STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014534	A. BUILDING: _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PALOS	11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463

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S 000	Initial Comments Complaint Investigations: 2390041/IL154904	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.1220b)3) 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 following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on interview and record review the facility failed to have interventions in place to address the behaviors of a resident pulling out a tracheostomy tube and inner cannula for one resident (R2) reviewed for accidents and incidents in a total sample of 6. This failure resulted in R2 pulling out the tracheostomy tube and being found unresponsive, CPR was initiated and R2 was pronounced deceased in the facility. Findings Include: Respiratory Therapy Note dated 10/7/22 documents that R2 was being admitted to the facility for rehab and reconditioning. R2's history	S9999		

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S9999	Continued From page 2	S9999		

documents that the resident was hospitalized on 7/28/22 after a fall where the resident sustained a subdural hematoma requiring a left craniotomy and craniectomy. R2 was placed on a ventilator and a trach and feeding tube was placed. R2 was weaned off the ventilator, decannulated and sent to acute rehab on 9/23/22. On 9/28/22 R2 suffered tracheal stridor and cardio-pulmonary arrest. R2 was transferred back to the hospital, tracheal stenosis was noted, and a new trach was placed.

Upon admission to the facility on 10/7/22 R2 was noted with a 28% aerosol trach collar in place with oxygen at 5 liters. R2 had no signs of respiratory distress, and all vital signs were stable. Trach care and suctioning done every shift and as needed.

Social Service Note dated 10/13/22 documents that R2 has a Brief Interview for Mental Status Score of 13 out of 15 indicating that the resident is cognitively intact. R2 is calm and cooperative and communicates with clear speech as English is the resident's primary language. The resident is her own responsible party. R2 has no history of delusions or hallucinations. R2 ambulates via wheelchair and requires assistance with ADLs.

Nurse's Notes dated 10/15/22 documents that nurse arrived to perform suctioning. Nurse observed R2's removable inner cannula on the bedside table. R2 was asked why she removed the inner cannula and stated because she "did not need it." R2 educated on the importance of having the inner cannula in place. Cannula cleaned; suctioning performed but Nurse had trouble putting the cannula back in place. Once the cannula was inserted R2 had complaints of shortness of breath. R2's aerosol trach collar

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S9999	Continued From page 3 applied and the resident still had complaints of shortness of breath. Nebulizer treatments done with no relief. Normal saline applied to the trach and suctioning done. Nurse removed a thick mucus plug with suctioning and resident no longer had troubles breathing. Vitals were stable, resident reeducated on leaving the inner cannula in place and verbalized understanding. Nurse's Notes dated 10/17/22 documents that at 10:37am the nurse entered the resident's room to give medications and noted that R2 was unresponsive. The nurse noted that the resident did not have a pulse and did not have respirations. R2's trach collar was in place but the tracheal tube and inner cannula had been removed from the stoma and was found in bed under the resident's covers. The nurse reinserted the tracheal tube and inner cannula and initiated CPR. The paramedics were called and R2 was pronounced deceased at 11:16am. The Death Certificate documents that the cause of death was acute respiratory insufficiency and mucus plug of the tracheal tube. On 1/28/23 at 12:30pm V3 (Respiratory Therapist) stated, "The resident was admitted to the facility with a trach that required maintenance after having a thyroid surgery where a partial tumor resection was done. The maintenance included suctioning, breathing treatments, cleaning out the cannula and this was the responsibility of the nursing staff when I'm not here. I work Monday through Friday during the day and I round 1-2 times per shift on all my residents. The resident was receiving humidity through the aerosol trach collar to maintain the airway. The resident was not on a ventilator and only required about 4-5 liters of oxygen. R2 did	S9999		

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have a history of pulling out the trach, she had done this before at another facility. R1 did pull out the inner cannula while here and I went in and educated the resident on the importance of keeping that inner cannula in place. The resident did not give a reason why she pulled out the inner cannula but she did verbalize understanding after education was complete."

On 1/28/23 at 2:35pm V5 (Nurse) stated, "I was coming back to the resident's room to give medications. The CNA was in the room with her so I went to take care of another resident and came back later. When I came back the resident was lying on the bed with her legs hanging out of the bed looking straightforward at the TV. R2 didn't respond to me when I spoke to her and that was abnormal because she talks with the trach. I asked if she was ok, she didn't respond so I assessed her and there was no pulse and she was not breathing. I called a code blue and initiated CPR. R2 had the aerosol collar on but it was loose. The trach was sitting on the opening of the ostomy site. The CNA was in the room with the resident providing care 10 minutes prior to this incident. A couple of days before this happened, R2 was with family and I was called in the room because the resident was having trouble breathing. R2 had the collar covering the neck but she was asking to be suctioned. That's when I noticed the inner cannula was not in, it was on the bedside table. I had trouble getting the inner cannula back in, I called the supervisor and had to use saline to get it in. Education was done on not pulling it out because it causes mucus plugs. The resident said she pulled it out because she didn't need it. I notified the supervisor and the nurse practitioner. I don't recall any new interventions being put into place. I just tried to monitor the resident every hour or

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S9999	Continued From page 5 so." On 1/28/23 at 2:40pm V6 (Nurse Practitioner) stated, "R2 was stable. She had the aerosol trach collar and was not on oxygen. The resident pulled the trach out over the weekend and that call would've gone to the on-call person, but there were no new interventions put into place. R2 was on nebulizers and getting suctioned as needed. R2 was alert and oriented x 3 and able to make her needs known. R2 did pull out the trach at another facility and there was a previous incident of the resident taking out the inner cannula." The care plan was reviewed and documents that R2 has a risk for respiratory impairment related to the presence of a tracheostomy. Staff is to monitor for signs of respiratory distress, suction and provide trach care based on physician's orders and as needed. There was no care plan or updated interventions in place to address the behavior of the resident pulling out the trach tube. (A)	S9999		