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	12/12/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure that residents were served meals at a safe, appetizing temperature by not checking the food temperature before serving. This applies to all 121 residents consuming food through the dietary service.The Findings include:On 12/09/2025 at 11:05 AM, during kitchen tray line observation, observed V20 (Dietary Aide) and V13 (Dietary Cook) started serving lunch from the kitchen steam table without checking the food temperature.On 12/09/25 at 11:20 AM, V13 stated, The old management never did that, and that's why I didn't check the food temp.12/09/25 at 11:25 AM, V14 (Dietary Manager) stated, I thought my cook (V13) checked the food temperature. We are supposed to check the food temperature before starting to serve.12/10/2025 11:00 AM V14 added, We took over this place in October. We don't have any documentation available to prove that we were checking the food temps.The facility presented the Policy and Procedure Manual, chapter 3, page 35, document: Record food temperature prior to service and again after half of the meal has been served.On 12/11/2025 at 9:07 AM, V2 (Director of Nursing) stated that 121 residents are consuming food from the dietary service.

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to follow their Medication Storage, Labeling, and Disposal Policy. The facility failed to ensure medications will be stored in locked storage area. This failure has the capacity to affect 19 residents (reviewed for medications) in a total sample of 29. On 12/09/2025 at 12:08 PM, during rounds on the unit, observed medication cart in unit A, first floor, to be unlocked, third drawer opened halfway, with no authorized staff in the hallway. The medication cart was facing in the opposite direction that V7 (Registered Nurse/RN) was in.On 12/09/2025 at 12:12 PM, V7 (Registered Nurse) walked out of a resident's room, noticed the cart was left unlocked and third drawer open, proceeded to turn the cart the opposite direction. V7 (RN) stated the medication cart should have been fully closed and locked, for safety. On12/10/2025 at 10:23 AM, V8 (Assistant Director of Nursing/ADON) stated it is important for nurses to make sure the medication carts are closed and locked when a nurse walks away from the medication cart to ensure the medications are secured.On 12/11/2025 at 1:36 PM V2 (Director of Nursing) stated the medication cart is considered a storage area and medications should always be locked in the medication cart when nursing staff are away from the cart.Facilities Medication Storage, Labeling, and Disposal with a revision date of 7/2/2025 documents: The facilities policy to comply with federal regulations and storage labeling and disposal of medications will be secured in lock storage area.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to follow their Call Light Policy. The facility failed to ensure call lights are placed within reach of residents who are able to use it at all times. This deficient practice affects 2 residents (R68 and R52) of 4 residents reviewed for accommodation of needs in a total sample of 29 residents.On 12/09/2025 at 8:13AM Observed R68 and R52 in the same room, each asleep in their assigned beds. The privacy curtain was fully extended out in between R68 and R52. Observed R68's call light attached and clipped high, in the middle of the curtain that was extended all the way to R68's foot bed frame, not within reach of R68. R52's call light was observed under R52's bed, on the floor close to the foot of the bed, not visible to R52. Both R68 and R52's call light string was attached and connected to the call light system. R68s Minimum Data Set (MDS) has a Brief Interview for Mental Status (BIMS) of 15/15, Cognitive intact.R52s Minimum Data Set (MDS) has a Brief Interview for Mental Status (BIMS) of 10/15, cognitive moderately impaired.On 12/09/2025 at 8:41AM, state agency and V9 (Registered Nurse/RN) observed R68 and R52 asleep in their beds, observed R68's call light attached/ clipped high, in the middle of the curtain that was extended all the way to R68's foot bed frame, not within reach of R68. Also observed R52's call light was observed under R52's bed, on the floor close to the foot of the bed, not visible to R52.V9 (RN) stated the call light should have been clipped, placed with the reach of R68 and R52.On 12/10/2025 at 10:23 AM V8 (Assistant Director of Nursing) stated the call light should have been placed within reach of both residents.Facilities Call Light Policy with a revision date of 6/30/25 documents procedures: Be sure call lights are placed within reach of residents who are able to use it at all times.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure specialty mattress devices were on the correct weight setting for residents who are high risk in developing pressure injuries. This failure has the potential to affect two resident (R27 and R69)) out of three residents reviewed for pressure injury prevention and treatment in a final sample of 29 residents.Findings Include:R69:On 12/9/25 at 8:00AM, observed R69 in bed, asleep using specialized mattress. Low Air loss mattress is set to 4 (250 lbs.)On 12/9/25 ay 8:07AM, confirmed with V3 (Registered Nurse) R69's Low Air loss mattress is set to 4 (250 lbs.). V3 stated the Low Air loss mattress has a sticker on it to let V3 know which number setting the resident needs. V3 stated that the supervisor is the one that updates the sticker. The mattress setting should be within the resident weights.R69 is [AGE] year-old female with diagnosis of but not limited to type 2 diabetes, vascular dementia, osteoarthritis, peripheral vascular disease, hemiplegia and hemiparesis affecting left dominant side.R69's Braden Scale and Clinical Evaluation Form dated 11/24/25, R69 scored 9 (High Risk).R69's Physician Order Sheet reviewed with order for low air loss mattress with start date of 7/20/25. R69's weight is 148.1 lbs., dated 12/8/25.R69's care plan reviewed and dated 7/3/25, reads in part: R69 at risk for further pressure ulcer development and or potential skin breakdown related to frail asking associated with aging process, R69 require substantial to max assistance with most of ADL task. R69 have multiple chronic co-morbidities and on multiple meds to include usage of antiplatelet. R69 is incontinent with both bowel and bladder, diagnosis of Peripheral Vascular Disease.R27:On 12/09/25 at 8:40AM, observed R27 in bed, asleep using specialized mattress. Low Air loss mattress is set to 9 (400 lbs.)On 12/9/25 at 8:45AM, confirmed with V4 (Registered Nurse) that the low air loss mattress is set to 9 (500 lbs.) Confirmed with V4 R27's weight and stated it is 136.1 lbs. V4 stated the low air loss mattress should be set to resident's weight.R27 is [AGE] year-old male resident with diagnosis but not limited to metabolic encephalopathy and hemiplegia and hemiparesis affecting the right side.R27's Braden Scale and Clinical Evaluation Form dated 11/30/25, R27 scored 12 (High Risk).R27's Physician order sheet reviewed with order for low air loss mattress with start date of 10/10/25.R27's weight is 136.1 lbs., dated 12/8/25.R27's care plan reviewed with created date of 12/11/25, reads in part: R27 have alteration in skin integrity and potential for pressure ulcer and or skin breakdown development related to Disease process, Immobility, clinical complexities, presence of g-tube. Intervention: Check air mattress if functioning properly every shift and prn.On 12/11/25 at 11AM, V19 (Wound Treatment Nurse) stated R69 is currently does not have any active pressure ulcer injury. Only has wound on right toe and it is an arterial wound. R69 is assessed to be high risk for Pressure ulcer injury due to history of pressure injury. V19 also stated R27 is currently does not have any active pressure ulcer wound. R27 is assessed to be high risk for pressure ulcer injury. R27 has a history of sacral wound pressure ulcer injury.V19 also stated that both R27 and R69 are using low air loss mattress as a preventative measure. The low airless mattress should be set on based on resident's weight. Nurses can change the setting at any time and to make sure that they check the resident's weight to know the right setting for the mattress.Policies Reviewed:Skin Care Regimen and Treatment Formulary Policy with a revised date of 7/23/25, reads in part: It is the Policy of the facility to ensure prompt identification, documentation and obtained appropriate treatment for residents with skin breakdown. Prevention use of pressure redistribution mattress.Braden scale policy with revised date of 6/30/25, reads in part: It is the policy of this facility to complete the Braden risk assessment for all its residents for the following objective: To be able to assess the resident's potential or risk factor to develop pressure ulcers.To be able to identify each risk factors unique to the resident that can potentially cause for the development of pressure ulcer and properly address them in the resident's care plan interventions. Licensed nurse shall complete the Braden scale assessment on admission, after admission, readmission, quarterly, annually and with significant (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change in condition MDS. Interpret and calculate score to determine risk potential either low risk or high risk.Each risk factor and potential caused should be reviewed individually and addressed in the residence care plan. Implement intervention per the residents Braden Scale and/or individual risk factors identified as reflected in the care plan. If the resident was assessed as low risk using the Braden scale but the facility feels that the resident is at high risk, the facility may put in place intervention to prevent development of pressure ulcers, put them in the care plan, and indicate that the resident is high risk for pressure sore development.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to follow MD order for daily weights for a dialysis resident. This failure has the capacity to affect 1 of 1 resident (R111) reviewed for dialysis in a total sample of 29.Findings include: R111's December Vital Signs Flowsheet (weights) documents missing weights on December 10th, 7th, 5th, and 3rd. Flowsheet documents missing weights on November 28th, 26th, 25th, 24th, 21st, 20th, 19th, 18th, 17th, 16th, and 15th. On 12-11-25 at 9:43 AM, V7 (Registered Nurse) said the daily weights are taken to observe for fluid overload especially for dialysis residents. V7 verified missing daily weights on the flow sheet.On 12-11-25 at 9:52 AM, V2 (Director of Nursing) said daily weights for dialysis resident monitors for fluid overload status. V2 said R111 has daily weight order and weights should be done every morning. V2 verified R111's flow sheet documents missing daily weights. On 12-11-25 at 12:23 PM, V18 (Nurse Practitioner) said daily weight is monitored to determine the fluid balance. V18 said if there is a significant weight gain this will determine how much fluid may be removed. V18 verified Physician Order Summary for daily weights. V18 said the facility is expected to obtain daily weight per MD order. Physician Order Summary documents: Monitor daily weight before breakfast. Notify MD of a 2 lb. weight gain in one day or a 5 lb. weight gain in one week.Dialysis Care Plan reviewed and documents: Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow their Hand Hygiene Policy. The facility failed to perform hand hygiene after direct resident contact. This deficient practice affects one resident (R 127) of three residents reviewed for hand hygiene in a total sample of 29 residents.On 12/09/2025 at 7:23am observed V12 (housekeeper) walking in the hall, second floor towards unit B wearing gloves pushing the janitor cart. V12 proceeded to open the door to unit Bs shower room, with gloves on, change out the garbage and place a new garbage bag, adjust the shower curtain, leave the shower room wearing the same gloves and proceed to walk pushing the janitor cart walking to wing A. On 12/09/2025 at 8:55AM observed V21 (Activity Aide) not wearing gloves to reposition R127 and not performing hand hygiene afterwards when walking out of R127s room. V21 confirmed she was just assisting to reposition R127 and did not have gloves on and did not perform hand hygiene afterwards. On 12/10/2025 V8 (Assistant Director of Nursing) stated hand hygiene should be completed after direct care resident contact and after cleaning a room. V8 stated hand hygiene is important to prevent the spread of infection and control infection. Facilities Hand Hygiene Policy with a revised date of 6/30/2025 documents: procedures: Hygiene using alcohol-based hand rub is recommended during the following situations before and after direct resident contact.