STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
IL6014534			B. WING				C 02/15/2023		
	PROVIDER OR SUPPLIER	11860 S	ADDRESS, CITY, S OUTHWEST H HEIGHTS, IL 6	IGHWAY	2 M	1			1, 5
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S 000	Initial Comments		S 000	N	=				ж 55с
8	Complaint investiga	ntion:							
	2391080/IL156191				146			Ω	
S9999	Final Observations		S9999		- P			9.1	
5	Statement of Licens	sure Violations:			10 00 0				
	300.610a) 300.1210b) 300.1210c) 300.1210d)5)			٠,					

facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the

The facility shall have written policies and procedures governing all services provided by the

Section 300.610 Resident Care Policies

medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.

Section 300.1210 General Requirements for **Nursing and Personal Care** 

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

Attachment A Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED		
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	care needs of the re	esident.						
-	and be knowledgea respective resident	19 No. 19	N I		10 20 - 21 30 - 50			
80 9 <sup>28</sup> 27	nursing care shall in	o subsection (a), general include, at a minimum, the be practiced on a 24-hour, basis:	1(4.		13 ° W			
# 15	pressure sores, heat breakdown shall be seven-day-a-week the enters the facility wind develop pressure sor clinical condition de sores were unavoid pressure sores shall services to promote	rogram to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who without pressure sores does not sores unless the individual's emonstrates that the pressure dable. A resident having all receive treatment and the healing, prevent infection, ressure sores from developing.			20			
<.	by:	s were not met as evidenced	2					
	facility failed to cons implement pressure prevent the develop pressure ulcers. Th three (R1) residents prevention. This faile a stage 3 pressure s	s and record review, the sistently monitor, assess, and e relieving interventions to oment of facility acquired his affected one resident of a reviewed for pressure ulcer lure resulted in R1 developing sore to the coccyx area, and a pre to the left buttocks.	20	S. E.	20	E		

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Findings include:

Review of R1's medical record notes R1 was

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С IL6014534 R. WING 02/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11860 SOUTHWEST HIGHWAY **HARMONY PALOS** PALOS HEIGHTS, IL 60463 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 2 S9999 admitted to this facility on 1/25/23 with diagnoses including: severe sepsis with shock related to UTI (urinary tract infection) and pneumonia, malaise, acute respiratory failure with low oxygen levels, chronic obstructive pulmonary disease, heart failure, dementia, and diabetes. R1 was discharged to home on 2/6/23. Review of R1's admission skin assessment. dated 1/25/23, notes no skin breakdown or reddened areas identified. Review of R1's POS (physician order sheet), dated 1/26/23, notes an order for an air mattress for skin integrity. On 2/10/23 at 10:50am, R1's family member stated that on the day of R1's discharge from facility, family member was cleaning R1 and saw wounds on R1's coccyx and buttocks. R1's family member stated when she got R1 home and removed his socks she observed a large blood blister on his right heel. R1's family member stated that facility did not notify her of these wounds. On 2/10/23 at 2:37pm, V4 (unit manager) stated that on 2/6/23 V4 was informed that R1's family member found wounds on R1's sacrum and left buttocks. V4 stated V4 was asked to assess these wounds. On 2/14/23 at 9:50am, V5 (wound care nurse) stated V5 performs a head-to-toe skin assessment on newly admitted residents. V5 stated that V5 informed staff that R1 required an air mattress because R1 did not move much. V5 stated R1 did not receive air mattress during his stay. V5 denied being made aware of any skin.

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breakdown on R1's coccyx and left buttock. V5

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С IL6014534 02/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11860 SOUTHWEST HIGHWAY HARMONY PALOS PALOS HEIGHTS, IL 60463 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 S9999 Continued From page 3 stated R1 had a scabbed area on right heel that V5 observed on 1/26/23. V5 stated she applied a foam dressing to R1's heel and changed every three days. V5 stated when residents are discharged home with wounds, the discharge instructions will note orders for wound care treatments. On 2/14/23 at 12:00pm, V10 (nurse) stated V10 provided care to R1 on 2/6/23. V10 stated R1's family member provided most of the care for R1 during his stay. V10 stated sometimes family would ask for staff assistance. V10 stated on 2/6, R1's family member asked V10 for assistance with turning R1. V10 stated family member was standing facing R1's back when he turned and observed wounds on coccyx and left buttocks. V10 stated there was some drainage observed from the wounds. V10 stated V10 informed V9 (unit manager) of R1's wounds. V10 denied contacting R1's physician for treatment orders. V10 stated R1's family member informed V10 that V10 was previously a wound care nurse and requested a calcium alginate dressing for R1's wounds. V10 stated V10 cleaned R1's wounds and applied calcium alginate dressing per family's request. V10 stated V10 also gave R1 some extra dressings for home use. Review of R1's medical record, dated 2/6/23, V10 RN noted new opening noted at coccyx 0.5cm (centimeters) width x 1.5cm length x 0.2cm depth. Review of R1's medical record, dated 2/6/23, V4 (unit manager) noted V4 was asked to assess the new wounds on R1. R1 has a stage 3 pressure ulcer on the coccyx area and a stage 2 pressure

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ulcer on the left buttocks.

PRINTED: 03/08/2023 FORM APPROVED

AND PLANOF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE	(X3) DATE SURVEY COMPLETED		
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j*	Review of R1's care risk for alteration in impaired mobility.	plan, dated 1/26/23, R skin integrity related to	t1 is at						
	revised 7/28/22, not document in the nur report form any skin assessment and ide	ntification. Furthermor	ound e.			ai m			
25 1	resident's physician.	nt must be obtained fro	m the	En l		1 23			
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