

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396048	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/18/2025
NAME OF PROVIDER OR SUPPLIER: HARMAR VILLAGE HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 715 FREEPORT ROAD CHESWICK, PA 15024		
STATE LICENSE NUMBER: 077802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a revisit survey completed on March 18, 2025, it was determined that Harmar Village Health and Rehab Center failed to correct the deficiencies cited during the survey of February 26, 2025, under the requirements of the 28 Pa, Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility cannot retroactively correct past staffing issues. To prevent this from reoccurring the Scheduler will be reeducated on staffing Nurses Aides to include expectations of HPPD and ratios by the DON/ designee. The facility will hold staffing meetings 5 days per week, consisting of the Nursing Home Administrator, Director of Nursing, Human Resources and Scheduler, to review ratio and PPD compliance for upcoming schedules. DON/ designee will monitor PPD hours 5 days a week and ongoing to ensure compliance. Ad hoc education will be provided as needed. The results of the meeting will be forwarded to the facility QAPI committee for further review and recommendations.	Completion Date: 04/14/2025 Status: APPROVED Date: 03/26/2025
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

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P 5520	<p>Continued from page 1</p> <p>Based on a review of staffing documents provided by the facility and staff interview it was determined that the facility failed to provide one nurse assistant (NA) per 10 residents on the day shift on one of 14 days (3/15/25) one NA per 11 residents on the second shift on one of 14 days (3/16/25) and one NA per 15 residents on the night shift on three of 14 days (3/6/25, 3/13/25 and 3/14/25) as required.</p> <p>Findings include:</p> <p>A review of facility staffing documents provided by the facility from 3/3/25 through 3/16/25, revealed the facility failed to provide NA on the following shifts as required:</p> <p>Day shift:</p> <table border="1" data-bbox="185 1398 786 1514"> <thead> <tr> <th>Date</th> <th>Census</th> <th>Actual hours</th> <th>Hours required</th> </tr> </thead> <tbody> <tr> <td>3/15/25</td> <td>97</td> <td>70.25</td> <td>72.75</td> </tr> </tbody> </table>	Date	Census	Actual hours	Hours required	3/15/25	97	70.25	72.75	P 5520		
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3/15/25	97	70.25	72.75									

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P 5520	Continued from page 2 Evening shift: Date Census Actual hours Hours required 3/16/25 99 65.00 67.50 Night shift: Date Census Actual hours Hours required 3/6/25 97 43.50 48.50 3/13/25 99 46.00 49.50 3/16/25 99 40.00 49.50 During an interview on 3/18/25 at 12:30 p.m., the Nursing Home Administrator confirmed that the facility failed to provide NA's in the facility on the above shifts as required.	P 5520		

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P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility cannot retroactively correct past staffing issues. To prevent this from reoccurring the Scheduler will be reeducated on staffing Licensed Practical Nurses (LPN) to include expectations of LPN ratios by the DON/ designee. The facility will hold staffing meetings 5 days per week, consisting of the Nursing Home Administrator, Director of Nursing, Human Resources and Scheduler, to review LPN ratio compliance for upcoming schedules. DON/ designee will monitor LPN ratios 5 days a week and ongoing to ensure compliance. Ad hoc education will be provided as needed. The results of the meeting will be forwarded to the facility QAPI committee for further review and recommendations.	Completion Date: 04/14/2025 Status: APPROVED Date: 03/26/2025

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P 5530	Continued from page 4 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift on one of 14 days (3/15/25). Findings include: Review of facility census data and nursing time schedules from 3/3/25 through 3/16/25 revealed the following LPN staffing shortage: Day shift: 3/15/25 census 97 25.00 actual hours 36.04 hours required. During an interview on 3/18/25, at 12:30 p.m. the Nursing Home Administrator confirmed the facility failed to provide the minimum of LPN's on the above day as required.	P 5530		

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P 5640	<p>Nursing services.</p> <p>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5640	<p>The facility cannot retroactively correct past staffing issues. To prevent this from reoccurring the Scheduler will be reeducated on minimum overall nursing hour staffing to include expectations of HPPD and ratios by the DON/designee. The facility will hold staffing meetings 5 days per week, consisting of the Nursing Home Administrator, Director of Nursing, Human Resources and Scheduler, to review ratio and PPD compliance for upcoming schedules. DON/designee will monitor PPD hours 5 days a week and ongoing to ensure compliance. Ad hoc education will be provided as needed. The results of the meeting will be forwarded to the facility QAPI committee for further review and recommendations.</p>	<p>Completion Date: 04/14/2025 Status: APPROVED Date: 03/26/2025</p>

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P 5640	Continued from page 6 Based on a review of nursing time schedules and staff interview, it was determined that the facility failed to provide a minimum of 3.20 PPD (per patient daily) hours of direct care for each resident on two of 14 days (3/6/25 and 3/16/25). Findings include: Review of staffing documents and nursing staff schedules from 3/3/25 through 3/16/25, indicated that the State required PPD minimum hours of 3.20 was not met on the following days: 3/6/25= 3.18 PPD. 3/16/25=3.03 PPD. During an interview on 3/18/25, at 12:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a minimum of 3.20 PPD hours of direct care on the above dates as required.	P 5640		



Certified End Page

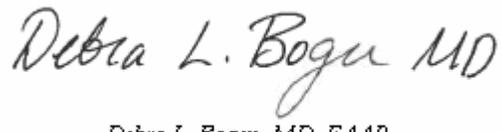
HARMAR VILLAGE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 077802

SURVEY EXIT DATE: 03/18/2025

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, 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