STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 R2 is on contact isolation for Clostridium difficile of the stool and has a stage 3 sacral pressure sore. E6 stated on 11/16/2011 at 11:45 AM that she is supposed to change soiled gloves and washed her hands and put on clean gloves before touching clean items for the resident. 4. On November 14, 2011 at 10:30 am during the initial tour in the third floor. E12 (Housekeeper) entered R13's room. R13 is on contact isolation for C-diff (Clostridium Difficile). E13 did not put on a gown and had only a glove on E13's right hand. E13 took the bed linens off. E13 went out of the room and took cleaning supplies from the cart. E13 then reentered the room and cleaned the bed with a rag, with the hand that did not have the glove on. E13 left R13's room without hand washing and proceed to push the cart and went to another resident's room. Review of the October 24, 2008 Policy and procedure to prevent and control the spread of clostridium difficile, states in part, "Wear gloves when entering the isolation room. Wear a gown when entering the room if substantial contact with the resident or environmental surfaces in the resident's room is anticipated.. Remove gloves and gown before leaving resident's room and wash hands with soap and water immediately."	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b)6)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. BUILDING ____ B. WING ____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	**3919 WEST FOSTER AVENUE CHICAGO, IL 60625**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 13	F9999		

300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	**3919 WEST FOSTER AVENUE CHICAGO, IL 60625**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 14 procedures: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, record review and interview the facility failed to safely turn a resident (R1) while providing care, causing R1 to fall . R1 subsequently sustained injuries and was sent to the local hospital via 911. The facility also failed to post oxygen signs to alert staff and visitors of oxygen use in the rooms of residents (R10) and (R27). Findings include: 1. On 11/14/11 during the initial tour with E13 (Registered Nurse, Minimum Data Set	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. BUILDING ____ B. WING ____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 15	F9999		

coordinator) R1 was lying in bed with a large bruise with swelling to the left side of the forehead, which contained a dressing over it. E13 stated that R1 had sustained a fall within the facility.

The facility's Incident/Occurrence Report for R1 dated 11/10/11 documents that R1 sustained a fall which lead to R1 being sent to the hospital while receiving care from E10 (Licensed Practical Nurse) and E11 (Certified Nursing Assistant). The Incident Report also documents that R1 sustained a "big Bump" to the forehead with bleeding and swelling to the left shoulder.

The Physician's Order Sheet for R1 dated 11/10/11 documents the following order: Send to local hospital via 911.

On 11/15/11 at 11:25am, (location- 4th floor)E11 stated that E11 and E10 was providing care to R1 prior to R1 going for dialysis. E11 stated that E10 turned R1 towards E11 and that E11 wasn't able to catch R1. E11 goes on to state "R1 was too heavy". E11 stated that R1 fell on top of E11 and they were both on the floor. E11 further states that R1 is not able to roll without assistance. E11 then stated that the men on the unit usually help, but were all busy and E10 offered assistance. E11 stated "it happened so fast."

On 11/16/11 during the morning meeting with the facility at 10:10am (location-conference room), E17 (Corporate Director of Reimbursement) stated to the survey team that R1 is not able to roll over or turn to the side without staff assistance. E17 further states that R1 has not had a significant change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. BUILDING _____ B. WING _____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	**3919 WEST FOSTER AVENUE CHICAGO, IL 60625**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 16	F9999		

Continued From page 16

On 11/17/11 at 10:55am via phone conversation, E10 stated that E10 was making rounds and noticed that E11 needed assistance with R1. E10 stated "we rolled R1 to the other side and R1 slipped." E10 then stated "R1's head went over 1st." E10 added that R1 has not been able to roll over or reposition without staff assistance since R1's last admission.

The Minimum Data Set (MDS) for R1 with an assessment reference date of 9/01/11 documents:
Section G,
1. ADL (Activities of Daily Living) self performance-
A. Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed) Code 4 - Total dependence (full staff performance every time).
B. Transfer (how resident moves between surfaces including to or from: bed) Code 4-Total dependence (full staff performance every time).

The Patient information and Transfer Form for R1 from the local hospital back to the facility dated 11/11/11 documents the following major diagnoses: head contusion and left frontal hematoma.

2. Room 214 was observed with a liquid oxygen container next to R10s bed. There was no oxygen hazards sign posted on the door.

3.Room 320 was observed with a large liquid O2 tank next to R27s bed . There was no oxygen hazard sign posted on the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. BUILDING ______ B. WING ______	**11/17/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	**3919 WEST FOSTER AVENUE** **CHICAGO, IL 60625**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 17 E1 (administrator) on 11/16/11 at 10:05AM in the conference room responded that all rooms containing Oxygen must be posted with Oxygen hazard signs. (B)	F9999		