Final Observations

Statement of Licensure Violations:

300.610a)
300.1010h)
300.1210d(3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the 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 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's
Continued From page 1

plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to conduct a follow up assessment of the change in eye condition and failed to follow the facility skin assessment policy and conduct a skin assessment every other day for 1 of 3 residents
Continued From page 2

(R1) reviewed for quality of nursing care. These failures resulted in R1's eye swelling and redness worsening and R1 being sent to the hospital for evaluation. R1 was admitted and treated for conjunctival infection. During the emergency room exam R1 was assessed with (2) unidentified deep tissue injuries to the inner thigh area.

Findings include:

R1 was admitted to the facility on 12/5/16, according to R1's facesheet. R1 was transferred to local hospital on 2/17/17.

On 2/28/17 at 12:46pm, Z1 (Emergency Room Nurse) stated that R1 arrived to the local hospital's ER (Emergency Room) on 2/17/17. Z1 stated that R1 had so much discharge and blood coming from both eyes that R1 was not able to open them. R1's skin around the colostomy site was reddened and they were ruling out infection. Z1 said R1 also had wounds on the thighs. The doctors wanted R1 to be sent to another hospital to be assessed and evaluated for possible burns to the thigh area. R1's conditions needed to be treated at a hospital with higher level care.

Review of R1's Emergency Physician Exam from (Hospital A) dated 2/17/17, documents: R1 had conjunctival infection, lid inflammation, and exudate (fluid) in both eyes. An ostomy with erosion and erythema (redness) of the mucosal surface with leaking of enteral contents. Pelvic exam revealed erythema and inflammation to vaginal mucosal tissue.

R1's Emergency Physician Evaluation dated 2/17/17 documents: not comfortable keeping patient at this facility without specialized wound care, recommend that patient be transferred to
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL6013684</td>
<td>A. BUILDING:</td>
</tr>
<tr>
<td></td>
<td>B. WING:</td>
</tr>
</tbody>
</table>

| (X3) DATE SURVEY COMPLETED | 03/02/2017 |

**NAME OF PROVIDER OR SUPPLIER**

HARMONY NURSING & REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3919 WEST FOSTER AVENUE
CHICAGO, IL 60625

---

**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td></td>
<td>Cross-referenced to the appropriate deficiency</td>
</tr>
</tbody>
</table>

Continued From page 3

Tertiary care center with burns. R1's Transfer Form indicates resident was sent to a different hospital on 2/18/17.

Review of R1's Admission History and Physical (Hospital B) documents in part: Eyes are crusted. Rash around colostomy bag and right upper inner thigh.

On 2/27/17, E2 (Director of Nursing) presented R1's Clinical Notes Report for review. R1's Nursing Daily Notes (dated 2/4, 2/7, and 2/12/17) documents, per E4 (RN), the following:

Colostomy bag changed and care rendered, discolorations around the site and small abrasion noted. No further documentation on these dates, reveal notification to the Physician or Nurse Practitioner. On 3/1/17 at 3:54 pm, E4 stated, "a" head-to-toe assessments are done with every shower (2-3 times a week) and documented on the shower sheets by the CNA’s (Certified Nurse Assistants). Nurses are required to document in the Nurse's Notes. If there is discoloration to the skin, we report it to the supervisor and make an incident report, inform the family and notify the doctor.

R1's Physician Progress Note (dated 2/10/17), documents in part by Z2 (Nurse Practitioner): R1's eyes with yellow crustiness noted on the upper/lower eye lids. Will order Artificial Tears twice a day. No subsequent or follow up regarding R1's eyes documented per nursing staff from 2/10/17-2/17/17. On 2/17/17, Z2 documented, Patient's eyes with more yellow drainage and crustiness, appears to worsened since the last week. Increased eye lid edema/purulent drainage now with photophobia (discomfort or pain to the eyes due to light exposure) /crustiness (dryed discharge). On
Continued From page 4

3/2/17 at 11:40am, surveyor inquired to Z2 regarding treatment plan for R1's eyes that was noted with yellow crustiness. Z2 stated, I continued R1 on Artificial Tears because it was just crustiness on the eyelids.

R1's Wound Care Consult from (Hospital A), date of service 2/17/17, reveals: Female genitalia with mirror image wound on bilateral inner thigh that is covered in eschar (dead tissue) and painful to palpitation.

R1's Braden Scale Assessment dated 12/7/16 documents resident as moderate risk level. On 3/1/17 at 3:52pm, E5 (Wound Care Nurse) stated, head-to-toe assessments are done every other day on residents who are considered moderate risk according to the Braden Scale (Pressure ulcer risk). Rashes, wounds, and bruises are documented on wound care notes.

R1's Wound Care Addendum notes reviewed (12/6/16, 1/2/17, 2/11/17, and 2/17/17). Revealed no documentation regarding R1's wounds on inner thighs.

On 3/2/17 at 1:20pm, Z3 (Wound Care Physician) stated I was called to see R1 for the 1st time since resident was admitted here. The initial concern from the staff was involving a facial rash. Then I noticed that R1 would not open eyes. If R1's eye condition was bacterial or viral, we are now looking at conjunctivitis. DTI (Deep tissue injury) starts because of pressure. First it starts as discoloration, then becomes dark, then eschar tissue. Eschar tissue develops over time. The nurse notified me to consult on an elbow wound, I was never notified of any wounds to R1's inner thigh.

On 2/27/17 at 1:37pm, E3 (Registered Nurse)
transferring R1 to hospital, stated R1 had yellowish drainage on both eyes on 2/17/17. On 2/14/17, the colostomy site had redness on it. When I came back to work on Friday 2/17/17, I noticed more redness at colostomy site.

On 3/2/17 at 3:30pm, E2 stated, the CNA's should notify the nurse with any new skin changes. Z2 was notified late regarding R1's colostomy site. Z2 was not notified until 2/8/17. It is a given that when you notice any new skin changes, you notify the Doctor or NP. Regarding R1's eyes, it's just not documented (follow-up from the nurses). We might have just missed the wound on R1's thighs because we were so focused on the facial rash.

Review of the facility's Skin Preventive Care Protocol (un-dated), indicates: B. Moderate Risk residents 2.) Resident will be checked for skin alteration daily during care. CNA to inform the nurse on duty with any skin issues. Nurse on duty will coordinate with wound care team for appropriate treatment.

The facility's Wound Assessment Policy and Procedure (un-dated) indicates: Procedure: 3. A complete wound assessment will be done weekly or with significant change by the wound care team for all pressure ulcers, venous stasis ulcers, diabetic ulcer and skin tears.

The facility's Colostomy/Ileostomy Care policy (dated 7/16) documents: When evaluating the condition of the resident's skin, note the following: Signs of infection (heat, swelling, pain, redness, purulent exudate, etc.)
<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL6013684</td>
<td></td>
<td>C 03/02/2017</td>
</tr>
</tbody>
</table>

NAME OF PROVIDER OR SUPPLIER: HARMONY NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3019 WEST FOSTER AVENUE, CHICAGO, IL 60625

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>