| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365601 | A. BUILDING _____ B. WING _____ | 10/07/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **HARMONY CENTER FOR REHABILITATION AND HEALING** | **164 OFFICE PARK DRIVE XENIA, OH 45385** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, staff interview, and policy review, the facility failed to notify the resident representative of an incident of alleged abuse when Resident #27 was found with her pants and disposable adult brief down at her knees and sitting on the bed of another Resident #57. This had the potential to affect one Resident (#27) of three reviewed for abuse. The facility census was 60. Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had severe cognitive impairment and had behaviors of delusions and wandering. The Resident required limited assistance for bed mobility, transfer, walk in room and in corridor, dressing, locomotion on and off unit, toilet use, and personal hygiene. The Residents balance during transitions and walking was not steady but she was able to stabilize without staff assistance. The Resident was always continent of bowel and bladder. Review of the progress note dated 09/05/20 at 6:27 A.M., revealed the resident was found in the room of Resident #57. Resident #27 was seated on the bed with her pants and disposable adult brief down to her knees. Resident #57 was standing beside his bed fully clothed. Neither resident could give an account to what was going on. Resident #27 was redirected out of the room and assessed with [REDACTED].#27 was checked for urinating or having a bowel movement on the bed and there was nothing on the bed or on the resident. Resident #27 was told she was not allowed to go into other residents rooms. The Assistant Director of Nursing (ADON) #30 was notified. Review of the progress note dated 09/11/20 at 1:36 P.M., revealed a Late Entry for 09/05/20 the family was made aware of the incident between this resident and another. The physician was made aware as well. 2. Review of the medical record for Resident #57 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 had severe cognitive impairment was able to make his self understood and usually understood others. He had behaviors including wandering, rejection of care and verbal aggression. Resident #57 required extensive assistance for transfer, toilet use, personal hygiene, and dressing. He required limited assistance for bed mobility and locomotion on the unit. He was unsteady but able to stabilize without staff assistance and he used no devices to assist with mobility. The Resident was frequently incontinent of bladder and occasionally incontinent of bowel. Interview on 09/09/20 at 2:40 P.M., with RN #09 revealed on 09/05/20 she was looking for Resident #27 to give her medications and she had not seen her for about five minutes. RN #09 found Resident #27 in Resident #57 room when she opened the door Resident #27 was sitting on the made bed with her pants and disposable adult brief down at her knees. Resident #57 was in close proximity about two feet away standing by the bed. RN #09 revealed she had not witnessed any touching by either resident and Resident #57 was fully clothed. RN #09 stated the situation did not look good so she wrote a progress note, notified the ADON, and checked to see if Resident #27 had a bowel movement or had urinated. RN #09 stated both residents wander and she had never seen Resident #27 take off her clothes before or Resident #57 have any sexual behaviors. RN #09 stated she had not notified the physician or family of the incident she reported the information to the next shift. Interview on 09/09/20 at 1:13 P.M., the Administrator revealed he became aware of the incident between Resident #27 and Resident #57 today. The Administrator verified he had not reported the incident to the state agency. Interview on 09/10/20 at 2:30 P.M., Physician #31 revealed he was notified of the incident between Resident #27 and Resident #57 and he was unsure of the date of notification. Physician #31 stated there was no sexual contact observed so he had not sent Resident #27 out to be examined. He further stated if the family wanted the resident sent out it was their right. He ordered the residents to be monitored. Interview on 09/10/20 at 2:53 P.M., with the family of Resident #27 revealed they were notified today 09/10/20 a few hours ago of the incident of Resident #27 being found in another resident room. The family member was unaware the incident occurred on 09/05/20 and was not told the date of the occurrence by the facility. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2016 revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment, of a resident. Facility staff should immediately report all such allegations to the Administrator and the state agency. All incident and allegations of abuse, neglect, and mistreatment must be reported immediately to the Administrator. Investigation protocol includes: interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed or heard the event, came in close contact with the resident the day of the incident, and employees who worked closely with the alleged victim the day of the incident. The Administrator will notify the Resident or the Resident Representative ,as appropriate, when a report has been made to the state agency. This deficiency is based on incidental findings discovered during the course of the complaint investigation OH 459. |
| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, staff interview, policy review, review of the facility investigation, and review of the self-reported incidents, the facility failed to implement its abuse policy when they did not thoroughly investigate, and report to the state agency an incident of alleged abuse when Resident #27 was found in Resident #57 room with her pants and disposable adult brief down at her knees and sitting on Resident #57 bed. This had the potential to affect one Resident (#27) of three reviewed. The facility census was 60. Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had severe cognitive impairment and had behaviors of delusions and wandering. The Resident required limited assistance for bed mobility, transfer, walk in room and in corridor, dressing, locomotion on and off unit, toilet use, and personal hygiene. The Residents balance during transitions and walking was not steady but she was able to stabilize without staff assistance. The Resident was always continent of bowel and bladder. Review of the progress note dated 09/05/20 at 6:27 A.M., revealed the resident was found in the room of Resident #57. Resident #27 was seated on the bed with her pants and disposable adult brief down to her knees. Resident #57 was standing beside his bed fully clothed. Neither resident could give an account to what was going on. Resident #27 was redirected out of the room and assessed with [REDACTED].#27 was checked for urinating or having a bowel movement on the bed and there was nothing on the bed or on the resident. Resident #27 was told she was not allowed to go into other residents rooms. The Assistant Director of Nursing (ADON) #30 was notified. Review of the progress note dated 09/11/20 at 1:36 P.M., revealed a Late Entry for 09/05/20 the family was made aware of the incident between this resident and another. The physician was made aware as well. 2. Review of the medical record for Resident #57 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 had severe cognitive impairment was able to make his self understood and usually understood others. He had behaviors including wandering, rejection of care and verbal aggression. Resident #57 required extensive assistance for transfer, toilet use, personal hygiene, and dressing. He required limited assistance for |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>bed mobility and locomotion on the unit. He was unsteady but able to stabilize without staff assistance and he used no devices to assist with mobility. The Resident was frequently incontinent of bladder and occasionally incontinent of bowel. Review of the facility investigation dated 09/05/20 revealed they completed skin assessments on 17 Residents (#11, #19, #24, #25, #26, #27, #35, #37, #42, #46, #48, #52, #54, #56, #57, #58, and #59) and spoke to RN #09 and one other staff member Nurse #100 about the incident between Resident #27 and #57. Interview on 09/09/20 at 2:40 P.M., with RN #09 revealed on 09/05/20 she was looking for Resident #27 to give her medications and she had not seen her for about five minutes. RN #09 found Resident #27 in Resident #57 room when she opened the door Resident #27 was sitting on the made bed with her pants and disposable adult brief down at her knees. Resident #57 was in close proximity about two feet away standing by the bed. RN #09 revealed she had not witnessed any touching by either resident and Resident #57 was fully clothed. RN #09 stated the situation did not look good so she wrote a progress note, notified the ADON, and checked to see if Resident #27 had a bowel movement or had urinated. RN #09 stated both residents wander and she had never seen Resident #27 take off her clothes before or Resident #57 have any sexual behaviors. RN #09 stated she had not notified the physician or family of the incident she reported the information to the next shift. Interview on 09/09/20 at 1:13 P.M., the Administrator revealed he became aware of the incident between Resident #27 and Resident #57 today. The Administrator verified he had not reported the incident to the state agency. Interview on 09/10/20 at 2:30 P.M., Physician #31 revealed he was notified of the incident between Resident #27 and Resident #57 and he was unsure of the date of notification. Physician #31 stated there was no sexual contact observed so he had not sent Resident #27 out to be examined. He further stated if the family wanted the resident sent out it was their right. He ordered the residents to be monitored. Interview on 09/10/20 at 2:53 P.M., with the family of Resident #27 revealed they were notified today 09/10/20 a few hours ago of the incident of Resident #27 being found in another resident room. The family member was unaware the incident occurred on 09/05/20 and was not told the date of the occurrence by the facility. Review of the self-reported incidents data base revealed the facility had not reported the alleged incident. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2016 revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment, of a resident. Facility staff should immediately report all such allegations to the Administrator and the state agency. All incident and allegations of abuse, neglect, and mistreatment must be reported immediately to the Administrator. Investigation protocol includes: interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed or heard the event, came in close contact with the resident the day of the incident, and employees who worked closely with the alleged victim the day of the incident. The Administrator will notify the Resident or the Resident Representative ,as appropriate, when a report has been made to the state agency. This deficiency is based on incidental findings discovered during the course of the complaint investigation OH 459. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review, staff interview, review of the self-reported incidents, review of the facility investigation, and policy review, the facility failed to report to the state agency an incident of alleged abuse when Resident #27 was found in Resident #57 room with her pants and disposable adult brief down at her knees and sitting on Resident #57 bed. This had the potential to affect one Resident (#27) of three reviewed for abuse. The facility census was 60. Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had severe cognitive impairment and had behaviors of delusions and wandering. The Resident required limited assistance for bed mobility, transfer, walk in room and in corridor, dressing, locomotion on and off unit, toilet use, and personal hygiene. The Residents balance during transitions and walking was not steady but she was able to stabilize without staff assistance. The Resident was always continent of bowel and bladder. Review of the progress note dated 09/05/20 at 6:27 A.M., revealed the resident was found in the room of Resident #57. Resident #27 was seated on the bed with her pants and disposable adult brief down to her knees. Resident #57 was standing beside his bed fully clothed. Neither resident could give an account to what was going on. Resident #27 was redirected out of the room and assessed with [REDACTED].#27 was checked for urinating or having a bowel movement on the bed and there was nothing on the bed or on the resident. Resident #27 was told she was not allowed to go into other residents rooms. The Assistant Director of Nursing (ADON) #30 was notified. Review of the progress note dated 09/11/20 at 1:36 P.M., revealed a Late Entry for 09/05/20 the family was made aware of the incident between this resident and another. The physician was made aware as well. 2. Review of the medical record for Resident #57 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed<br>Resident #57 had severe cognitive impairment was able to make his self understood and usually understood others. He had behaviors including wandering, rejection of care and verbal aggression. Resident #57 required extensive assistance for transfer, toilet use, personal hygiene, and dressing. He required limited assistance for bed mobility and locomotion on the unit. He was unsteady but able to stabilize without staff assistance and he used no devices to assist with mobility. The Resident was frequently incontinent of bladder and occasionally incontinent of bowel. Review of the facility investigation dated 09/05/20 revealed they completed skin assessments on 17 Residents (#11, #19, #24, #25, #26, #27, #35, #37, #42, #46, #48, #52, #54, #56, #57, #58, and #59) and spoke to RN #09 and one other staff member about the incident between Resident #27 and #57. Interview on 09/09/20 at 2:40 P.M., with RN #09 revealed on 09/05/20 she was looking for Resident #27 to give her medications and she had not seen her for about five minutes. RN #09 found Resident #27 in Resident #57 room when she opened the door Resident #27 was sitting on the made bed with her pants and disposable adult brief down at her knees. Resident #57 was in close proximity about two feet away standing by the bed. RN #09 revealed she had not witnessed any touching by either resident and Resident #57 was fully clothed. RN #09 stated the situation did not look good so she wrote a progress note, notified the ADON, and checked to see if Resident #27 had a bowel movement or had urinated. RN #09 stated both residents wander and she had never seen Resident #27 take off her clothes before or Resident #57 have any sexual behaviors. RN #09 stated she had not notified the physician or family of the incident she reported the information to the next shift. Interview on 09/09/20 at 1:13 P.M., the Administrator revealed he became aware of the incident between Resident #27 and Resident #57 today. The Administrator verified he had not reported the incident to the state agency. Interview on 09/10/20 at 2:30 P.M., Physician #31 revealed he was notified of the incident between Resident #27 and Resident #57 and he was unsure of the date of notification. Physician #31 stated there was no sexual contact observed so he had not sent Resident #27 out to be examined. He further stated if the family wanted the resident sent out it was their right. He ordered the residents to be monitored. Interview on 09/10/20 at 2:53 P.M., with the family of Resident #27 revealed they were notified today 09/10/20 a few hours ago of the incident of Resident #27 being found in another resident room. The family member was unaware the incident occurred on 09/05/20 and was not told the date of the occurrence by the facility. Review of the self-reported incidents data base revealed the facility had not reported the alleged incident. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2016 revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment, of a resident. Facility staff should immediately report all such allegations to the Administrator and the state agency. All incident and allegations of abuse, neglect, and mistreatment must be reported immediately to the Administrator. Investigation protocol includes: interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed or heard the event, came in close contact with the resident the day of the incident, and employees who worked closely with the alleged victim the day of the incident. The Administrator will notify the Resident or the Resident Representative ,as appropriate, when a report has been made to the state agency. This deficiency is based on incidental findings discovered during the course of the complaint investigation OH 459. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review, staff interview, review of the facility investigation, and policy review, the facility failed to thoroughly investigate an incident of alleged abuse when Resident #27 was found in Resident #57 room with her pants and disposable adult brief down at her knees and sitting on Resident #57 bed. This had the potential to affect one Resident (#27) of three reviewed. The facility census was 60. Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) |

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| F 0610<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>assessment dated [DATE] revealed Resident #27 had severe cognitive impairment and had behaviors of delusions and wandering. The Resident required limited assistance for bed mobility, transfer, walk in room and in corridor, dressing, locomotion on and off unit, toilet use, and personal hygiene. The Residents balance during transitions and walking was not steady but she was able to stabilize without staff assistance. The Resident was always continent of bowel and bladder. Review of the progress note dated 09/05/20 at 6:27 A.M., revealed the resident was found in the room of Resident #57. Resident #27 was seated on the bed with her pants and disposable adult brief down to her knees. Resident #57 was standing beside his bed fully clothed. Neither resident could give an account to what was going on. Resident #27 was redirected out of the room and assessed with [REDACTED].#27 was checked for urinating or having a bowel movement on the bed and there was nothing on the bed or on the resident. Resident #27 was told she was not allowed to go into other residents rooms. The Assistant Director of Nursing (ADON) #30 was notified. Review of the progress note dated 09/11/20 at 1:36 P.M., revealed a Late Entry for 09/05/20 the family was made aware of the incident between this resident and another. The physician was made aware as well. 2. Review of the medical record for Resident #57 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 had severe cognitive impairment was able to make his self understood and usually understood others. He had behaviors including wandering, rejection of care and verbal aggression. Resident #57 required extensive assistance for transfer, toilet use, personal hygiene, and dressing. He required limited assistance for bed mobility and locomotion on the unit. He was unsteady but able to stabilize without staff assistance and he used no devices to assist with mobility. The Resident was frequently incontinent of bladder and occasionally incontinent of bowel. Review of the facility investigation dated 09/05/20 revealed they completed skin assessments on 17 Residents (#11, #19, #24, #25, #26, #27, #35, #37, #42, #46, #48, #52, #54, #56, #57, #58, and #59) and spoke to RN #09 and one other staff Nurse #100 about the incident between Resident #27 and #57. Interview on 09/09/20 at 2:40 P.M., with RN #09 revealed on 09/05/20 she was looking for Resident #27 to give her medications and she had not seen her for about five minutes. RN #09 found Resident #27 in Resident #57 room when she opened the door Resident #27 was sitting on the made bed with her pants and disposable adult brief down at her knees. Resident #57 was in close proximity about two feet away standing by the bed. RN #09 revealed she had not witnessed any touching by either resident and Resident #57 was fully clothed. RN #09 stated the situation did not look good so she wrote a progress note, notified the ADON, and checked to see if Resident #27 had a bowel movement or had urinated. RN #09 stated both residents wander and she had never seen Resident #27 take off her clothes before or Resident #57 have any sexual behaviors. RN #09 stated she had not notified the physician or family of the incident she reported the information to the next shift. Interview on 09/09/20 at 1:13 P.M., the Administrator revealed he became aware of the incident between Resident #27 and Resident #57 today. The Administrator verified he had not reported the incident to the state agency. Interview on 09/10/20 at 2:30 P.M., Physician #31 revealed he was notified of the incident between Resident #27 and Resident #57 and he was unsure of the date of notification. Physician #31 stated there was no sexual contact observed so he had not sent Resident #27 out to be examined. He further stated if the family wanted the resident sent out it was their right. He ordered the residents to be monitored. Interview on 09/10/20 at 2:53 P.M., with the family of Resident #27 revealed they were notified today 09/10/20 a few hours ago of the incident of Resident #27 being found in another resident room. The family member was unaware the incident occurred on 09/05/20 and was not told the date of the occurrence by the facility. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2016 revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment, of a resident. 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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, observations, staff interviews, review of the staff sign in and respiratory assessment screening, and review of the facility policy, public health information, and information provided by the Center for Disease Control and United States Food and Drug Administration the facility failed to maintain an infection prevention and control program that helped prevent the spread of communicable diseases when they failed to appropriately screen a nurse who had coronavirus 2019 (COVID-19) symptoms and allowed the staff member to work on the dementia unit. This had the potential to affect all 11 Residents (#24, #27, #35, #37, #41, #46, #48, #52, #54, #56, and #58) who resided on the dementia unit on 08/31/20. In addition the facility failed to provide approved KN95 mask and eye protection for staff during resident care. The finding potentially affected all facility residents on contact/droplet precautions. The facility census was 60.<br>Findings include: 1. Review of the Staff Sign In and Respiratory assessment dated [DATE] revealed the questionnaire asked: Do you have one of the following symptoms: cough, short of breath, sore throat, malaise/fatigue, nausea/vomiting, diarrhea, chills, shaking, new muscle pain, loss of taste or smell. Are you currently taking medication to reduce fever or symptoms listed above? Have you had any exposure with any person under investigation or diagnosed with [REDACTED].? If yes to any of the above questions you may not enter the facility. Review of the document further revealed Licensed Practical Nurse (LPN) #10 had a temperature of 96.8 Fahrenheit and wrote down yes to the above questions. Interview on 09/08/20 at 4:35 P.M., LPN #10 reported prior to work on 08/31/20 she had not felt well. She stated she was tired, sluggish, had a runny nose, and was not feeling right. She text the Director of Nursing (DON) before work on 08/31/20 and told her she was not feeling well and wanted to know if someone could work for her. The DON stated she would put her name on the list for agency to come relieve her. LPN #10 verified she wrote down Yes she had symptoms on Staff Sign In and Respiratory Assessment form prior to working on 08/31/20. LPN #10 stated the facility was unable to find someone to work for her, so she worked on the dementia unit from 5:50 A.M. until after 2:00 P.M. when her lab results came back positive from the all employee COVID-19 testing that was completed on 08/28/20. LPN #10 was then sent home. Interview on 09/09/20 at 1:34 P.M., the DON revealed she denied ever being told by LPN #10 that she was ill and had symptoms of COVID when she worked on 08/31/20 . The DON stated that no employee screens staff they screen themselves. The DON revealed once the Staff Sign In and Respiratory Assessment form is completed it is placed in her box for her or the assistant director of nursing to review. Review of facility policy titled Coronavirus Prevention and Management revised on 08/31/20 revealed symptoms of COVID-19 can include: cough, short of breath, sore throat, malaise/fatigue, nausea/vomiting, diarrhea, chills, shaking, new muscle pain, and loss of taste or smell. Employees will be screened upon entrance utilizing an at-the-door symptom check for signs and symptoms of COVID-19 and will be sent home if symptoms are present upon entering or arise during their shift.<br><br>2. Surveyor observations completed on 09/30/20 starting at 7:40 A.M. until 10:20 A.M. revealed staff providing resident care included Registered Nurse (RN) #80, Licensed Practical Nurse (LPN) #71, State tested Nursing Assistant (STNA) #90, STNA #91, Certified Occupational Therapy Assistant (COTA) #102, Physical Therapy Assistant (PTA) #101, PTA #100, LPN #70, LPN #81 and Activities staff #105. All the staff were observed wearing the same KN95 mask that had straps around the ears with only KN95 printed on the mask. The box in which the mask were purchased listed the company Lucheng Huali, KN95 and the words five layer structure (non medical) with no other no information or numbers. The surveyor could not verify the mask was acceptable for staff to use as N95 protection from COVID 19. Interview on 09/30/20 at 10:30 A.M. with LPN #70, the Infection Control Preventionist and Administrator verified the staff had been wearing the observed KN95 mask since 09/25/20. The Administrator stated the above KN95 mask would be replaced with approved N95 mask as soon as possible after surveyor intervention on 09/30/20. 3. Clinical record review revealed Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician order dated 08/11/20 revealed the resident had contact/droplet precautions. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Observation on 09/30/20 at 7:40 A.M. revealed RN #80 was standing in front of a medication cart in the hallway, was not wearing a face shield and had no face shield on her cart. At that time, RN #80 verified she had no face shield and stated it was personal preference to use a face shield. Observation on 09/30/20 at 7:48 A.M. revealed LPN #71 was standing in front of a medication cart in the hallway, was not wearing a face shield and had no face shield on her cart. At that time, LPN #71 verified she had no face shield and also stated it was personal preference to use a face shield. Observations |

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| **HARMONY CENTER FOR REHABILITATION AND HEALING** | **164 OFFICE PARK DRIVE XENIA, OH 45385** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 3)<br>during the breakfast meal service on 09/30/20 at 7:52 A.M. revealed Resident #24 resided on the isolation unit with a double barrier entrance. STNA #90 was not wearing a face shield and served the resident his breakfast tray, then used her arms to pull the resident up to reposition him in the bed with the assistance of STNA #91. Interview with STNA #90 at that time verified she was not wearing a face shield/eye protection since the beginning of her shift at 6:00 A.M. Observations with the Administrator and LPN #70 on 09/30/20 at 8:25 A.M. verified there were no face shields/eye protection available for the staff in the isolation supply carts located on both the isolation/South hallways and the first and second isolation supply carts in the West hallway. Phone interview on 10/01/20 at 12:15 P.M. with LPN #70 revealed Resident #24 was on isolation due to the high risk of respiratory infections. LPN #70 stated that all facility residents were on contact/droplet precautions from 08/11/20 until further notice from the local county health department staff who had made the recommendation. Review of the facility policy titled Coronavirus Prevention and Management Policy revised 09/30/20 revealed under the section Caring for a Resident with suspected or confirmed COVID-19 staff initiated Contact and Droplet Isolation Precautions, implemented the universal use of N95 face masks (if available) by all staff while in the facility and implemented all recommended personal protective equipment (PPE) for the care of all residents (gloves, gown, eye protection, face mask). Review of the public health information posted for county on 10/01/20 revealed the COVID-19 positivity rate for the county was 5.5 percent indicating a medium risk of community activity. The Ohio county information revealed a level 2 (orange) meaning increased exposure/spread and to exercise caution. Review of information from the United States Food and Drug Administration dated 09/28/20 titled Personal Protective Equipment revealed no evidence the KN95 mask worn by the staff from 09/25/20 until 09/30/20 was an approved mask. Review of information provided by the Center for Disease Control dated 07/15/20 regarding the use of eye protection/face shields in nursing homes revealed eye protection should be worn by staff especially during resident care if the community risk was moderate or higher. This deficiency substantiates Complaint Number OH 459. |