Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

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S 000	Initial Comments Complaint Investigation 2283749/IL146872	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010 h) 300.1210 b) 300.1210 d)3) 300.1210 d)5) 300.3240 a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to monitor and assess a change in condition for one resident (R1) reviewed for change of condition. This failure resulted in R1 going into septic shock requiring hospitalization and critical care. Findings include: R1's medical record (Face Sheet, Progress	S9999		

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S9999	Continued From page 2 Notes) documents is a 72-year-old, admitted to the facility on 02/16/2022 following L3-L4 decompression arthrodesis, with diagnoses including but not limited to: Fusion of Spine, Lumbar Region; Radiculopathy, Low Back Pain, Spinal Stenosis, Lumbar Regions without Neurogenic Claudication, Muscle Weakness, Essential Hypertension, Unspecified Atrial Fibrillation, and Constipation. MDS (Minimum Data Set, 02/24/2022) documents R1's Cognitive Skills for Daily Decision Making as independent-decisions consistent/reasonable. R1 requires extensive assistance with transfer and toilet use. Skin/Wound Note (02/17/2022) documents in part: 1. Left flank area proximal, surgical -0.6 x 6.6 cm -Surgical incision approximated and remains free of s/s (signs/symptoms) of infection or drainage -No c/o (complaint of) pain or discomfort 2. Left flank area, distal surgical -0.8 x 1.1 cm -Surgical incision approximated and remains free of s/s (signs/symptoms) of infection or drainage -No c/o pain or discomfort 3. Left elbow, dry scab -0.3 x 0.3 cm -No drainage noted -No odor noted -No c/o pain or discomfort 4. Upper back noted with soft bump 5. Blanchable redness noted to bilateral heels 6. Spider veins note to bilateral feet 7. Old surgical scars noted to R (right) knee, mid	S9999		

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lower back, right mid abdomen, and left upper chest
8. Skin tags noted to left mid abdomen, and symphysis pubis
9. Bruises noted to r(ight) antecubital area, and left dorsum
10. Dry skin noted to bilateral lower legs
Resident is continent of bowel and bladder

On 02/24/2022 R1 was sent to hospital; R1 received fluid resuscitation (rapid administration of IV fluids to correct fluid volume imbalances), intubation (insertion of tube into the airway to aid with breathing), and administration of pressors (medication to elevate blood pressure). R1 underwent emergent debridement (surgical removal of dead, devitalized or contaminated tissue) on 02/24/2022 for Fournier's Gangrene (a type of flesh-eating disease that affects the scrotum, penis or perineum); additional debridement on 02/26/2022, and diverting colostomy (a surgical procedure in which one end of the large intestine is diverted through an incision made in the abdominal wall) on 03/07/2022 to aid in wound healing.

On 02/24/2022 at 9:43 AM, V3's progress note documents BP: 102/50, HR: 98

On 02/24/2022 at 2:54 PM, V5's (DO) progress note documents in part: "Seen with NP (Nurse Practitioner) today and patient reports new onset bowel/bladder incontinence. States that LLE (left lower extremity) weakness remains the same, denies saddle/perineal anesthesia. Drowsy due to meds. EXAM: VSS (vital signs stable), distress."

On 02/24/2022 R1's ambulance run sheet documents ambulance was dispatched to nursing home (arrived on scene at 12:34 PM) for

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S9999	Continued From page 4 transport of R1 to ER (Emergency Room) for new bowel and urinary incontinence after lumbar fusion. Pain to low back and new pain to left abdomen (6/10 on pain scale). States (R1) feels weak. Blood pressure range: systolic 97-85, diastolic 60-55 (lowest blood pressure was 85/55). IV started, 250 cc NS (normal saline) given. Arrived at hospital at 1:25 PM. On 02/24/2022 at 1:59 PM, R1's ED (Emergency Department) Notes document in part, "Per patient, reports (R1) has been incontinent x2 for the past 3 days, had problems with urination after lumbar fusion and had (indwelling urinary catheter) in place that was (discontinued). Patient states discomfort to lower abdomen, also having LBP (low blood pressure). Also has testicular (bilateral) swelling that is tender to touch. On 02/24/2022 at 12:00 AM, R1's Procedure Notes documents, in part, "(R1) is a 72-year-old with noted (Fournier's Gangrene) by ultrasound, CT, and exam. I immediately called in the OR team. Physical exam was consistent with (Fournier's gangrene). Dead and necrotic tissue was removed." On 02/25/2022 at 6:38 PM, Consult Notes document in part, "In the ED on arrival, patient found to be hypotensive (low blood pressure) with BP as low as 77/50. Patient received 3l n/s (normal saline) bolus (a large volume of fluid given intravenously to hasten a response) in ED, but BP remained low despite fluid resuscitation, so central line placed and patient initiated on pressors." On 03/08/2022 at 10:10 AM, R1's Consult Notes document in part, "On 02/24/2022, (R1) was seen in Emergency Department for urinary retention	S9999		

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S9999	Continued From page 5 and abdominal pain and was subsequently admitted for sepsis related to Fournier's Gangrene as noted on the CT of the abdomen and pelvis requiring emergent operative debridement. (R1) was admitted to the ICU, intubated on pressor support and IV antibiotics. (R1) returned to the operating room a few days later as the necrosis had extended posteriorly to (R1's) rectal area requiring further debridement. On 03/07/2022, (R1) underwent a diverting colostomy in an effort to facilitate further wound healing." On 06/29/2022 at 8:00 PM, R1 said, "I had surgery on my back on 02/15/2022. I was discharged to (Nursing Home) on 02/16/2022. They removed the catheter (indwelling urinary) at (local hospital). I wasn't able to use the toilet at facility; I needed help to stand up. They gave me a urinal to use. I was left in diapers for prolonged periods of time, that's what I felt. It was hard to use the urinal with the diapers. I complained about having a painful rash to my "crotch" and I felt like I had a bladder infection because I had to urinate, and nothing would come out. I complained to staff about it around the 19th or the 20th (of February). I sent at least three messages via the patient portal, to V5 (DO/Doctor of osteopathic medicine) or V18 (Neurosurgeon), with my concerns around 21st of February. They (Physical therapist) put me on a stationary bike, and I told the therapist you have to stop this because it's irritating me (discomfort to scrotal area)." On 06/30/2022 at 10:38 AM, R1 said, "I sent the first message to V18 on 02/17/2022 at 10:53 PM, This place is the pits. I've only had one PT (Physical Therapy session). I'm getting a lot pain in the right leg and I've had to ask for pain	S9999		

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medication and no shower.'"

On 02/21/2022 at 9:55 AM, V19 (PA-Physician Assistant) responded, "I'm just checking if you're having a better experience at the nursing home. Are you getting PT? Have you been showered? Is your right leg getting better? At 3:50 PM, R1 responded, "not able to take shower. I have painful skin rash from diapers, not helped with bladder issue (couldn't urinate but felt urge), they have not offered rash cream yet. At 3:56 PM, R1 responded, "PT session very short." R1 states the message was viewed by staff on 02/21/2022. R1 said, "It was painful, I could feel it, it was in the "crotch", it was from the diaper, it started around 02/20/2022 or 02/21/2022, that's when I first asked for rash cream."

V18 (Neurosurgeon) and V19 (PA) were not available for interview.

R1's progress notes do not document R1's aforementioned complaints.

On 06/30/2022 at 1:28 PM, V5 (DO) said, "(R1) is status post L3-L4 arthrodesis (lumbar spinal fusion). When I saw (R1) at the nursing home, (R1) was altered, (R1) had altered mental status and wasn't answering appropriately. (R1) was incontinent, I was concerned that he could have had an impingement (compression of spinal nerves resulting in numbness and tingling). I wasn't notified (by nursing home staff) that (R1) was incontinent. There was no timeline. (R1) could have been incontinent for a few minutes. I saw (R1) but I couldn't say (if I examined R1), an exam took place, but I couldn't say it was a head to toe. I didn't know at the time that (R1) was septic (septic shock is a severe complication of sepsis that can include very low blood pressure,

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an altered mental state, and organ dysfunction)."

On 06/30/2022 at 3:30 PM, V3 (LPN) said, "(V5, DO) assessed (R1). (V5) asked me what (R1's) baseline was, did (R1) have any complaints? I (V3) said, 'Doc, to be honest, at the beginning of my shift, I did (R1's) vital signs, (R1) had no complaints, I offered (R1) pain medication.' I didn't know if (R1) was telling the truth. I had to be honest to the doctor. I didn't know if (R1) was incontinent or not. My CNA (Certified Nursing Assistant) reported to me that (R1) was incontinent. (V5) wanted (R1) sent to the hospital right away, that means the same day, today. I completed my med pass, then did my note and called (Private Ambulance). I finished my med pass around 10:30 AM. (R1) was picked up in the afternoon. I'm pretty sure that I started (R1's) paperwork then. To be honest, I didn't know it was serious. I asked the doctor why I had to send (R1) out. I didn't know what (R1's) baseline was before; I didn't know if (R1) was telling the truth (about incontinence). I did assess (R1) before (R1) left (assessment I consisted of vital signs only). I don't really touch the patients. I give their meds, check vital signs, give pain med if they ask for it, and of course tell the doctor what's going on. I held one medication (Enalapril) because (R1's) blood pressure was low. I mentioned this to (V5,DO); (V5, DO) didn't really say anything."

(A)