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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>366220 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>10/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Harmony Court Rehab and Nursing |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6969 Glenmeadow Lane<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and staff interview, the facility failed to ensure medications were given as prescribed. This affected one (#15) of four residents reviewed for medication administration. The facility census was 107. Findings include: Review of the medical record for Resident #15 revealed an admission date of 5/30/25. The resident was admitted with diagnoses including schizoaffective disorder, Chronic Obstructive Pulmonary Disease (COPD), major depressive disorder and syndrome of inappropriate secretion of anti-diuretic hormone. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact and required supervision with eating, bed mobility, toileting hygiene and transfers. Observation on 10/29/25 at 10:19 A.M. of the medication pass with Registered Nurse (RN) #100 for Resident #15 revealed he prepared Fluphenazine (antipsychotic) one 10 milligram (mg) tablet (tab), Hydroxyzine Pamoate (antihistamine) 25 mg, Metoprolol (high blood pressure) 25 mg tab, Lamotrigine (Bipolar disorder) 25 mg, Trihexyphenidyl (Tremors) five mg tab, Turmeric (supplement) 500 mg capsule, Stress formula vitamin one tab, Sennosides (constipation) 8.6 mg tab, Lorazepam (anxiety) one, one mg tablet and Geodon (antipsychotic) 20 mg tablet and placed them into a medication cup. Observation on 10/29/25 at 10:29 A.M. revealed RN #100 took the medication cup to the table where Resident #15 was seated. Resident #15 looked in the medication cup and asked where her Bumex (diuretic) and Aspirin (salicylate) were. RN #100 returned to the medication cart and opened the electronic medical record for Resident #15. After reviewing the medications, he opened the medication drawer and removed the card for Bumex one mg tablet and placed it into a medication cup, he then opened a bottle of Aspirin 81 mg, enteric coated and added it into the medication cup. He then delivered the additional two pills to Resident #15. Review of the physician orders for Resident #15 revealed an order for Fluphenazine 10 mg tablet, give two tablets, two times daily with a start date of 08/19/25. Further review revealed an order for Aspirin 81mg chewable tablet with a start date of 05/31/25 and an order for Bumex one mg by mouth daily with a start date of 05/31/25. Interview on 10/29/25 at 10:27 A.M., RN #100 verified he had only given one tablet of Fluphenazine instead of two and had given an 81 mg, enteric coated Aspirin instead of the chewable tablet as ordered. RN #100 acknowledged he did not prepare Bumex and Aspirin for administration until Resident #15 informed him it was not present in the medication cup. This deficiency represents non-compliance investigated under Complaint Number 2591479.</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record reviews, observations and staff interviews the facility failed to ensure medications were administered as ordered resulting in three medication errors out of 27 opportunities observed which resulted in an 11.11 percent (%) error rate. This affected one (#15) of four residents reviewed for medication administration. The facility census was 107. Findings include: Review of the medical record for Resident #15 revealed admission date of 5/30/25. The resident was admitted with diagnoses including schizoaffective disorder, Chronic Obstructive Pulmonary Disease (COPD), major depressive disorder and syndrome of inappropriate secretion of anti-diuretic hormone. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact and required supervision with eating, bed mobility, toileting hygiene and transfers. Review of the medical record for Resident #15 revealed a physician order dated 08/19/25 for Fluphenazine Hydrochloride (schizoaffective disorder) 10 milligram (mg) give two tablets by mouth two times a day. A second order dated 05/31/25 for Bumetanide (diuretic) on mg by mouth daily and a third order dated 05/31/25 for Aspirin (blood thinner) 81 mg chewable tablet by mouth daily. Observation on 10/29/25 at 10:19 A.M. of the medication pass with Registered Nurse (RN) #100 for Resident #15 revealed he prepared Fluphenazine (antipsychotic) one 10 milligram (mg) tablet (tab), Hydroxyzine Pamoate (antihistamine) 25 mg, Metoprolol (high blood pressure) 25 mg tab, Lamotrigine (Bipolar disorder) 25 mg, Trihexyphenidyl (Tremors) five mg tab, Turmeric (supplement) 500 mg capsule, Stress formula vitamin one tab, Sennosides (constipation) 8.6 mg tab, Lorazepam (anxiety) one, one mg tablet and Geodon (antipsychotic) 20 mg tablet and placed them into a medication cup. Observation on 10/29/25 at 10:29 A.M. revealed RN #100 took the medication cup to the table where Resident #15 was seated. Resident #15 looked in the medication cup and asked where her Bumex (diuretic) and aspirin were. RN #100 returned to the medication cart and opened the electronic medical record for Resident #15. After reviewing the medications, he opened the medication drawer and removed the card for Bumex one mg tablet and opened a bottle of Aspirin 81 mg enteric coated and put one pill into the medication cup. He then delivered the additional two pills to Resident #15. Interview on 10/29/25 at 10:27 A.M., RN #100 verified he had only given one tablet of Fluphenazine instead of two and had given an enteric coated 81 mg Aspirin instead of the chewable tablet as ordered. RN #100 acknowledged he did not prepare the Bumex and Aspirin for administration until after Resident #15 informed him it was not present in the medication cup. This deficiency represents non-compliance investigated under Complaint Number 2591479.</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, staff interview, and review the facility policy, the facility failed to ensure proper storage of medication. This had the ability to affect all 25 residents on the hall. The facility census was 107. Findings include: Observation on 10/29/25 at 10:09 A.M. of the medication pass revealed RN#100 prepared medication for Resident #14 removed the medication cup from the cart, turned in the opposite direction, walked approximately five feet down the hall and entered Resident #14's room. The unattended medication cart was left unlocked in the hall for approximately four minutes. Interview on 10/29/25 at 10:09 A.M. with RN #100 acknowledged the medication cart should not be left unlocked if unattended. RN #100 verified he he did not lock the medication cart and left it unsecured in the hallway. Review of the facility policy, Medication storage in the facility dated 11/11 revealed medications should be stored safety and securely.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interviews and Centers for Disease Control and Prevention guidelines the facility failed to ensure proper infection control measures were followed during medication administration. This had the potential to affect one Resident (#14) of four reviewed. The facility census was 107. Findings include: Review of medical record for Resident #14 revealed admission date of 12/13/17. The resident was admitted with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), hemiplegia, bipolar disorder and depression. The annual Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 11 indicating impaired cognition and he required supervision with eating, bed mobility, toileting hygiene and transfers. Observation on 10/29/25 at 9:58 A.M. of the medication pass with Registered Nurse (RN) #100 for Resident #14 revealed RN #100 unlocked the medication cart and removed the medication card from the drawer of the cart. He was observed punching the medication into his ungloved hand and then placed it into a medication cup. This same action was observed for a second medication. Interview on 10/29/25 at 10:03 A.M., RN #100 acknowledged he should not punch medication into his ungloved hand, and it should be transferred directly into the medication cup. Observation at 10/29/25 at 10:05 A.M. revealed RN#100 placed the medication card over the medication cup. When he punched the medication, the pill missed the cup and landed directly onto the cart. Using his ungloved fingers, RN #100 picked up the medication and placed it into the medication cup. Interview on 10/29/25 at 10:09 A.M. with RN #100 verified he picked up medication from the top of the medication cart and placed it into the medicine cup. Review of the Centers for Disease Control and Prevention website: <a href="https://www.cdc.gov/infection-control/hcp/core-practices/index.html">https://www.cdc.gov/infection-control/hcp/core-practices/index.html</a> revealed Standard Precautions are the basic practices that apply to all patient care and apply to all settings where care is delivered. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to other patients. These precautions are recommended for medication safety. This deficiency represents non-compliance investigated under Complaint Number 2591479.</p> |   |  |