STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145324	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Park Ridge	1001 North Greenwood Avenue Park Ridge, IL 60068

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow physician order in using oxygen for resident who has respiratory disorder. This deficiency affects two (R2 and R3) of three residents reviewed for Respiratory/oxygen management.Findings include:1. On 12/26/25 at 10:34AM, Observed R2 sitting in wheelchair in his room with nasal cannula oxygen tubing in his mouth. R2 said he got tired of putting oxygen in his nose, so he put it in his mouth. R2 added that he still received the same oxygen. R2 is alert, oriented and response appropriately. R2 can verbalize his needs to staff. R2 had a long oxygen tubing from the oxygen concentrator at 3LPM (liters per minute) with no label or date of changed. R2 said they seldom changed his oxygen tubing. His oxygen concentrator was set at 3LPM, while his oxygen tank at the back of his wheelchair was set at 5LPM. V3 Nursing supervisor said R2's oxygen tank is almost empty but still okay. V3 added r2 usually asked the staff if his oxygen tank needs to be changed. R2 uses his portable oxygen tank when he goes out of his room. R2 said his full tank of oxygen runs for 2 and 1/2 hours or less. R2 said it takes a while for them to change his portable tank. Observed nebulizer mask exposed on top of bedside drawer connected to portable nebulizer machine placed on the floor. V6 said nebulizer machine should not be place on the floor and nebulizer mask should be in plastic bag after each use for infection control.R2 is admitted on [DATE] with diagnosis listed in part but not limited to Chronic obstructive pulmonary disease (COPD) with exacerbation. Acute respiratory failure unspecified whether with hypoxia or hypercapnia, Chronic respiratory failure with hypoxia, Dependence on supplemental oxygen, Personal history of other malignant neoplasm of bronchus and lung, bipolar disorder. Active physician order sheet indicated: Oxygen 3-5 LPM via nasal cannula to maintain oxygen saturation level equal or above 92%, may titrate if needed. Comprehensive care plan indicated he has altered respiratory status/difficulty breathing related to COPD, respiratory failure, shortness of breath with exertion and at rest. Interventions: Ensure oxygen levels for portable oxygen tank has adequate supply. Give oxygen as ordered by the physician. R2's MAR (Medication Administration Record) did not reflect oxygen administration as ordered.On 12/26/25 at 1:00PM, Reviewed R2's medical records with V2 DON. Informed DON that oxygen order was not reflected accurately in MAR or TAR (Treatment administration record). There is no documentation of R2's amount of oxygen received to maintained 92% oxygen saturation. V2 said oxygen ordered by the physician should reflect accurately in MAR or TAR (Treatment Administration Record) as indicated in their policy. V2 presented R2's record of oxygen saturation daily monitoring without indication of amount of oxygen usage. V2 said they change oxygen tubing weekly and as needed. V2 said nebulizer machine should not be place on the floor and nebulizer mask should be in plastic bag after each use for infection control.2. On 12/26/25 at 1:57PM, Rounds made with V6 RN. Observed R3 up in wheelchair in her room with oxygen via nasal cannula (NC) at 1LPM with oxygen label dated 12/7/25. Nebulizer masks were exposed on top of the bedside drawer. V6 RN said R3 supposed to be on 2LPM and usually night shift changes the oxygen tubing every 72 hours.R3 was re-admitted on [DATE] with diagnosis listed in part but not limited to Chronic respiratory failure with hypoxia, Emphysema, Fracture right pubis, General anxiety disorder. Active physician order sheet indicated: Apply oxygen at 2-3 LPM via NC to keep oxygen saturation greater than or equal to 90% as needed (PRN) related to chronic respiratory failure with hypoxia. Change oxygen tubing/bubblers weekly and PRN. Check and record oxygen saturation every shift related to chronic respiratory failure with hypoxia. Comprehensive care plan indicated: She is at risk for alteration in respiratory functioning related to chronic respiratory failure with hypoxia, emphysema. Intervention: Administer oxygen and other medication and respiratory treatments as ordered. R3's MAR for December 2025 indicated apply oxygen at 2-3 LPM via NC to keep O2 saturation greater than or equal to 90% as needed. No documentation of oxygen was given on 12/26/25 during survey investigation.On 12/26/25 at 2:00PM, Reviewed R3's medical records with V6 RN. Informed V6 that R3's oxygen ordered is 2-3 LPM but she is only receiving 1 LPM. The tubing was changed last 12/7/25 instead of weekly as ordered. V6 said they should be following physician order.On 12/26/25 at 3:30PM, Informed V1 Administrator and V2 DON of above concerns.Facility's policy on Oxygen Therapy and Administration revised 7/2/25 indicated: Oxygen therapy shall be administered to patients as indicated upon a physician's order. Purpose: To assure adequate oxygenation to all spontaneously breathing and ventilator dependent patients. Procedure: Confirm order from physicianNote: c. Oxygen setups should be changed every seven days and as needed if heavy soiling is present.Facility's policy on Physician orders revised 7/3/25 indicated: