STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. BUILDING _____ B. WING _____	03/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARMONY COURT REHAB AND NURSING	6969 GLENMEADOW LANE CINCINNATI, OH 45237

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to update resident care plans to reflect discharge planning. This affected one (#78) of three residents review for discharge planning. The census was 98. Findings include: Review of record for Resident #78 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of Minimum Data Set ((MDS) dated [DATE] for Resident #78 revealed the resident was cognitively impaired and required extensive assistance of one staff with activities of daily living. Review of the care plan for Resident #78 initiated 09/06/19 revealed no documentation regarding the resident's preferences regarding discharge and/or discharge planning for resident. Review of social service progress note for Resident #78 dated 09/05/19 revealed the resident was not able to communicate desires about discharge. Further review of note revealed the facility contacted resident's representative, and her preference was for long term placement. Review of social service progress note for Resident #78 dated 09/17/19 revealed the resident's representative attended care conference for Resident #78, and said plan was for resident to stay in the facility long term. Review of progress note dated 11/26/19 for Resident #78 revealed the facility faxed a referral for resident to transfer to Nursing Facility A. Review of progress note dated 12/12/19 for Resident #78 revealed the facility faxed a referral for resident to transfer to Nursing Facility B. Review of progress note for Resident #78 dated 01/31/20 revealed a care conference was held with the resident's representative and her preference was for resident to reside in a different facility closer to her home and facility would assist with finding new placement. Review of nurse progress note for Resident #78 dated 02/21/20 revealed the facility faxed a referral for resident to be transferred to Nursing Facility C. Interview on 03/13/20 at 3:00 P.M. with the Administrator confirmed Resident #78 was unable to express his discharge preferences due to dementia and resident's representative's wishes regarding discharge plans had changed throughout his stay at the facility from desiring long term placement, to wanting placement at a facility closer to her home, to wanting to care for him at home herself, and back to wanting placement at a facility closer to her home. Administrator confirmed Resident #78's care plan contained no documentation and/or instructions regarding the resident's/representatives wishes regarding discharge and/or discharge planning. This deficiency is based on incidental findings discovered during the course of this complaint investigation.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, policy review and review of information from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to implement timely assessment, measurement, and treatment for [REDACTED]. This affected one (#78) of three residents reviewed for impaired skin integrity. The census was 98. Findings include: Review of record for Resident #78 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of Minimum Data Set ((MDS) dated [DATE] for Resident #78 revealed the resident was cognitively impaired and required extensive assistance of one staff with activities of daily living and coded as negative for the presence of pressure ulcers. Review of the pressure ulcer risk assessment for Resident #78 dated 10/16/19 revealed the resident was at risk for developing pressure ulcers. Review of care plan for Resident #78 dated 09/06/19 revealed the resident was at risk for skin breakdown due to dementia, decreased mobility, and incontinence. Interventions included the following: keep skin clean and dry, assist to toilet and bedpan daily upon request, assist with care daily, encourage optimal mobility daily, encourage resident to be out of bed as tolerated, assist to turn and reposition routinely, encourage resident to turn and reposition every two hours, observe skin integrity daily with care, report pertinent changes in skin status to physician, perform weekly skin checks per house policy, protective skin barrier as ordered., provide diet as ordered and monitor nutritional status and dietary needs, consult with physician. Review of the weekly skin assessment for Resident #78 dated 03/09/20 revealed the resident had no pressure ulcers. Review of the nurse progress notes for Resident #78 dated 03/11/20 revealed resident had a deep tissue injury (DTI) to his right heel, a stage I pressure ulcer to his left heel, and a stage I pressure ulcer to his left hip. The note was contained no documentation regarding measurements or a detailed description of the wounds. Review of physician orders for Resident #78 revealed an order for [REDACTED].#78 for March 2020 revealed the application of the [MEDICATION NAME] dressing to the resident's left heel and left hip was not documented as being completed. Review of the nurse progress notes for Resident #78 dated 03/11/20 through 03/13/20 revealed the notes contained no documentation regarding the application of the [MEDICATION NAME] dressings to resident's bilateral heels and left hip. Review of the weekly wound documentation for Resident #78 dated 03/13/20 timed at 8:01 A.M. revealed resident had a suspected DTI to his right heel which was maroon in color without drainage or odor measuring four centimeters (cm) long by three cm wide by zero cm deep with natural color and dry skin to the peri wound. The note indicated the wound was first identified on 03/11/20 but this was the first assessment of the area. Review of the weekly wound documentation for Resident #78 dated 03/13/20 timed at 8:29 A.M. revealed the resident had a stage I pressure ulcer to his left heel which was pink and non-blanchable without drainage or odor measuring three cm long by two cm wide by zero cm deep with natural color and dry skin to the peri wound. The note indicated the wound was first identified on 03/11/20 but this was the first assessment of the area. Review of the weekly wound documentation for Resident #78 dated 03/13/20 timed at 8:29 A.M. revealed the resident had a stage I pressure ulcer to his left hip which was pink and non-blanchable without drainage or odor measuring three cm long by two cm wide by zero cm deep with natural color and dry skin to the peri wound. The note indicated the wound was first identified on 03/11/20 but this was the first assessment of the area. Interview on 03/12/20 at 9:43 A.M. with Licensed Practical Nurse (LPN) #30 confirmed Resident #78 did not have any pressure ulcers. Observation on 03/13/20 at 11:45 A.M. of Resident #78 confirmed there was an intact [MEDICATION NAME] dressing to resident's left hip and right heel both dated 03/13/20. There was no dressing on resident's left heel. Interview on 03/13/20 at 11:45 A.M. with LPN #110 confirmed he had not placed the dressings on Resident #78's left hip or right heel and he was not aware Resident #78 had orders for [MEDICATION NAME] dressings. Interview on 03/13/20 at 11:47 A.M. with LPN #110 confirmed Resident #78 had orders for [MEDICATION NAME] dressings to be changed every three days to the left hip and bilateral heels. LPN #110 further confirmed he would apply a [MEDICATION NAME] dressing to resident's left heel. Review of the facility policy titled Skin Program Policy and Procedure undated revealed all residents would receive an individualized preventative skin plan of care which would be updated if residents developed actual skin problems. Review of the NPUAP clinical guidelines online resource dated 2017 (http://www.internationalguideline.com/static/pdfs/NPUAP-EPUAP-PPPIA-CPG-2017.pdf) revealed treatment needs of a pressure ulcer change over time, in terms of both healing and deterioration, and treatment strategies should be continuously re-evaluated based on the current status of the ulcer. Further review of the guidelines revealed signs of deterioration such as an increase in wound dimensions, change in tissue quality, increase in wound exudate or other signs

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. BUILDING _____ B. WING _____	03/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARMONY COURT REHAB AND NURSING	6969 GLENMEADOW LANE CINCINNATI, OH 45237

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) of clinical infection should be addressed immediately, and nurses should assess and document physical characteristics of the wound including location, category/stage, size, tissue type(s), color, condition, wound edges, exudate, and odor on a consistent basis. This deficiency is based on incidental findings discovered during the course of this complaint investigation.
F 0805 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and physician interview, review of personnel files, review of the facility menus and review of facility policy, the facility failed to ensure a resident on a mechanically altered diet was provided food in the correct texture assessed to meet their individual needs. This resulted in Immediate Jeopardy for one (#99) resident who experienced serious life-threatening harm when staff served Resident #99 the incorrect texture of food items during a meal, the resident subsequently choked requiring staff and Emergency Medical Service (EMS) intervention to perform the [MEDICATION NAME] maneuver in an effort to remove the food bolus from the residents airway, the resident's condition deteriorated and the resident passed away at the facility. This affected one (#99) of seven residents reviewed for choking and/or mechanical altered diets. The facility identified six (#27, #43, #47, #63, #68, #91) current residents with a dysphagia [DIAGNOSES REDACTED]. The facility census was 98. On [DATE] at 4:09 P.M., the Administrator, Director of Nursing (DON), the Regional Director of Clinical Operations, and Registered Nurse (RN) #10 were notified Immediate Jeopardy began on [DATE] at approximately 4:30 P.M. when Resident #99 who was edentulous, had a [DIAGNOSES REDACTED]. The nurse performed the [MEDICATION NAME] maneuver which resulted in the resident expelling a piece of meat. EMS was called and took over rescue efforts and retrieved a large piece of meat from Resident #99's airway. Resident #99 was pronounced dead by EMS personnel on [DATE] at approximately 4:45 P.M. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 4:45 P.M., the nurse on duty performed the [MEDICATION NAME] maneuver on Resident #99 and staff summoned EMS personnel. EMS personnel took over Resident #99's care. At 4:45 P.M., Resident #99 was pronounced dead at the facility. On [DATE], the DON and Dietary Supervisor (DS) #60 did an audit of the printed meal tray ticket for every resident in the facility to ensure the correct diet orders were noted. The audit was 100 percent in compliance. On [DATE], following Resident #99's choking incident, State tested Nursing Assistant (STNA) #40 and Cook #50 were removed from the schedule. On [DATE], STNA #40 and Cook #50 were terminated. On [DATE] beginning at 6:00 P.M., the DON educated all nurses and STNAs regarding ensuring residents were served the correct diet based upon their tray ticket. The education was completed on [DATE] at 7:00 P.M. On [DATE], DS #60 educated all dietary staff on ensuring trays were sent out from the kitchen with a tray ticket with the resident's name and correct diet. On [DATE], Registered Dietitian (RD) #90 completed an audit of various meals to ensure the resident received the correct diet which matches the diet listed on the tray ticket. The audit was in 100 percent compliance. On [DATE], the Quality Assurance Performance Improvement (QAPI) Committee met to review and investigate the incident regarding Resident #99. The committee performed a root cause analysis and determined staff made errors and did not follow proper procedure when the kitchen staff sent out a tray for the resident without a tray ticket which would have indicated the correct diet for Resident #99. On [DATE], the governing body of the facility met to review the choking incident. On [DATE], the Administrator implemented audits of meal delivery. The audits will be completed five times weekly for four weeks and then weekly for one month. The QAPI Committee will meet monthly and the results of the audits will be reviewed with the committee. The QAPI Committee will determine the need for further monitoring. On [DATE] between 3:00 P.M. and 3:10 P.M., interviews with Licensed Practical Nurse (LPN) #20 and Cook #80 confirmed they received education on [DATE] regarding the meal delivery process and ensuring residents receive the correct physician ordered diets. On [DATE] at 8:00 A.M., observation of the breakfast meal revealed Resident #19, #78, and #50 received the correct diets as ordered by the physician and each resident's tray had a ticket which indicated the resident's name and the correct diet. On [DATE], six (#27, #43, #47, #63, #68, #91) current residents with a dysphagia [DIAGNOSES REDACTED]. The medical record reviews revealed current physician orders for mechanically altered diets were accurate and no concerns were identified. On [DATE] between 11:52 A.M. and 12:14 P.M., observations revealed Resident #27, #43 and #63 were served mechanical soft diets as ordered by the physician. Further observations of the resident's meal tickets revealed the correct diet was listed. On [DATE] between 11:45 A.M. and 11:53 A.M., interviews with LPN #110, STNA #120, and STNA #130 confirmed they had received education on [DATE] from the DON regarding ensuring residents received the correct diet and to check the meal ticket prior to serving the resident. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective actions and monitoring for effectiveness and on-going compliance. Findings include: Review of the closed medical record for Resident #99 revealed the resident was admitted to the facility on [DATE]. Resident #99 passed away at the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #99's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired, required supervision and set up for eating and was edentulous. Review of the care plan for Resident #99 dated [DATE] revealed resident had an alteration in nutrition related to dysphagia and poor dentition. Interventions included the following: encourage compliance with diet guidelines, monitor for signs and symptoms of dysphagia, monitor diet tolerance, supervision and assistance with meals and snacks as needed. Review of the [DATE] physician orders for Resident #99 revealed an order for [REDACTED].#99 dated [DATE] timed at 6:49 P.M. revealed the resident was eating dinner with supervision in the fine dining room and became non-responsive and turned blue while eating the meal. Further review of the note revealed the nurse performed the [MEDICATION NAME] maneuver on Resident #99 and was able to remove a small piece of meat, nine-one-one (911) was called immediately, and EMS personnel arrived and took over rescue efforts. EMS personnel removed another piece of meat from the resident's airway and provided oxygen to the resident and monitored her noting she continued to be non-responsive but had a faint pulse. EMS personnel pronounced Resident #99's death at the facility. Resident #99's guardian and attending physician were notified and an order was given to release the resident's body to the funeral home. Review of nurses progress notes for Resident #99 dated [DATE] timed at 7:00 P.M. revealed the resident's body was released to the funeral home. Review of Resident #99's MDS dated [DATE] revealed the resident passed away in the facility. Interview on [DATE] at 11:00 A.M. with the DON confirmed Resident #99 had a physician's order for a mechanical soft diet but received a regular diet for dinner on [DATE]. The DON confirmed the entre for dinner on [DATE] was smoked sausage, and Resident #99 received a whole intact sausage on her dinner tray instead of ground sausage. The DON confirmed Resident #99 was edentulous and had a [DIAGNOSES REDACTED].M., Resident #99 turned blue and became non-responsive. The DON stated Registered Nurse (RN) #100 performed the [MEDICATION NAME] maneuver on Resident #99 and was able to remove a small piece of meat, 911 was called immediately, and EMS personnel arrived and took over rescue efforts. The DON stated EMS personnel were able to remove another piece of meat from Resident #99's airway, EMS personnel provided oxygen to the resident and monitored her noting she continued to be non-responsive but had a faint pulse. EMS personnel pronounced Resident #99's death at 4:45 P.M., and the appropriate notifications were made to the resident's guardian and attending physician. The DON stated an order was given to release the resident's body to the funeral home. The DON stated RN #100 is currently on leave and not available for an interview but the DON further confirmed she was in the facility at the time of the choking incident and assisted with Resident #99's care. Interview on [DATE] at 12:00 P.M. with Physician #70 confirmed the coroner's office would be completing Resident #99's death certificate but stated the choking incident which occurred on [DATE] was a factor in the resident's death. Interview on [DATE] at 1:17 P.M. with the Administrator confirmed Cook #50 and STNA #40 were terminated on [DATE] due to not following facility policy. The Administrator further confirmed the facility's investigation of the incident determined the root cause of Resident #99's choking incident and subsequent death was due to facility staff not providing Resident #99 with the correct physician ordered mechanical soft textured diet at the dinner meal on [DATE]. On [DATE] at 10:00 A.M., a request was made to obtain Resident #99's EMS squad run report from [DATE]. Review of the personnel file for former STNA #40 revealed a date of hire of [DATE] and a termination date of [DATE] due to failing to comply with facility policies. Further review of the file reveals STNA #40 was terminated [DATE] for serving a resident a meal tray without a ticket indicating the resident's correct diet. Further review of the termination notice revealed the STNA gave the resident a regular diet tray, but the resident who was supposed to be on a mechanical soft diet, choked during the meal and expired as a result. Review of the personnel file for former Cook #50 revealed a date of hire of [DATE] and a termination date of [DATE] due to failing to comply with facility policies. Further review of the file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. BUILDING _____ B. WING _____	**03/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARMONY COURT REHAB AND NURSING	**6969 GLENMEADOW LANE CINCINNATI, OH 45237**

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 0805 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) revealed Cook #50 was terminated on [DATE] for providing a meal tray for a resident without obtaining a written ticket which indicated the resident's correct diet. Further review of the termination notice revealed the resident was provided a regular diet tray but was supposed to be on a mechanical soft diet, and the resident choked on the meal and expired as a result. Review of the facility menu for the dinner meal on [DATE] revealed the entre was smoked sausage. Review of facility's undated policy titled Standard House Diets revealed the facility would ensure appropriate modified texture diets would be available to residents to ensure meal trays were prepared and served accurately. Further review of the policy revealed a mechanical soft diet would be prepared to accommodate residents with difficulty chewing to include ground meats. This deficiency substantiates Complaint Number OH 810.