nutritional Assessment dated 2/17/25, 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". Review of Resident R81's clinical record conducted on 3/13/25, at 9:30 a.m. failed to include that the	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 106 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. 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. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0692		
F 0693 SS=E		F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=E	Continued from page 107 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	R31s tubing was dated and labeled. R95s tubing was dated, labeled and the correct tube feeding was hung. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee reviewed current residents with enteral tube feedings to ensure proper enteral feeding is hanging, enteral feeding bag and water flush bag are dated and syringe is dated. Corrections made as needed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated licensed staff on the enteral tube feeding policy (appropriate enteral feed and dating). To monitor and maintain ongoing compliance the DON/designee will audit enteral tube feedings for correct tube feed, correct labeling and expiration 2x a week x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=E	Continued from page 108	F 0693	further review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=E	Continued from page 109 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). Findings include: Review of facility policy "Enteral Feeding Tube" dated 1/10/25, 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.	F 0693		

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F 0693 SS=E	Continued from page 110 Review of Resident R31's clinical record indicated the resident was admitted to the facility on 9/13/13. 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. 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. During a tour of unit on 3/10/25, at 9:30 a.m.	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=E	Continued from page 111 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. Review of the clinical record indicated Resident R95 was admitted to the facility on 2/12/25. Review of Resident R95's MDS dated 3/5/25, 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. 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. During a tour of unit on 3/10/25, at 9:45 p.m. Resident R95's enteral feeding was observed	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=E	Continued from page 112 hanging at bedside. Fibersource HN was hanging, use be date 9/18/24. Water flush bag failed to have a date written. During an interview on 3/10/25, 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. During an interview on 3/10/25, 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. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.	F 0693		
F 0695 SS=E		F 0695		

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HARMAR VILLAGE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **077802**	**715 FREEPORT ROAD** **CHESWICK, PA 15024**

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F 0695 SS=E	Continued from page 113 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	R253's humidification bottle was added. R31, R42, R74, R81, and R203's O2/Neb tubing was changed and dated, bags provided for storage. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee completed and audit of current residents with oxygen therapy and nebulizer orders to ensure oxygen therapy is being delivered as ordered and tubing is dated and stored appropriately. Corrections will be made as needed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee licensed educated staff on the oxygen administration and nebulizer policy. To monitor and maintain ongoing compliance the DON/designee will audit residents with oxygen therapy and nebulizers to ensure oxygen therapy is being delivered as ordered and tubing is dated and stored appropriately. weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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: _____	03/14/2025

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**

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F 0695 SS=E	Continued from page 114	F 0695	be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 115 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). Findings include: 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. Humidifcation should be added if flow rate is more than four liters per minute of oxygen. 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	F 0695		

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F 0695 SS=E	Continued from page 116 via a nebulizer machine. Review of Resident R31's clinical record indicated the resident was admitted to the facility on 9/13/13. 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). 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. 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	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 117 control purpose, when not in use. 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. Review of Resident R42's clinical record indicated the resident was admitted to the facility on 5/13/17. Review of Resident R42's MDS dated 2/2/25, 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. Review of physician's order dated 12/4/23, indicated to administer Oxygen via nasal cannula continuously at two liters per minute.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 118 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. 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. 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. Review of Resident R74's clinical record indicated the resident was admitted to the facility on 5/20/24. Review of Resident R74's MDS 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). MDS Section O- Special treatment,	F 0695		

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F 0695 SS=E	Continued from page 119 Procedures, Programs Section O0100 C1 indicated that resident utilizes oxygen. 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. Review of physician orders dated 1/7/25, indicated to administer Ipratropium-Albuterol inhalation via nebulizer four times a day as needed. 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.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 120 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. Review of Resident R81's clinical record indicated the resident was admitted to the facility on 3/6/24. Review of Resident R81's MDS dated 2/18/25, 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. During an observation on 3/10/25, at 10:37 a.m. Resident R81's oxygen tubing was dated 2/12/25. 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 .	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 121 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. 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. 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.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 122 Review of Resident R203's medical record revealed a physician's order dated 3/5/25, to provide oxygen at 5 liters/minute. 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. 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. Review of the clinical record indicated Resident R253 was admitted to the facility on 3/6/25, with diagnoses of pulmonary fibrosis (thickening of the tissue around and between the air sacs in the lungs),	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=E	Continued from page 123 high blood pressure, and gastroesophageal reflux disease (GERD - when stomach acid frequently flows back into the esophagus). Review of a physician order dated 3/7/25, indicated to administer oxygen via nasal cannula continuously at 5 liters/minute. 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. 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. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	Facility cannot retroactively correct for Resident #66. Moving forward the community will continue to provide consistent and complete communication with the dialysis center(s) for residents receiving hemodialysis. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee completed and audit of current residents receiving hemodialysis to ensure communication forms were in place. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated staff on the regulatory requirements of F698 regarding consistent and complete communication with the dialysis center. To monitor and maintain ongoing compliance the DON/designee will audit residents receiving hemodialysis for communication form in place 2x a week x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0698 SS=D	Continued from page 125 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. Findings include: 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. A review of Resident R66 physician orders last revised on 10/27/24, indicate dialysis Mondays, Wednesdays and Fridays. A review of Resident R66's dialysis binder indicated dialysis sheets completed on 1/3/25, 1/6/25, 1/8/25,	F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0698 SS=D	Continued from page 126 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. 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. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0698		
F 0700 SS=E		F 0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0700 SS=E	Continued from page 127 483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 0700	R 65 and 47 had a bed rail assessment completed, order obtained, and care plan updated. R 253 had a bed rail assessment and bed rails were discontinued. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee reviewed current residents with bedrails to ensure a physician order is obtained and ongoing accurate assessments are completed. Negative findings will be addressed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated staff on the bedrail policy. To monitor and maintain ongoing compliance the DON/designee will audit bedrails for need, order and care plan weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0700 SS=E	Continued from page 128 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). Findings include: 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. Review of the clinical record indicated Resident R47 was admitted to the facility on 3/21/21. Review of Resident R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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(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 0700 SS=E	Continued from page 129 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). Review of a physician order dated 6/29/23, indicated bilateral (both sides) assistive handrails to aid in positioning. Review of Resident R47's clinical record revealed the last "Enabler/Physical Restraint/Side Rail Review" was completed on 5/8/24. During an observation on 3/10/25, at 9:05 a.m. two top enabler bars were present on Resident R47's bed. Review of the clinical record indicated Resident R65 was admitted to the facility on 7/24/20. Review of Resident R65's MDS dated 2/5/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and	F 0700		

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: _____	03/14/2025

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F 0700 SS=E	Continued from page 130 depression. Review of a physician order dated 6/30/25, indicated bilateral assistive handrails to aide with positioning. Review of Resident R65's clinical record indicated the last "Enabler/Physical Restraint/Side Rail Review" was completed on 9/16/24. During an observation on 3/10/25, at 9:32 a.m. two top enabler bars were present on Resident R65's bed. Review of the clinical record indicated Resident R253 was admitted to the facility on 3/6/25, with diagnoses of pulmonary fibrosis, high blood pressure, and gastroesophageal reflux disease. Review of Resident R265's "Enabler-Restraint Observation" dated 3/6/25, indicated "none of above" were being utilized.	F 0700		

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F 0700 SS=E	Continued from page 131 During an observation on 3/10/25, at 9:12 a.m. two top enabler bars were present on Resident R265's bed. Review of Resident R253's active physician orders on 3/11/25, failed to reveal an order for enabler bar usage. 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." 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.	F 0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0700 SS=E	Continued from page 132 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (e)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0700		
F 0725 SS=E		F 0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0725 SS=E	Continued from page 133 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	R1, R8, R22, R60, R81, R90 medical records are unable to be altered. R1 weight remained stable. R8 was discharged from the facility. R22 wound remains stable. R60 was discharged home. R81 is no longer at the facility. R90 was discharged from the facility. No resident experienced adverse effects related to the staffs documentation in the medical record. The facility staff identified will be provided disciplinary action per handbook. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated the NHA/DON on regulatory requirements of F725 licensed nursing staff education on what to do if unable to complete an assigned task. The DON/designee will audit the facility activity report to review any omissions of care and follow up as appropriate 2 times per week x 4 weeks then monthly X 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0725 SS=E	Continued from page 134	F 0725	Improvement (QAPI) committee for further review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0725 SS=E	Continued from page 135 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). Findings include: 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. 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	F 0725		

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F 0725 SS=E	Continued from page 136 documentation on required charting, medication/treatment administration, incidents/accidents, physician orders, admission/transfer/discharge, weights/vitals, etc. 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." 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." 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." Review of Resident R60's February 2025 MAR	F 0725		

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F 0725 SS=E	Continued from page 137 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." 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." 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." 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. 28 Pa. Code: 201.14(a) Responsibility of licensee.	F 0725		

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F 0725 SS=E	Continued from page 138 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.	F 0725		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 139 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Annual performance evaluations were completed for nurse aide employees. The Director of Nursing (DON)/designee reviewed employee files for current nursing assistants to ensure annual performances evaluations are completed. Negative findings will be addressed. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated NHA/DON/HR on regulatory requirements of F730. To monitor and maintain ongoing compliance the DON/designee will audit employee files for performance evaluations weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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F 0730 SS=E	Continued from page 140 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). Findings include: 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. 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. 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. 28 Pa Code: 201.20 (a)(b)(d) Staff development.	F 0730		

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F 0755 SS=E	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 0755	The observed 2nd floor box of medication was returned to pharmacy. The observed medication in the third floor medication room were returned to pharmacy. The Director of Nursing (DON)/designee audited medications rooms to ensure discontinued medications were disposed of or reconciled. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated DON and ADON on the process for medication return/destruction. To monitor and maintain ongoing compliance the DON/designee will audit medication rooms/nursing stations for medications needing destruction or return to pharmacy 2 x a weekly x 4 weeks, then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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F 0755 SS=E	Continued from page 142	F 0755		

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F 0755 SS=E	Continued from page 143 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). Findings include: 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. 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	F 0755		

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F 0755 SS=E	Continued from page 144 cardboard box contained the following medications and biologicals: - 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	F 0755		

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F 0755 SS=E	Continued from page 145 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 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." 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	F 0755		

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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 0755 SS=E	Continued from page 146 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. During an observation on 3/11/25, at 10:33 a.m. of the Third Floor Medication Room revealed the following: - 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 prostrate	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 147 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 - Buspirone (a medication used to treat anxiety) - 54 pills - One bottle of Lactulose (a medication used to treat constipation) 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	F 0755		

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F 0755 SS=E	Continued from page 148 destroyed." 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. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.9 (a)(1)(j.1)(k) Pharmacy services.	F 0755		
F 0758 SS=D		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 149 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident #62 no longer resides at the facility. To identify other residents that have the potential to be affected, the DON/designee reviewed current residents on psychotropic medications to ensure resident medication regimens are free from unnecessary medications and that there is a diagnosed specific condition for treatment. Corrections will be made as needed. To prevent this from recurring, the RDCS/designee educated DON, ADON and pharmacy consultant on the regulatory requirements of F758 on ensuring resident medication regimens are free from unnecessary medications, and that there is a diagnosed specific condition for treatment. To monitor and maintain ongoing compliance the DON/designee will review the medical record of 3 residents on psychotropic medications weekly x4 then monthly x2 to ensure that there is a diagnosed specific condition for treatment regarding medication. Negative findings will be addressed. Ad Hoc education will be provided	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 150 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 151 Based on facility policies, clinical record review, and staff interview, it was determined that the facility failed to identify a diagnosed specific condition for treatment for one of three residents receiving psychotropic medications (Resident R62). Review of facility policy "Psychoactive Medication Policy" dated 1/10/25, indicated diagnoses supporting the use of psychoactive medication will be documented in the medical record. Review of the clinical record revealed Resident R62 was admitted to the facility on 9/1/21. Review of Resident R62's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/25/25, 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). Review of a physician order dated 11/14/24, indicated to administer Seroquel (an antipsychotic)	F 0758		

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F 0758 SS=D	Continued from page 152 25 mg (milligrams) twice a day. The physician order failed to identify a specific condition for treatment. Review of a physician order dated 11/24/24, indicated to administer trazodone (an antidepressant) 50 mg twice a day. The physician order failed to identify a specific condition for treatment. During an interview on 3/12/25, at 1:58 p.m. the Director of Nursing confirmed that the facility failed to identify a diagnosed specific condition for treatment for psychotropic medication usage for Resident R62 as required. 28 Pa. Code: 211.5(f) Medical records. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services.	F 0758		
F 0761 SS=D		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=D	Continued from page 153 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The observed 2nd floor box of medication was returned to pharmacy. The observed medication in the third-floor medication room were returned to pharmacy. Medication rooms and medication carts were audited, any expired meds or supplied were destroyed. The DON/designee completed and audit of all medication carts and medications rooms to ensure medications are stored and labelled appropriately. There were no negative findings. To prevent this from recurring, the RDCS/designee educated licensed nursing staff on requirements of F761 and proper storage, labelling and returning/destruction of medications. To monitor and maintain ongoing compliance the DON/designee will audit medication carts and medication room/refrigerators weekly x4 then monthly x2 to ensure medications are stored, labelled and returning/destruction of medications appropriately. Negative findings will be addressed. Ad Hoc education will	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=D	Continued from page 154	F 0761	be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=D	Continued from page 155 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). Findings include: Review of facility policy "Storage and Expiration Dating of Medications and Biologicals" dated 1/10/25, 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. Facillity 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	F 0761		

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F 0761 SS=D	Continued from page 156 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. 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: - 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	F 0761		

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F 0761 SS=D	Continued from page 157 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 - 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	F 0761		

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F 0761 SS=D	Continued from page 158 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." 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 properly store medications on the Second Floor nursing unit. During an observation of the Third Floor Medication Room refrigerator on 3/11/25, at 10:27 a.m. revealed the following: - Resident R31's Lopressor (a medication used to treat high blood pressure) suspension with a "do not use after" date of 3/5/25	F 0761		

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F 0761 SS=D	Continued from page 159 - 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 During an observation of the Third Floor Medication Room supplies on 3/11/25, at 10:29 a.m. revealed two expired 23 gauge (the needle size) needles with the expiration date of 10/18/24. During an interview on 3/11/25, 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. During a medication cart review (Third Floor South) on 3/11/25, at 11:15 a.m. revealed the following: - Amelog Solostar Lispro Insulin Pen (a medication used to lower blood sugar levels) expired 3/10/25 - Lantus Insulin Pen (a medication used to lower	F 0761		

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F 0761 SS=D	Continued from page 160 blood sugar levels) no opened or expired date - Insulin Glargine Pen (a medication used to lower blood sugar levels) no resident identification and expired During an interview on 3/11/25, at 11:23 a.m. LPN Employee E4 confirmed the above expired insulin pens and one insulin pen failed to reveal resident information. During a medication cart review (Third Floor East) on 3/12/25, at 12:02 p.m. revealed the following: - Insulin Glargine Pen - expired - Insulin Lispro - expired During an interview on 3/12/25, at 12:15 p.m. LPN Employee E22 confirmed the above expired insulin pens. During an interview on 3/12/25, 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	F 0761		

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F 0761 SS=D	Continued from page 161 rooms (Third Floor Medication Room), and two of three medication carts (Three South Medication Cart and Three East Medication Cart). 28 Pa. Code: 211.9(a)(1)(j.1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0761		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 162 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	The dietary manager cleaned the fan. No other concerns were noted during survey. The dietary manager completed an audit of the kitchen to address any additional findings. To prevent this from recurring, the RDCS educated dietary staff on maintaining clean equipment and the regulatory requirements of F812. To monitor and maintain ongoing compliance the dietary manager /designee will audit the kitchen fan for cleanliness weekly x4 weeks then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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:	03/14/2025

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F 0812 SS=F	Continued from page 163 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. Findings include: 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 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. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(f) Dietary services.	F 0812		

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F 0814 SS=F	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 0814	The dumpster lid was closed upon observation. Moving forward the NHA/designee will ensure the facility properly contains and disposes of garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation. To prevent this from recurring, the RDCS educated housekeeping, laundry and dietary staff on the regulatory requirements of F814. To monitor and maintain ongoing compliance the NHA/designee will audit the dumpster lid to ensure it is closed 2x/day x4 weeks then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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F 0814 SS=F	Continued from page 165 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). Findings include: 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. During an observation on 3/13/25, at 8:29 a.m. the lid/cover of dumpster one was noted to be open. During an interview on 3/13/25, at 8:30 a.m. the Nursing Home Administrator confirmed that the facility failed to properly contain and dispose of garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation.	F 0814		

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F 0814 SS=F	Continued from page 166 28 Pa. Code 201.18(b)(3) Management.	F 0814		
F 0842 SS=E	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where	F 0842	The facility cannot correct the documentation omission regarding care conferences for R 44, R62 and R65. Care conference schedule developed. Moving forward, it will be audited for compliance. To prevent this from happening again, DON/designee educated Social Services on the regulatory requirements of F842 and maintaining complete and accurate documentation. To monitor and maintain ongoing compliance the DON /designee will audit care conferences to ensure they occurring as scheduled and documented in the medical record. Negative findings will be corrected. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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F 0842 SS=E	Continued from page 167 permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's	F 0842		

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F 0842 SS=E	Continued from page 168 progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=E	Continued from page 169 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). Findings include: 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. Review of the clinical record indicated Resident R44 was admitted to the facility on 7/28/15. 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	F 0842		

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F 0842 SS=E	Continued from page 170 blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). 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. Review of the clinical record revealed Resident R62 was admitted to the facility on 9/1/21. Review of Resident R62's MDS dated 2/25/25, indicated diagnoses of high blood pressure, hyperlipidemia, and dementia. 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	F 0842		

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F 0842 SS=E	Continued from page 171 the clinical record failed to reveal documentation to indicate that the scheduled care conference had been performed on 2/6/25. Review of the clinical record indicated Resident R65 was admitted to the facility on 7/24/20. Review of Resident R65's MDS dated 2/5/25, indicated diagnoses of high blood pressure, hyperlipidemia, and depression. 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. 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	F 0842		

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F 0842 SS=E	Continued from page 172 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." 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. 28 Pa. Code 211.5(f) Clinical Records.	F 0842		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 173 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	R39, R81 and R62 no longer resides at the facility, unable to correct. To identify other residents that have the potential to be affected, the DON/designee reviewed current residents on hospice to ensure 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. To prevent this from happening again, DON/designee educated Social Services on the regulatory requirements of F849. To monitor and maintain ongoing compliance the DON /designee will audit hospice residents for hospice order contains name/phone number, and diagnosis present in the care plan weekly x4 then monthly x2. Negative findings will be corrected. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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F 0849 SS=D	Continued from page 174 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849		

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F 0849 SS=D	Continued from page 175 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849 SS=D	Continued from page 176 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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(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 0849 SS=D	Continued from page 177 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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: _____	03/14/2025

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

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F 0849 SS=D	Continued from page 178 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). Findings include: 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 Review of the clinical record revealed that Resident R39 was admitted to the facility on 10/24/24.	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0849 SS=D	Continued from page 179 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). Review of Resident R39's clinical record revealed a physician's order dated 2/17/25, to admit to hospice services. Review of Resident R39's comprehensive care plan failed to indicate a plan of care that included that Resident R39 was receiving hospice services. Review of the clinical record revealed Resident R62 was admitted to the facility on 9/1/21. Review of Resident R62's MDS dated 2/25/25, indicated diagnoses of high blood pressure, hyperlipidemia, and dementia. Review of Section O, Question O0110K1 indicated the resident received	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0849 SS=D	Continued from page 180 hospice care while in the facility. Review of a physician order dated 10/24/24, indicated to admit resident to hospice services with a diagnosis of parkinsonism. 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. Review of Resident R81's clinical record indicated the resident was admitted to the facility on 3/6/24. Review of Resident R81's MDS dated 2/18/25, indicated diagnoses of high blood pressure, wound infection, and septicemia (the body's extreme response to an infection that can be life threatening) . Review of Resident R81's clinical record revealed a physician's order dated 2/10/25, to admit to hospice	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0849 SS=D	Continued from page 181 services. 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. 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. 28 Pa. Code: 201.14(a) Responsibilities of licensee. 28 Pa. Code: 201.18(b)(1)(3) Management.	F 0849		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 182 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident #81 had no negative outcome from potential cross contamination. Immediate education was provided to the Nurse involved (E7) regarding clean dressing change and hand hygiene. She did not perform any other dressing changes. There were no other issues identified during survey related to dressing changes. To prevent this from happening again, DON/designee educated nursing staff on the clean dry dressing change policy and hand hygiene including donning and doffing of gloves. To monitor and maintain ongoing compliance the wound nurse /designee will observe 2 dressing changes a week x4, then monthly x2. Negative findings will be corrected. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 183 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 184	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 185 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). Findings include: 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. Procedure: - 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	F 0880		

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F 0880 SS=D	Continued from page 186 - Don 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 - Don clean gloves - Cleanse with ordered solution or normal saline soaked gauze pads - Remove gloves and discard - 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 Review of the clinical record indicated Resident R81 was admitted to the facility on 2/10/25.	F 0880		

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F 0880 SS=D	Continued from page 187 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). 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). 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	F 0880		

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F 0880 SS=D	Continued from page 188 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. 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. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.	F 0880		

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F 0883 SS=D		F 0883		

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F 0883 SS=D	Continued from page 190 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	R 63 has been offered the pneumococcal and influenza vaccines. To identify other residents that have the potential to be affected, the Infection Preventionist/ designee reviewed current residents to validate if they have received the influenza and pneumococcal vaccinations. The medical records will be updated accordingly if they received said vaccinations at an outside setting. Those residents who have not received influenza and pneumococcal vaccinations will be reviewed with the physician for appropriateness to offer. To prevent this from recurring the RDCS educated the facility IP re: offering vaccinations for residents per policy. To monitor and maintain ongoing compliance the Infection Preventionist / designee will review 3 residents weekly x4 then monthly x2 to ensure residents are offered the influenza and pneumococcal vaccinations and that vaccinations are provided and documented accurately and timely. Negative findings will be addressed. Ad Hoc	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 191 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883	education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0883 SS=D	Continued from page 192 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). Findings include: 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. Review of Resident R63's clinical record indicated the resident was admitted to the facility on 1/23/25. Review of Resident R63's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0883		

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F 0883 SS=D	Continued from page 193 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. 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. 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	F 0883		

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: _____	03/14/2025

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 0883 SS=D	Continued from page 194 was provided to Resident R63. 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. 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). 28 Pa. Code 211.5(f) Clinical records	F 0883		
F 0887 SS=D		F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 195 483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 0887	R6 and R63 have been offered covid immunizations. To identify other residents that have the potential to be affected, the Infection Preventionist(IP)/ designee reviewed current residents to validate if they have received covid vaccinations. The medical records will be updated accordingly if they received said vaccinations at an outside setting. Those residents who have not received covid vaccinations will be reviewed with the physician for appropriateness to offer. To prevent this from recurring the RDCS educated the facility IP re: offering vaccinations for residents per policy. To monitor and maintain ongoing compliance the Infection Preventionist / designee will review 3 residents weekly x4 then monthly x2 to ensure residents are offered covid vaccines and that vaccinations are provided and documented accurately and timely. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 196 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887	Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 197 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). Findings include: 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. Review of Resident R6's clinical record indicated the resident was admitted to the facility on 3/29/24. Review of Resident R6's Minimum Data Set (MDS	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 198 - 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. Review of clinical records indicated that Resident R6 last received a COVID-19 vaccination on 2/17/21. 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. Review of Resident R63's clinical record indicated the resident was admitted to the facility on 1/23/25.	F 0887		

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F 0887 SS=D	Continued from page 199 Review of Resident R63's MDS 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-19 vaccine was coded a "0"- resident not up to date. 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. 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	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 200 Resident R63. 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. 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). 28 Pa. Code 211.5(f) Clinical records	F 0887		
F 0941 SS=D		F 0941		

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F 0941 SS=D	Continued from page 201 483.95(a) Communication Training §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by:	F 0941	Nurse aide employees will be trained on effective communication by 4.14.2025. Current CNAs are up to date with communication training. To prevent this from recurring, the NHA/designee educated Human Resources on regulatory requirements of F941. To monitor and maintain ongoing compliance the DON/designee will audit employee records for communication training weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0941 SS=D	Continued from page 202 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). Findings include: Review of the "Facility Assessment" dated 1/26/25, indicated that new staff are trained during orientation and existing staff are trained monthly on specific topics to ensure educational requirements are met. Review of facility provided documents and training records revealed the following staff members did not have documented training on effective communication. 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. NA Employee E12 had a hire date of 7/1/23, failed	F 0941		

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F 0941 SS=D	Continued from page 203 to have effective communication in-service education between 7/1/23, and 7/1/24. 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. 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. 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. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a) Staff development.	F 0941		

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H 0009	51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	Reportable event was completed on 3.11.2025. Moving forward, the facility will report follow the state requirement for reporting events. To prevent this from recurring, the RDCS educated the NHA/DON on the licensure requirements for notification (0009). To monitor and maintain ongoing compliance the DON/designee will audit facility events/progress notes weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/07/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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H 0009	Continued from page 1 health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009		

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H 0009	Continued from page 2 Based on facility reports, review of clinical record, and staff interviews it was determined that the facility failed to notify the Department of Health of a reportable event. Findings include: During a review of progress notes on 3/11/25, at 11:00 a.m. indicated a nurse aide was in resident's room and noticed a "burning plastic" smell. Staff immediately investigated where the smell was coming from in resident's room. Outlets and bedroom heater was checked. Staff and this writer could not locate the smell, but room began to get hazy/smoky. Resident and roommate were immediately taken out of the room and placed in an empty bed in another room. Placed call to fire department, all staff was immediately notified of events in case an evacuation plan was needed. Went out front to allow officers and fire department in building. Upon fire department's investigation, roommate's overhead light was burning and melting plastic. Fire department stated that it was best to	H 0009		

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H 0009	Continued from page 3 leave resident and her roommate out of the room until light fixture was repaired. During an interview on 3/10/25, at 11:11 a.m. Nursing Home Administrator stated, "I didn't think that we had to report that incident" and confirmed that the facility failed to notify the Department of Health of a reportable event, as required.	H 0009		

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H 0010	35 P. S. § 448.809b Photo Id Reg Law amended July 11, 2022 Act 79 2022 HB 2604 (1) The photo identification tag shall include a recent photograph of the employee, the employee's first name, the employee's title and the name of [the health care facility or employment agency.] any of the following: (i) The health care facility. (ii) The health system. (iii) The employment agency. (iv) The fictitious name of an entity under subparagraph (i), (ii) or (iii) which is registered with the Department of State under 54 Pa.C.S. Ch. 3 (relating to fictitious names) or a successor statute. (2) The title of the employee shall be as large as possible in block type and shall occupy a one-half inch tall strip as close as practicable to the bottom edge of the badge. (3) Titles shall be as follows: (i) A Medical Doctor shall have the title "Physician." (ii) A Doctor of Osteopathy shall have the title "Physician." (iii) A Registered Nurse shall have the title "Registered Nurse." (iv) A Licensed Practical Nurse shall have the title "Licensed Practical Nurse." (v) All other titles shall be determined by the department. Abbreviated titles may be used when the title indicates licensure or certification by a Commonwealth agency.	H 0010	A name badge sign-up sheet was created to identify any staff member in need of a badge. The Human Resources designee completed an audit of current staff to ensure they have proper identification badges. ID badges have been ordered for any staff member in need. To prevent this from recurring he Director of Nursing/designee re-educated Human Resources on the requirements of photo identification tags. Human Resources Designee will provide new employees with name badges upon hire. To monitor and maintain ongoing compliance the Nursing Home Administrator/designee will randomly audit 4 staff on duty for name badges weekly x4 then monthly x2 to ensure employee has appropriate photo identification tag on. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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H 0010	Continued from page 5 (4)A notation, marker or indicator included on an identification badge that differentiates employees with the same first name is considered acceptable in lieu of displaying an employee's last name. This REGULATION is not met as evidenced by:	H 0010		

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: _____	03/14/2025

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H 0010	Continued from page 6 Based on observations, and staff interviews, it was determined that the facility failed to make certain that staff members displayed identification badges to include a name, title, and a photo as required for six of six employees (Employee E9, E16, E17, E18, E19, and E20). Findings include: Review of the Photo Identification Tag Regulation indicates that staff must wear a photo identification tag that shall include a recent photograph of the employee, the employee's first name, the employee's title and the name of the health care facility or employment agency. During an observation and interview on 3/10/25, at 9:30 a.m. Certified Occupational Therapist Assistant (COTA) Employee E16 did not display a name tag with name, title, and photo. COTA Employee E16 stated that she started her employment at the facility about two weeks ago but was not given a photo identification badge.	H 0010		

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H 0010	Continued from page 7 During an observation and interview on 3/10/25, at 9:33 a.m. Licensed Practical Nurse (LPN) Employee E17, Nurse did not display a name tag with name, title, and photo. LPN Employee E17 stated that she was not given a photo identification badge. During an observation and interview on 3/10/25, at 10:44 a.m. LPN Employee E9, did not display a name tag with name, title, and photo. During an observation and interview on 3/10/25, at 10:45 a.m. Registered Nurse (RN) Employee E18, Nurse did not display a name tag with name, title, and photo. RN Employee E18 stated that she was not given a photo identification badge. During an observation and interview on 3/10/25, at 10:46 a.m. Medical Records Employee E19, did not display a name tag with name, title, and photo. During an observation and interview on 3/10/25, at	H 0010		

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H 0010	Continued from page 8 11:05 a.m. LPN Employee E20, did not display a name tag with name, title, and photo. During an interview on 3/10/25, at 11:31 a.m. the Director of Nursing confirmed that the facility failed to make certain that Employees E9, E16, E17, E18, E19 and E20 properly worn photo identification tags with the require information displayed as required.	H 0010		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	Moving forward the facility will ensure that the required multidisciplinary members are present at the Infection Control meeting, will report health care associated infections monthly and will provide written notification to the resident/family member of a healthcare-associated infection. To prevent this from recurring, the RVPO/RDCS educated the IP on requirements of 1020 and the responsibility of the licensee and will ensure the appropriate team members are present at the meetings. To monitor and maintain ongoing compliance the RDCS/designee will audit infection control/PASRS reporting weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1020	Continued from page 1 Based on state regulations, staff interview, and review of the facility's Infection Control Committee Meeting attendance records, it was determined that the facility failed to ensure that all of the required nine multidisciplinary members were present at the Infection Control meeting for one of four quarters (Quarter Four- lab member), failed to report health care associated infections for two of 12 months (January 2025, and February 2025), and failed to provide written notification to the resident/family member within seven days of a healthcare-associated infection for two of twelve months (January 2025, and February 2025). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including	P 1020		

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P 1020	Continued from page 2 representatives from each of the following if applicable to that specific health care facility." A review of the applicable members at infection control meetings includes medical staff, administration, laboratory personnel, nursing staff, pharmacy staff, physical plan personnel, patient safety officer, a community member, and a member of the infection control team. Review of MCARE Act, Section 403(a)(1), 40 P.S. § 1303.405(a) - Patient Safety Authority Jurisdiction, states: The occurrence of a healthcare-associated infection is deemed a serious event. Written notification to the resident/family member/responsible party within seven days of the serious event should be documented. Review of the facility's Infection Control Committee Meeting attendance log forms dated October 2024, November 2024, and December 2024 (Quarter Four), failed to reveal that a member of lab was in attendance.	P 1020		

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P 1020	Continued from page 3 During an interview on 3/11/25, at 1:05 p.m. Regional Clinical Director-Infection Preventionist (IP) Employee E6 stated "The last IP left the facility at the end of December 2024, then I took over. The facility has not been able to get the correct access to report health-acquired infections. I have been tracking them, but I can ' t report them. As soon as someone gets access, we will. The facility had a total of six health care acquired infections for January 2025, and seven for February 2025 that still need reported. No letters have been sent to the resident or family members for that time either". During an interview on 3/11/25, at 1:10 p.m. IP Employee E6 stated the facility failed to notify residents or representatives with a written notification within seven days of a healthcare-associated infection for two of 12 months (January 2025, and February 2025). During an interview on 3/11/25, at 1:15 p.m. IP Employee E6 confirmed that the facility failed to ensure that all of the required nine multidisciplinary	P 1020		

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P 1020	Continued from page 4 members were present at the Infection Control meeting for one of four quarters (Quarter Four- lab member), failed to report health care associated infections for two of 12 months (January 2025, and February 2025), and failed to provide written notification to the resident/family member within seven days of a healthcare-associated infection for two of twelve months (January 2025, and February 2025).	P 1020		
P 1570		P 1570		

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P 1570	Continued from page 5 Staff development. (3) Emergency preparedness in accordance with 42 CFR 483.73(d) (relating to emergency preparedness). This REGULATION is not met as evidenced by:	P 1570	Nurse aide employees will be trained on emergency preparedness by 4.14.2025. To prevent this from recurring, the NHA/designee educated Human Resources on regulatory requirements of F1570. To monitor and maintain ongoing compliance the DON/designee will audit employee records for Emergency Preparedness weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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P 1570	Continued from page 6 Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on Emergency Preparedness for one of five staff members (Employee E12). Findings include: Review of the "Facility Assessment" dated 1/26/25, indicated that new staff are trained during orientation and existing staff are trained monthly on specific topics to ensure educational requirements are met. Review of facility provided documents and training records revealed the following staff member did not have documented training on Emergency Preparedness. NA Employee E12 had a hire date of 7/1/23, failed to have Emergency Preparedness in-service education between 7/1/23, and 7/1/24. During an interview on 3/14/25, at 12:31 p.m. the Nursing Home Administrator confirmed that the	P 1570		

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P 1570	Continued from page 7 facility failed to provide training on Emergency Preparedness for one of five staff members.	P 1570		
P 1580	Staff development. (4) Fire prevention and safety in accordance with 42 CFR 483.90 (relating to physical environment). This REGULATION is not met as evidenced by:	P 1580	Nurse aide employees will be trained on fire prevention and safety by 4.14.2025. To prevent this from recurring, the NHA/designee educated Human Resources on regulatory requirements of F1580. To monitor and maintain ongoing compliance the DON/designee will audit employee training records for Fire prevention and safety weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/08/2025**

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P 1580	Continued from page 8 Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on Fire Prevention and Safety for one of five staff members (Employee E12). Findings include: Review of the "Facility Assessment" dated 1/26/25, indicated that new staff are trained during orientation and existing staff are trained monthly on specific topics to ensure educational requirements are met. Review of facility provided documents and training records revealed the following staff member did not have documented training on Fire Prevention and Safety. NA Employee E12 had a hire date of 7/1/23, failed to have Fire Prevention and Safety in-service education between 7/1/23, and 7/1/24. During an interview on 3/14/25, at 12:31 p.m. the Nursing Home Administrator confirmed that the	P 1580		

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P 1580	Continued from page 9 facility failed to provide training on Fire Prevention and Safety for one of five staff members.	P 1580		

Certified End Page

HARMAR VILLAGE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 077802

SURVEY EXIT DATE: 03/14/2025

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