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	04/23/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure necessary services and treatment were provided to prevent the development and/or worsening of pressure injuries for one (R2) of three residents reviewed for pressure ulcers. This failure resulted in R2 developing a Stage 3 pressure ulcer to the left buttock and a Stage 4 pressure ulcer to the right buttock while residing in the facility.Findings:R2 was a [AGE] year-old resident. admission nursing note dated 02/05/2025 documented incontinence and slight redness to the sacral area. A skin assessment completed the same date indicated pressure ulcers to the right and left buttocks.On 04/20/2025 at 1:45 PM, V4 (R2's family member) stated R2 had two black holes on their buttocks while they lived in this facility. V4 stated R2 did not come to this facility with wounds but got them while they lived in the facility. V4 stated they visited daily and R2 was typically saturated in urine and sometimes feces. V4 stated the incontinence briefs being used on R2 were too large and leaked urine on the bed, therefore, R2 usually lay in wet briefs and sheets when they arrived at the facility; V4 began providing incontinence briefs from home at this time to try to assist the situation. V4 stated V16 (Registered Nurse) and V4 (Certified Nursing Assistant) told them R2 had two large wounds on their buttocks. V4 stated that shortly after this time, R2 was sent to the hospital and did not have them return to this facility; V4 stated R2 was admitted to an alternative facility following their stay at the hospital. Review of R2's clinical record lacked documentation of daily interventions to address ongoing incontinence or prevent prolonged exposure to moisture.On 04/20/2026 at 4:30 PM, record review revealed an admission nursing note dated 02/05/2025 at 9:56 PM, states in part but not limited to incontinent of urine, sacral slight redness noted.ETAR (electronic treatment administration record) dated February 2025 has an order dated 02/05/2025 for Remedy Z-Guard to sacral, buttocks, and peri area, as needed, and weekly skin assessment (fill out the skin inspection in wound assessment manager).Skin assessment dated [DATE], created by V16 (RN), includes (visual body map and Braden Risk Assessment Report, indicates a skin tear present on right shin and two pressure ulcers present (right and left buttock). Braden Risk Assessment Score (assessment for risk for skin impairment) was 14, moderate risk.Skin assessment dated [DATE], created by V16 (RN), includes a skin assessment (visual body map and Braden Risk Assessment Report), which indicates a skin tear present on the right shin and two pressure ulcers present (right and left buttock). Braden score was an 18 with a risk level of mild. No additional documentation on wound care or consulting with wound care team found for this date.R2's MDS (minimum data set), Section M, dated 02/11/2025, does not indicate sacral/buttock area redness.Review of R2's initial care plan dated 02/14/2025 includes: R2 is at risk for impaired skin integrity/skin breakdown, referencing the Braden Scale score of 14 (slight redness on sacrum). Interventions include (but not limited to): Daily skin inspection, report any changes in skin or signs of possible skin breakdown or redness, turn and reposition frequently as tolerated and as patient allows, use absorbent pads or incontinent products that wick and hold moisture, use moisture barrier per protocol.The clinical record did not reflect completion of the daily skin inspections identified in the care plan. Facility staff were asked for any documentation pertaining to daily skin assessments and they were unable to provide any requested documentation.Physician order dated 02/17/2025 written (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	by V17 (Medical Doctor/Facility Medical Director) was placed in the ETAR (electronic treatment administration record) to reposition R2 every 2 hours, for sacral wound cleanse with normal saline pat dry, then apply Medi honey over with foam dressing daily.Nursing note created by V14 (Registered Nurse), entered on 02/20/2025 at 3:32 AM includes: wound care to the back scheduled with Medi honey and dry dressing.Nursing note created by V15 (Licensed Practical Nurse) 02/20/2025 at 2:24 PM states in part but not limited to pressure ulcer//right buttock//wound to right buttocks, treatment put in place, calcium alginate with honey, cover with dry dressing daily.Facility wound care documents dated 2/20/25 include Stage 3 wound is present on the left buttock that measures 3.0 cm x 3.0 cm and a Stage 3 wound is present on the right buttock that measures 3.0 cm x 2.0 cm.Care plan created date 02/21/2025 for impaired skin integrity includes: AEB pressure ulcer, at risk for further skin breakdown. Skin tear on right lateral shin, Stage 4 right buttock, Stage 3 left buttock. Interventions in care plan include but are not limited to: Refer to POS/ETAR for any modification or treatment plan and care, low air loss mattress, assess and document wound with measurements, notify physician if no progress per PUSH (pressure ulcer scale for healing) tool after two weeks, pressure ulcer dressing per protocol, turn and reposition resident frequently as tolerated and as patient allows.Physician's order was placed in the ETAR dated 02/22/2025 for sacral wound, cleanse with normal saline, pat dry, then apply Medi honey and cover with foam dressing daily and for right buttocks, to cleanse with normal saline, pat dry, then apply Medi honey, then calcium alginate, cover with dry dressing daily.On 02/24/2025, identical orders from 02/22/2025 for the sacrum, were ordered for the right buttock and left buttock.Review of the ETAR showed on 02/26/2025, an order for a low air loss mattress was placed, an order for right buttock to cleanse with wound cleanser, pat dry, apply Santyl (ointment that assists in removing dead cells from wounds), hydro fiber (woven fibers that transform into a gel upon contact with wound exudate) and cover with dry dressing daily, an order was placed for the left buttock to cleanse with wound cleanser, pat dry, apply Santyl, hydro fiber and cover with dry dressing daily.Record review indicated that on 02/26/2025, the facility contracted wound care company performed an initial wound evaluation and management summary for R2. The evaluation lists a Stage 4 wound to the right buttock with measurements of 7.9 cm x 4.5 cm x 0.3 cm and a Stage 3 wound to the left buttock with measurements of 6.7 cm x 8.6 cm x 0.3 cm.On 04/21/2026 at 12:21 PM, this surveyor interviewed V18 (Certified Nursing Assistant). V18 stated the expectation is for CNAs to look at the skin of residents while performing peri care, bathing/showering and to update nursing if any changes are noted. V18 stated they would have filled out a paper with findings from bathing/showering or peri care and placed it in a tray for the nurses to assess. V18 stated they told V16 (Registered Nurse), directly, of any changes to residents' skin, etc. V18 stated showers are given twice weekly to residents.On 04/21/2026 at 2:30 PM, this surveyor interviewed V2 (Director of Nursing). V2 stated it is the facility protocol, unwritten, for all new admissions to be seen by the in-house wound care team within 24-48 hours of admission, regardless of skin condition at time of admission. V2 also stated all new admission residents are assessed by their admitting nursing team, upon admission and documentation is to be created.On 04/22/2026 at 9:05 AM, this surveyor spoke to V21 (Wound Care Physician). V21 confirmed being the rounding wound care physician during the period when R2 resided in the facility. V21 stated their protocol for wound care rounding is to see their residents weekly. V21 stated when a new resident is added to their service, they will see them within the same week to assess, establish a baseline, and possibly begin treatment; V21 stated it is their priority, within their role, to see residents on a weekly basis and to see new residents within the week of being added to service. The clinical record indicated the initial wound care evaluation occurred on 02/26/2025.Facility Policy labeled Skin Care Regimen and Treatment Formulary, dated 07/03/2025 states in part but not limited to:2. Routine daily wound care treatment/dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician.a. Pressure Injuries/Vascular Wounds (Stasis/Arterial/Diabetic)b. Surgical Woundsc. Other Skin Conditions5. Refer any skin breakdown to the skin care team and physician (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	including wound physician/NP for further review and management as indicated.6. Residents who cannot turn and reposition themselves will be turned and repositioned at least every two hours unless otherwise specified by the physician.8. Residents with Stage III and IV pressure injuries will be placed in specialized air mattresses like low air loss mattresses with an incontinence brief if they are incontinent only; incontinence pad which will also act as repositioning aid, and a flat/fitted sheet which are all necessary to prevent infection control issues.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision and implement appropriate interventions for one (R1) of three sampled residents reviewed for accidents and supervision who had severe cognitive impairment and was assessed as high risk for elopement. This failure resulted in R1 being sent to an outside medical appointment without an escort, leaving the medical building unsupervised, and being found confused and wandering in the street. Findings include:R1 is a [AGE] year-old, male, originally admitted in the facility on 11/11/25 with the following diagnoses: Encephalopathy, Unspecified; and Dementia in other Diseases Classified Elsewhere Moderate, with Agitation.MDS (Minimum Data Set) dated 02/10/26 documented R1's BIMS (Brief Interview for Mental Status) score of 5, which means severe cognitive impairment. MDS indicated R1 has no impairments on the upper and lower extremities. R1 is ambulatory with no assistive devices.On 04/20/26 at 10:43 AM, R1 was observed walking in the unit, alert, oriented with confusion. R1 went to his room, was asked regarding recent doctor's appointment outside facility. R1 stated, It was a tattoo appointment. I did the tattoo appointment, see, look, come here, you see that house, you go inside, that's where the appointment was. It was not raining. I did it alone. R1 went to the window while pointing to a house across the street. R1 was asked again regarding medical appointments. R1 verbalized, I never went out for an appointment.On 04/20/26 at 2:30 PM, R1 was observed standing by the nurses' station on the first floor in the facility. He was roaming around the unit and when about to go near the reception area, the alarm went off. R1 was redirected.On 04/21/26 at 9:40 AM, R1 was observed sitting on the couch on the first floor.R1 is a resident on the third floor in the facility.POS (Physician Order Sheet) dated 02/19/26 recorded R1 has a dermatology appointment on March 31, 2026 at 8:30 AM in the city.Incident Report dated 03/31/26 recorded: On 03/31/26, at approximately 10:30 AM, Transportation Coordinator (V3) received a phone call from the dermatology office that transportation company came to pick up R1 and they were unable to locate him (R1) in the lobby. V1 (Administrator) was notified and advised staff to inform family and law enforcement. V1 located R1 outside of the clinic by private transportation. R1 stated he wanted to go see his mother and old house. R1 was immediately assessed with no injuries.On 04/20/26 at 12:39 PM, V3 was asked regarding R1's medical appointment. V3 replied, Last 03/31/26, he went out for an appointment. On that day, when I called the transportation to make sure he was picked up, they said that he went out, and he could not be found. I called the doctor's office and asked about what happened, was told he was there and seen. The office said he was in the waiting area. I called transportation again but said he was not there. I called the medical office again and called police. (V1) was notified and came looking for him, and she (V1) found him. He went to an appointment alone; no staff went with him. That was the second time he had been to an appointment by himself. He was familiar with the office clinic and the environment. I do send an escort with residents if they need one. For him (R1), the nurses said he was okay to go alone. On 04/20/26 at 1:22 PM, V1 was interviewed regarding R1's incident on 03/31/26. V1 stated, Last 03/31/26, I was actually off and got a call late morning reporting that he (R1) left for his appointment. At that point, I directed staff that family be notified and police and was reassured that they were notified. From there, two employees from facility and myself from my house drove separately to appointment location to get more information and support. What was the situation? Because he (R1) was waiting at the lobby for transportation and had left. Luckily, I was able to locate him (R1) safely. I saw him within the proximity of the clinic office. He was walking, ambulatory, pleasant, said he was going to see his mom's house and checked his old house which was within the neighborhood. It was drizzling, he was not wet or cold. I pulled over, parked and he had a big smile and told him to go back to the clinic building. He said he was fine. He got into my vehicle. I brought him back to the clinic building, at that point police were notified and updated. He was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	transported back into the facility. Not that I am aware that he had an escort. I was told that he always go there for an appointment without escort arrangement and he is familiar with the clinic. After evaluating the situation, we discussed that he would require an escort moving forward. There were no injuries, he is oriented, in good spirits. V1 further stated, I found him walking on the street around 11:30 AM. The appointment was in the city, and he was walking in a residential side street stating he was going to his old home address.Per R1's face sheet, his previous address was two miles from the appointment clinic, but he needs to cross busy streets and intersections. Progress notes dated 03/31/26 documented R1 came back around 12:45 PM, alert and a little confused, skin, intact, ate lunch and he was good.On 04/20/26 at 2:13 PM, V9 (Registered Nurse, RN) was asked regarding R1. V9 verbalized, He is alert, oriented to self; confused a lot of times. He knows people but not to where he is. He is ambulatory, he wanders from floor to floor. On 03/31/26, he came late from his doctor's appointment. I came to work at 7 AM and night nurse endorsed to me that ambulance to pick him up at 7:30 AM for his appointment. He was already dressed up and ready to go. I handed him the envelope and ambulance crew took him. My shift ended around 3:40 PM. He came back late around 1:40 PM, almost 2:00 PM. I was told that the driver was looking for him at the clinic and he was not there and was later found. When he came back, he was alert but mostly confused. He was not sweating. I asked him to remove his clothes so I could assess him, there was nothing. I dressed him up and gave him foods to eat. V9 was asked if R1 is an elopement risk. V9 replied, I was not aware that he was an elopement risk at the time. There was no endorsement.R1's elopement risk evaluation dated 11/12/25 documented in part but not limited to the following:Score 9, which means high risk for elopement6. The resident roams or wanders throughout the facility and does not respond favorably to staff redirection - yes7. Resident attempts to leave the facility unsupervised and does not respond favorably to staff redirection - yes8. The resident is confused to time and place and has the physical ability to leave the building - yesCheck all interventions that apply:a. personal safety alarm deviceb. exit and stairwell alarmsd. frequent monitoringf. identification braceletso. photo on potential elopement listp. staff aware of residents on wander/elopement riskV10 (Director of Social Services) was interviewed on 04/20/26 at 2:34 PM regarding R1 and elopement risk. V10 stated, He is alert, oriented, familiar with staff, familiar with room, with a bit of confusion, ambulatory. I don't believe he was an elopement risk at the time. He can be redirected and had no history of elopement while in the facility. V10 was asked if R1 needs supervision during medical appointments. V10 stated, I don't think he required an escort at the time because he was responsive, pleasant, very agreeable. He is redirected, can follow directions. He was admitted with dementia. In his case, he did not need an escort at that appointment.On 04/21/26 at 12:24 PM, V18 (Certified Nurse Assistant, CNA) mentioned during interview that R1 is pretty much independent, alert, forgetful, roams around the unit and wears a device which triggers alarms to prevent elopement. He maybe is considered elopement risk. He always sits in the sofa by the nurses' station, walks around the first floor.On 04/21/26 at 1:41 PM, V2 (Director of Nursing) was asked regarding R1 and supervision when out for medical appointments. V2 replied, He is alert with confusion, he converse with staff, with residents, moves around; walks around. There was no episode that he attempted to elope while in the facility. He was assessed upon admission as high risk; staff should have awareness for elopement risk and residents should be monitored. At the time of the appointment, he (R1) was alert with confusion, with awareness of the clinic and appointment, he does not need an escort for medical appointments. R1's care plans documented the following:Date initiated 11/12/25, canceled date 04/14/26:1. I have impaired cognitive function/dementia or impaired thought processes related to or as evidenced by: diagnosis: major neurocognitive disorder; dementia with agitation, adjustment disorder with disturbance of mood/anxietyInterventions:Cue, reorient and supervise me as needed.2. I demonstrate(s) movement behavior that may be interpreted as wandering, pacing or roaming, on wander guard to left leg.Interventions:Staff to provide my photo for potential for elopement list; staff to educate other staff, to be aware of my wander/elopement risk.Date initiated 11/11/25, canceled date 04/14/26:I am (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	at risk for altered thought process Dementia, Disease process with diagnosis of Encephalopathy, UTI (urinary tract infections), altered mental statusInterventions:Offer cues, direction and redirection as needed.Incident report dated 03/29/26 recorded that R1 was involved in an incident of pulling another resident's shirt to get off the chair because he (R1) believes he (R1) works at the facility in that post area. The incident showed R1 is confused and requires staff monitoring.Care plan dated 03/29/26, canceled dated 04/14/26 documented: R1 believes he works at the facility as he stations at the front door greeting others - Interventions: Staff to monitor.On 04/21/26 at 1:25 PM, V17 (Medical Director) was asked regarding R1. V17 verbalized, I am the primary physician of this resident (R1). He is confused, he has Dementia, as far as I know. I was notified that he went out for an appointment and got lost. If he was assessed as high risk for elopement risk, and was documented as elopement risk, it would be preferrable that he needs to be escorted during medical appointments. Facility's policy titled, Appointment and Transportation Policy dated 6/26/25 stated in part but not limited to the following:Policy: When a resident requires an appointment outside the facility, the appointment will be scheduled in a timely manner as outlined below.Procedure: 4. Depending on the resident's medical, physical and cognitive needs and condition, the resident may require an escort while out of the facility for an appointment. If the resident has no representative, family member, friend, etc to escort him/her during the appointment, the facility will provide one. Facility's policy titled, Elopement dated 6/30/25 documented in part but not limited to the following:Policy Statement:It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual plan of care.