STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145893	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Palos	11860 Southwest Highway Palos Heights, IL 60463

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 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** 40066 Based on interviews and records reviewed the facility failed to develop interventions to safely turn and reposition a resident (R1) who expressed a fear of rolling out bed during repositioning. This failure affected one of three R1 resident reviewed for safety during care. This failure resulted in R1 sustaining an acute clavicle shaft fracture. The findings include: R1's diagnosis include, but are not limited to Vertebra Fracture, Cognitive Communication Deficit, Unspecified Symptoms and Signs Involving the Nervous System, History of Falling, Dementia, Depression, Anxiety, and Osteoarthritis. Incident report provided to IDPH states on 8/20/24 R1 complained of pain to the right shoulder. X-rays were obtained with findings of acute appearing clavicle fracture. On 9/24/24 at 12:07PM V1, Licensed practical Nurse (LPN), said, The Hospice nurse notified me that [R1's] shoulder looked weird, it was swollen on that side and reddened. The doctor ordered the x-ray. [R1] said it just started hurting when someone was changing her. Hospice staff said it looked off and that prompted her to ask [R1] about it. On 9/24/24 at 12:01PM V4, Doctor, said R1 reported a pain in her shoulder. V4 said R1 said when they turned her in the past 24 hours, she felt a pain in her shoulder. V4 said R1 presented with her shoulder depressed. V4 said, I wanted an X-ray and it showed she had a fracture. When I last saw [R1], she had no complaints. She was pretty deconditioned and had fragile bones. On 9/24/24 at 12:48PM V2, Restorative Certified Nursing Assistant (CNA), said R1 was on a turning and repositioning program. V2 said R1 never said her arm hurt. V2 said for the turning program R1 can turn but needed assistance of 2 persons while turning. V2 said R1 could turn towards the right well but needed assistance turning to the left. V2 said the CNAs check the Kardex for care instructions for the residents. [The surveyor did not find documentation of this program.] On 9/24/24 at 2:04PM V5, Assistant Director of Nursing, said, I spoke to [R1] regarding the results of the X-ray. [R1] said when she was turned, she felt a pop of pain instantly. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 9/24/24 at 2:07PM V7, CNA, said R1 was incontinent. V7 said before R1 had the sling (8/20/24), when R1 turned one way it would hurt. V7 said to her left she could go all the way. V7 said when R1 turned to the right it was hard and R1 was about to cry. V7 said it was something new for her. V7 said, I would get help to turn her. I don't remember if the nurses knew about it. I was assigned to R1 many times. On 9/24/24 V8, CNA, said she took care of R1 on evening shift. V8 said R1 was in bed and was incontinent and needed to be changed by staff. V8 said before the sling, R1 was good to turn on her side. V8 said R1 was scared to turn because she feared falling out of bed. V8 said R1 had no grab bar or rail on the bed. V8 said she repositioned R1 by herself, she was a '1 person'. On 9/24/24 at 3:07PM V10, MDS Nurse, said, We complete the assessments on the residents to coordinate their care. Restorative assessments are done upon admission, readmission, and with an open MDS, Quarterly, Annually and Significant Change. Activity of Daily Living are part of the Restorative Assessments. The purpose of the assessment is to provide the safest transfer, movement, turning, repositioning, showering, standing, and walking activity. To make sure staff knows how to assist properly. The staff will know the level of assistance needed when they see it under tasks in the computer. When completed, the assessment feeds into the tasks section for the CNA to see the care required. [R1] was partial moderate/extensive assist of 1 staff. If the resident complains of pain or is not able to move, we can provide more assistance. V10 reviewed R1's tasks section with the surveyor. The surveyor asked V10 what level of assistance R1 needed for bed mobility and/or turning and repositioning. V10 responded, It is not in here. On 9/25/24 at 9:31AM V12, CNA, said, I didn't take care of [R1] much, I think just that one time. I check the computer to see how much assistance the person needs with cares. [V12 was assigned R1 on 8/19/24 11:00PM-7:00AM shift. On 9/25/24 at 11:05AM V13, Restorative Nurse, said, I help out once or twice a week at the facility. I did not work yesterday (9/24/24). I do at times work from home, with remote access. On 9/24/24 [R1's] assessments were open. Someone called me and said state was there and I had to fill them out and locked them yesterday. V13 said, For the CNA tasks, I need to enter it manually for the CNAs to see it. When I do my assessment, I relay to the CNAs verbally the care identified. [R1] was max assist with bed mobility. It was under the tasks, she needed 1 person assist. On 9/25/24 at 10:17AM V3, Director of Nursing, said R1 said she was turned and as she turned, she developed a sudden pain, and the x-ray was ordered. V3 said per staff that had cared for her the night before and previous day, there was no fall or report of pain. V3 said R1 never reported pain and nothing unusual happened. V3 said the initial report of pain began on 8/20/24 as staff was turning and changing R1. The surveyor asked V3 at the time of R1's injury how many staff persons were required to turn R1. V3 said, I am not sure. V3 said if R1 had a fear of turning then staff should communicate that so we could implement an intervention. V3 said if R1 had a fear she could have more resistance when turning. V3 said R1 had a serious injury. (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.	Facility initial incident report dated 8/22/24 states, R1 complained to V4 of right shoulder pain. X-ray results acute appearing right clavicle fracture. R1 sent to hospital for further evaluation. R1 states, 'when staff was turning me in bed during care, that's when I felt the sudden pain on the shoulder'. Final investigation dated 8/26/24 states R1 is long term hospice resident. R1 is alert times 2-3 with periods of confusion. R1 had swelling and tenderness to the right shoulder. R1 was unable to remember when turning led to her pain, nor the time or date or description of the staff. R1's Medication Administration Record includes order for Morphine Sulfate to be give as needed for shortness of breath or pain. The order was initiated on 8/11/24, medication was given on 9/20/24 at 12:08PM for a pain level of 5. Controlled Drug Administration Record indicates on 8/18/24 at 11:35AM and 7:00PM Morphine was given. There is no correlating pain rating or progress note. Morphine is signed out on 8/19/24 at 12:35PM and on 8/20/24 at 12:00PM, [almost 12 hours apart]. Review of R1's hospice records dated 8/19/24 visit between 12:45PM and 1:30PM, R1 reported to V15, Hospice RN, patient reports left arm pain. RN administered morphine and instructed V14 to administer every 2 hours as needed for pain. V14 verbalized understanding. Pain assessment documents right shoulder pain severity 8/10, intermittent. On 8/20/24 visit between 11:30AM and 12:30PM pain in right shoulder, 10/10, throb, constant. R1's Restorative GG Admission assessment effective date 8/11/24 states it was completed on 9/24/24 at 3:04PM. When the surveyor reviewed the electronic health record on 9/24/24 before 2:59PM, the assessment was not complete. R1's Restorative UDA assessment effective date 8/11/24 states it was completed on 9/24/24 at 2:59PM. When the surveyor reviewed the electronic health record on 9/24/24 before 2:59PM, the assessment was not complete. (Lock/Completion date and time did not print on print out received.) Review of R1's Documentation Survey Report completed. Record does not indicate the level of assistance R1 required for bed mobility. R1's MDS dated [DATE] type of assessment Significant change: R1's cognition score is 7. Toileting hygiene is coded 01 (dependent). Roll left to right code 03 (partial moderate assistance. MDS indicates R1 is always incontinent of bowel. The facility provided radiology results dated 8/20/24 X-ray of right shoulder due to pain. Findings: clavicle shaft fracture Conclusion: acute appearing clavicle fracture. R1's care plan was reviewed, and no follow up intervention is noted by the surveyor to prevent reoccurrence of an injury during repositioning or care. The surveyor requested the information between 10:30AM and 11:00AM from V3 and from V6, Administrator, at 1:10PM.

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interviews and records reviewed the facility failed to conduct a comprehensive pain assessment after the new onset of pain for greater than 12 hours. This failure affected one of three (R1) residents reviewed for pain. This resulted in R1's pain increased from intermittent to constant. Using the reasonable person concept, it is reasonable to conclude, that this failure resulted in R1 having constant untreated pain, rating a 10 out of 10, from a right clavicle fracture. The findings include: R1's diagnosis include, but are not limited to Vertebra Fracture, Cognitive Communication Deficit, Unspecified Symptoms and Signs Involving the Nervous System, History of Falling, Dementia, Depression, Anxiety, and Osteoarthritis. Incident report provided to IDPH states on 8/20/24 R1 complained of pain to the right shoulder. X-rays were obtained with findings of acute appearing clavicle fracture. On 9/24/24 at 2:07PM V7, CNA, said R1 was incontinent. V7 said before R1 had the sling (8/20/24), when R1 turned one way it would hurt. V7 said to her left she could go all the way. V7 said when R1 turned to the right it was hard and R1 was about to cry. V7 said it was something new for her. V7 said, I would get help to turn her. I don't remember if the nurses knew about it. I was assigned to R1 many times. On 9/24/24 V8, CNA, said she took care of R1 on evening shift. V8 said R1 was in bed and was incontinent and needed to be changed by staff. V8 said before the sling, R1 was good to turn on her side. V8 said R1 was scared to turn because she feared falling out of bed. V8 said R1 had no grab bar or rail on the bed. V8 said she repositioned R1 by herself, she was a '1 person'. On 9/25/24 at 10:17AM V3, Director of Nursing, said the initial report was on 8/20/24 to V4, Doctor, that R1 had pain on her right shoulder. V4 said the injury began on 8/20/24. V3 said pain is assessed every shift. V3 said R1 did not have a lot of pain. V3 said the expectation when a new onset of pain occurs, the nurse should call the physician and check for as needed pain medication. V3 said a pain assessment should be completed. On 9/26/24 at 3:03PM V16, Hospice Supervisor, said the assigned Hospice nurse, V15, discussed with the facility nurse, V14, to assess R1 for pain and administer the medication if needed. V16 said, We absolutely expect collaboration from the facility to follow the plan of care. The facility should provide the care, they are obligated to. Regarding R1's pain situation, V16 said it is the expectation the facility nurse should assess and utilize the assessment to determine if the medication is needed as V15 had discussed with her. On 9/24/24 V14, LPN, said, I don't remember [R1]. If a new onset of pain occurred or was reported, I would do an assessment. I would evaluate, do my own assessment and document. On 9/24/24 at 12:01PM V4, Doctor, said R1 said when they turned R1 in the past 24 hours, R1 felt a pain in her shoulder. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Pain assessments reviewed. R1 has assessment dated [DATE] and 8/24/24, none for 8/19/24-8/21/24. R1's medication Administration record has no pain scale ratings from 8/11/24 until 8/19/24. On 8/19/24 at 12:35PM R1 reported pain as a 4 to V14, LPN. On 8/20/24 at 12:08PM R1 reported pain as a 5 to V1, LPN. No other as needed (PRN) medication is documented as given on the MAR, with a pain scale. Controlled Drug Administration Record indicates on 8/18/24 at 11:35AM and 7:00PM Morphine was given. There is no correlating pain rating or progress note. Morphine is signed out for R1 on 8/19/24 at 12:35PM and on 8/20/24 at 12:00PM, [almost 12 hours apart]. Review of R1's hospice records dated 8/19/24 visit between 12:45PM and 1:30PM, shows R1 reported to V15, Hospice RN, 'patient reports left arm pain'. RN administered morphine and instructed V14 to administer every 2 hours as needed for pain. V14 verbalized understanding. Pain assessment documents right shoulder pain severity 8/10, intermittent. On 8/20/24 visit between 11:30AM and 12:30PM pain in right shoulder, 10/10, throb, constant. Review of progress notes, Medication Administration Record, and assessment no pain rating was found for 8/19/24 after 12:35PM. According to hospice record, R1's pain was intermittent on 8/19/24 and became constant on 8/20/24. R1 did not have pain interventions for her shoulder for nearly 24 hours. (R1 has a history of vertebra fracture and no pain assessments.) The facility Pain policy dated 8/16/24 states it is the policy of the facility to ensure that all residents are assessed for pain in every situation/incident that might result in pain. The nursing staff may document in any part of the resident's medical record that includes Nurses notes, incident report, and medication administration record. Policy does not indicate frequency the nurse should conduct a pain assessment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interviews and records reviewed the facility failed to ensure medical records for one resident are complete and accurately documented by containing accurate and complete restorative assessments and interventions to address care plan needs. This affected one of three residents (R1) reviewed for medical records. The findings include: R1's diagnosis include, but are not limited to Vertebra Fracture, Cognitive Communication Deficit, Unspecified Symptoms and Signs Involving the Nervous System, History of Falling, Dementia, Depression, Anxiety, and Osteoarthritis. Incident report provided to IDPH states on [DATE] R1 complained of pain to the right shoulder. X-rays were obtained with findings of acute appearing clavicle fracture. R1 was sent for evaluation to the hospital on [DATE] and returned the same day to the facility. R1 was a hospice patient and died on [DATE]. On [DATE] at 12:48PM V2, Restorative CNA, said R1 was on a turning and repositioning program. V2 said R1 can turn but needed 2 person assistance turning. There was no documentation of this program in the records. On [DATE] at 2:07PM V7, CNA, said it was hard for R1 to turn on the right, she was about to cry. V7 said this was something new. V7 said, I don't remember if the nurses knew about it. I had R1 ,d+[DATE] times. There was no documentation of this in R1's chart. On [DATE] at 2:15PM V8, CNA, said R1 was afraid to turn because she feared falling out of bed. V8 said before [DATE] R1 was 1 person assist for turning. On [DATE] at 2:30PM V3, Director of Nursing, said there is no risk management (incident report) for R1's injury. V3 said, I was told the IDPH reportable serves as the documentation. The surveyor asked how someone would know the resident's status regarding R1 new injury. V3 responded, We would know something happened based on the IDPH report and any x-rays. V3 said the IDPH reportable and risk watch (incident reports) are not part of the resident chart. V3 said it would be very important for providers to know if a fall or incident occurred. On [DATE] at 10:17AM V3 said, We do a root cause analysis on everyone. We have a separate binder for that. V3 said the purpose of the root cause analysis is to analyze the situation and determine if something can be done differently to prevent event from happening again. The surveyor reviewed R1's incident report with V3. V3 said R1 had some blood under his nails and some dried abrasions on his knee. V3 said we did an incident report on R1 in case R1 fell or complications occur later. The surveyor discussed R1's injury and documentation compared to R1's documentation. V3 said R1 required probably 1 CNA to turn. V3 said, I am not sure how many CNAs were being used but [R1] was not independent with turning. V3 said R1 did not struggle to get her to move. V3 said an incident report was not done for R1 because it was determined R1 did not have a fall. V3 said an incident report was not required. V3 said the doctor documented the pain, x-ray, and ordered a sling. V3 said R1 had an incident of a serious injury. V3 said a pain assessment should be completed for R1 having pain on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's incident report dated [DATE] classified as other completed. R1 has no incident report for [DATE]. The facility nurse did not document a pain assessment on [DATE] to include type of pain, severity of pain, or interventions outcome. There is no documentation in R1's facility record to indicate the injury was an expected outcome related to her medical condition or diagnosis. R1's record has no documented additional interventions to prevent a similar injury from reoccurring. Review of R1's physician orders has no order for pain assessments. Review of R1's restorative assessments performed by the surveyor on [DATE] before 2:30PM, assessments were not complete and remained open. Responses were not entered for all questions. After 3:00PM when the surveyor looked at the restorative assessment during the interview with V10, both assessments were filled out with date of [DATE] at 2:59 PM and 3:04PM. On [DATE] 11:05pm V13, Restorative Nurse, said R1's assessments were open, someone called me and said state was there and I had to fill them out and locked them yesterday. The facility care plan for R1 was reviewed on [DATE] by the surveyor. Care plan includes risk for alteration in musculoskeletal status related to T8 vertebral fracture, gout, osteopenia. Dated [DATE]. Care plan risk for pain related to T8 vertebral fracture, gout, OA, history fall, Depression, GERD, history of breast cancer. Dated [DATE]. The facility printed care plan presented on [DATE] pages 9 and 26 now include right clavicle fracture. (This change was made to the care plan at least 27 days after her death.) Facility policy for documentation was requested on [DATE]. No policy was provided. Facility policy for incident/accident procedures dated [DATE] states an accident/incident report must be completed by the nurse for all incidents/accidents including injuries of unknown source.