STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: _____ B. WING _____	C 10/18/2022

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HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

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S 000	Initial Comments Facility Reported Incident of 9/18/22/IL151841	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These Requirements were not met evidenced by: Based on observation, Interview and record review, 1. Facility failed to ensure that one resident (R1) with known diagnosis of seizures, psych disorders; use of anticoagulants and history of scissors puncturing him in the past is free of accident hazards such as grooming scissors, stainless steel blades and other hazards; 2. Facility failed to assess if R1 is appropriate to use grooming scissors independently; 3. Facility failed to provide assistance and supervision to a resident who	S9999		

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S9999	Continued From page 2 requires assistance for personal hygiene and grooming. As a result of the facility's failures, on 9/18/2022, R1, was found with bleeding in the right lower abdominal area with a pair of scissors embedded in R1's abdominal wall. R1 was sent to the hospital where CT of the abdomen and pelvis under Impression documents in part: Scissors embedded in the subcutaneous tissue of the right lateral anterior abdominal wall. These failures affected one of three (R1) residents reviewed for hazards and accidents. On 10/12/22 at 10:15 AM, R1 had in his possession two sharp, pointed grooming scissors, and a box of 4 stainless steel blades used for shaving at his bedside. Findings include: R1's medical record showed that R1 was admitted to the facility on 8/27/2022. Diagnosis includes but not limited to: Cauda Equina Syndrome, Paraplegia, Lumbago with Sciatica, Syncope and Collapse, Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Opioid Dependence, Arteriosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Hyperlipidemia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Constipation, Insomnia, Other Generalized Epilepsy and Epileptic Syndromes, Major Depressive Disorder, Anxiety Disorder, Radiculopathy, Obesity, Post Traumatic Stress Disorder, Old Myocardial Infarction, Need for Assistance with personal care, Chronic Pain, Unspecified Convulsions, and Essential Hypertension.	S9999		

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S9999	Continued From page 3 R1's Minimum Data Set (MDS) dated 10/06/2022, Section C- Brief Interview for Mental Status Score is 14 indicating R1 is cognitively intact. Section G of the MDS affirms that R1 requires limited assistance for personal hygiene. CMS 3.0 RAI Manual dated October 2019 on page G-4 defines Personal Hygiene as "how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)." R1's progress notes dated 09/18/22 written by V6, Registered Nurse, documents in part: 2:05 AM- Patient pulled the call light, assigned nursing assistant went to answer the call light and to turn off the light, patient refused the assigned nursing assistant to turn off the light and requested to see the RN immediately. RN went into the patient room immediately, patient verbalized "I accidentally injured myself with a scissor take me out of here" patient words. Patient was observed with minimal bleeding in the right lower abdominal area with scissor laying on the superficial area of the abdomen. No other visible injury noted. At 2:08 AM- Called 911. At 2:25 AM- 911 arrived; patient taken to Local Emergency Department (ED). On 10/12/22 at 10:15 AM, in the presence of V1 Administrator and V2 Director of Nursing, R1 showed in his possession two sharp, pointed grooming scissors, and a box of 4 stainless steel blades used for shaving at his bedside. On 10/12/22 at 1:48 PM, V6, Registered Nurse/RN in charge of R1 at the time of the incident stated the last time I saw R1 during my	S9999		

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S9999	Continued From page 4 shift on 9/18/2022 was around 12:00 AM when R1 came to the nursing station to ask me (V6) for a PRN (as needed) pain medication. V6 stated I asked R1 to rate his level of pain and R1 reported his pain level to me (V6). V6 stated I proceeded to administer the PRN pain medication to R1 and R1 returned to his bedroom. V6 stated at about 2:00 AM, the CNA\Certified Nursing Assistant requested I come into R1's room. V6 stated when I arrived at R1's room, R1 stated he had injured himself. V6 stated R1 showed me his abdomen where I (V6) saw a pair of scissors stuck in his abdomen. V6 stated I asked R1 what are you doing with scissors and R1 stated I use them to trim my mustache. V6 stated R1 said I did not know the scissors were in the bed when I tried to roll myself over and the scissors got stuck in my abdomen. V6 stated the scissors were left in R1's abdomen when R1 was transported to the hospital via ambulance. V6 stated R1 has never requested assistance from me (V6) regarding grooming. V6 stated R1 does require assistance with grooming. On 10/12/2022 at 11:03 AM, V3 Director of Nursing/DON, stated that R1 does not need help with shaving and beard/mustache trimming. V3 also stated that after the incident, she did a whole house sweep to check if any residents have any scissors, razors, blades and other hazards at the bedside and documented on a log that the residents had no sharps located in their possession. V3 stated R1 is able to trim his mustache, R1 is alert and oriented times three. V3 stated R1's BIMS (Brief Interview for Mental Status) score is 14. V3 stated R1 is able to make his needs known to staff. V3 stated the trimming of R1's mustache/beard is a part of grooming and R1 has been coded on the MDS (Minimum Data Set) as requiring assistance with grooming. V3	S9999		

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S9999	Continued From page 5 stated R1 has the following mental health conditions: Conversion disorder, Depression and Anxiety Disorder. V3 stated it is not safe for R1 to have scissors at R1's bedside. V3 stated the nursing staff should be completing rounds on each resident every two hours. V3 stated that R1 did not have any scissors, blades or any hazardous materials at the bedside anymore. V3 also stated that R1 was educated on the importance of asking staff for assistance if he needs to trim his beard/mustache and shave his face. On 10/12/2022 at 11:42 AM, with V1(Administrator) and V3 (DON\Director of Nursing), R1 was observed with two pairs of sharp, pointed grooming scissors, a box of 4 double sided steel blades used for shaving inside a black grooming kit bag. R1 stated he has had the grooming scissors since he first got admitted in the facility about 2 months ago. R1 stated nobody checked his belongings when he got admitted. After the incident, when he came back from the hospital on 9/21/22, R1 stated that nobody told me I shouldn't have any scissors in my room, nobody checked my belongings, nobody educated me to ask for assistance if I wanted to use scissors to shave and trim my mustache\beard. R1 stated I have been using the scissors or razor blades since I was readmitted into the facility. On 10/13/2022 at 10:07 AM, V7 (CNA\Certified Nursing Assistant) stated R1 has never asked me for assistance with grooming. V7 stated I did not know R1 had grooming scissors in R1's room. V7 stated I (V7) don't feel that it is safe for any resident to have sharps or scissors in their possession in their rooms.	S9999		

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S9999	Continued From page 6 On 10/13/2022 at 10:09 AM, V8 (CNA\Certified Nursing Assistant) stated, R1 is very independent, R1 has never requested help from me (V8) with assisting in grooming himself. V8 stated I (V8) have witnessed two residents with scissors in their possession before we had the in-service about inventorying a resident's belongings and removing sharp objects from a resident's room. V8 stated the in-services on completing an inventory of a resident's belongings and removing sharps from a resident's possession where both given on 9/19/2022. V8 stated after the in-service staff did remove the scissors from out the two resident's rooms. V8 stated I do not think it is safe for residents to have scissors or sharps in their possession. On 10/13/2022 at 10:50 AM, V12 (CNA\Certified Nursing Assistant) stated I(V12) don't think it is safe for any resident to have sharps or scissors in their possession. On 10/13/2022 at 11:03 AM, V13 (CNA\Certified Nursing Assistant) stated, I was doing rounds for my assigned residents, it was past midnight, R1's call light was on, so I answered R1's call light. V13 stated when I arrived in R1's room, R1 was yelling at me to get the nurse because R1 did not want any other staff to look at his injury. V13 stated, I (V13) went to get the nurse immediately. V13 stated, when I (V13) returned to R1's room with the nurse, the nurse and I saw a pair of scissors laying laterally in R1's stomach and the handle of the scissors was sticking out of R1's abdomen. V13 stated, I asked R1 what happened and R1 stated he rolled over and the pair of scissors got into him. V13 stated, I have not seen R1 with scissors before this incident occurred. V13 stated, R1 left going to the hospital with the pair of scissors embedded in his (R1's) abdomen.	S9999		

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S9999	Continued From page 7 V13 stated, after R1 left going to the hospital we did a sweep of R1's room and the staff did not find any other sharp objects. V13 stated, I work the overnight shift and R1 has never requested assistance from me with shaving or trimming his mustache. V13 stated, I have not received an in-service from staff regarding supervising residents with razors or scissors. R1's Hospital records dated 09/18/2022 under History and Physical documents in part: After trimming his beard, patient put blades on the table, his Air Pod case has a magnet, blade attached to the magnet, patient placed Air Pod next to him on bed and rolled with resultant abdominal stab. Patient stated pain, severe, brought to the ED (Emergency Department), initial images revealed a nonpenetrating stab. Surgery consulted; blades removed in the ED. Patient admitted for observation. CT of the Abdomen and Pelvis done at the hospital dated 09/18/2022 documents in part under Impression: "Scissors embedded in the subcutaneous tissues of the right lateral anterior abdominal wall. No evidence of injury to the underlying bowel, musculature or vasculature. No active bleeding at this time. " R1's hospital records dated 09/18/2022 under Past Surgical History documents in part, Procedure: 12/2019 Repair RLQ stab wound to abdomen. Patient states passed out and fell on scissors. On 10/12/2022 and 10/13/2022 interviews with V4, V7, V8, V9 and V10 all CNAs\Certified Nursing Assistants affirm that they did not have any knowledge that R1 had a pair of sharp, pointed scissors at the bedside.	S9999		

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S9999	Continued From page 8 On 10/13/2022 at 11:24 AM, V15 (Restorative Director) stated R1's MDS (Minimum Data Set) dated 10/06/2022 Section G. Personal Hygiene was coded for Limited assistance. V15 stated, I (V15) coded R1 like that because R1 needs cueing, R1 needs assistance. V15 stated, the CNAs\Certified Nursing Assistants are encouraged to assist R1 or to ask R1 if they can provide assistance to R1 with R1's personal hygiene needs due to R1's medical condition. On 10/17/2022 at 4:00 PM, V16 (R1's Primary Care Doctor) stated, R1 was strongly recommended to see a psychiatrist due to behaviors R1 was having. V16 stated, R1 was seeking pain medications more often and being rude with staff when R1 did not receive the pain medications from staff. V16 stated, R1 requires supervision when using scissors or blades for shaving. V16 stated, surgery was not required to remove the pair of scissors from R1's abdomen. V16 stated, R1 is not safe to use scissors and blades independently and should not have scissors or blades at the bedside. V16 was asked by the surveyor if someone like R1 with diagnosis of seizures, psychiatric diagnosis such as major depression, anxiety, post traumatic stress disorder and behaviors such as medication seeking behaviors, should have hazards at the bedside and use sharp pointed scissors independently, V16 (R1's PCP) stated no, R1 requires supervision with using such items as scissors or shaving blades. POS (Physician's Order Statement) affirms R1 is receiving Enoxaparin Sodium and Aspirin and is at risk for bleeding and bruising due to anticoagulant use according to Care Plan dated 09/01/2022.	S9999		

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S9999	Continued From page 9 Face sheet affirms R1 has diagnosis (Dx) of Seizures and psychiatric dx which include Major Depressive Disorder, Anxiety Disorder and Post -traumatic stress disorder. R1's care plan affirms he has narcotic seeking behaviors, maladaptive behavior and factitious\conversion disorder. Reviewed R1's care plan dated 09/01/2022 documents in part, Focus: R1 has an ADL Self Care Performance Deficit and Impaired Mobility related to lower extremity Paralysis, Cauda Equina Syndrome, B/L weakness and numbness, chronic back pain, Hemiparesis and Hemiplegia affecting left dominant side. Goal: R1 will maintain his current self-care and mobility status through next review. Interventions: Personal Hygiene/Oral Care: R1 requires (1) staff participation with personal hygiene and oral care. Focus: I have Seizure Disorder. Goal: I will be free from injury from seizure activity through next review date. Intervention: Seizure Precautions: Do not leave resident alone during a seizure, protect from injury, if resident is out of bed, help to the floor to prevent injury, remove or loosen tight clothing, don't attempt to restrain resident during a seizure as this could make the convulsions more severe, protect from onlookers, draw curtain etc. Focus: Narcotic Seeking. I exhibit on-going pathology including medication seeking behavior. I may express untruthful pain assessment with exaggerated perception of pain. I am diagnosed with conversion disorder (d/o). I seek narcotics on a regular basis. I have demonstrated poor response to education explaining the physical/mental dangers of addiction (I know what the outcome will be). Behavior includes attempting to manipulate the nurses for additional medications, even requesting that nurses call my	S9999		

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S9999	Continued From page 10 MD. I engage in histrionic behavior such as throwing myself on the floor. Clinical interviews and records indicate that this has been going on for a long period of time. I am caught in a cycle of addiction, but I do not acknowledge this. At this time, I will not take the first step towards recovery by recognizing the addiction problem. Goal: I will acknowledge my opiate addiction and work with IDT to engage in counseling through the next review. Intervention: Educate resident on the physical and psychological dangers of addiction. Counsel and remind the resident to refrain from asking for medication that is unnecessary and not prescribed for their use. Use phrases such as "I will not have that discussion with you" or "You need to address your medication questions to the doctor" if/when the resident asks for additional narcotics or increased dosages. Remind\instruct the resident to have all medication discussions with the doctor, not the floor nursing staff (who do not prescribe). Focus: Maladaptive Behavior. I am an adult living with significant medical, mental health (conversion d/o) and addiction. I display little to no insight. I display socially inappropriate and maladaptive behavior including trying to subtly or discretely video record my caregivers. I demonstrate mood liability. Showing little ability to self-regulate anger/temper and mood state. I make irrational requests to call 911 when I am not experiencing a crisis. Goal: I will have no further episodes of using my cell phone device to record my care partners nor will I intentionally slide from my chair. Intervention: Conversion d/o related behavior. If R1 states he has extreme pain or is "passing out" listen to him and provide consistent medical evaluation/treatment. This may also be R1's way of saying he does not want to engage in therapy. Encourage him to work on his mental health issues with the clinical therapist.	S9999		

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S9999	Continued From page 11 Focus: Factitious Conversion Disorder. I present with signs/symptoms of conversion d/o. I display excessive anxiety and I allow myself to reach a state of dysregulation. I ask (or demand) that the nurses call 911. I believe I am having an emergency. I do not need hospital care, but I insist I am in crisis. I demonstrate limited self-awareness and do not recognize how my behavior is detrimental. Symptoms include Poor engagement in psychiatric or psychological evaluation/treatment, sabotaging my care plan or suddenly becoming more ill and seeking powerful narcotics. Goal: I will seek mental health treatment, engage in self-improvement goals and have no further incidence of asking nurses to call the 911 system when an emergent crisis does not exist. Intervention: Psychiatric and psychological evaluation and treatment, as indicated. Promote therapy working to resolve underlying psychological issues that may not be causing the behavior. Meet with these providers to discuss best systems and best approaches for working with a person with a conversion disorder. Encourage the resident to work with the therapist on permanent behavior change, reducing or eliminating negative and troubling coping patterns and replacing them with positive life-fulfilling behavior. Focus: R1 has potential for bruising, hemorrhage due to anticoagulant use. Goal: R1 will remain free of hemorrhage and/or bleeding. Interventions: administer medication as ordered and monitor for adverse or allergic reaction, call MD for any changes in condition. R1's care plan was not updated following incident on 9/18/2022. On 10/12/2022 facility did not provide evidence of providing education to R1.	S9999		

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HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

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S9999	Continued From page 12 On 10/18/2022 reviewed the following Policies: Policy titled "Hazards" Adopted 7/28/2016, reviewed\revised 7/28/2022 Policy Statement documents in part, it is the facility's policy to ensure the safety of each resident in the building and remove hazardous items and correct situations to prevent accidents. Procedures 1. Ensure that residents have no access to medications, sharps, and chemicals that would be hazardous to them. Policy titled "General Care" Adopted 11/21/2016, Reviewed/Revised 7/28/2022 documents in part, Policy Statement: It is the facility's policy to provide care for every resident to meet their needs. Procedures: 1. Upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. Physical needs would include, but are not limited to ADL, wound care, medical needs etc. Psychosocial needs would include but are not limited to areas of mental and psychosocial well-being. 10/18 2022 review of Certified Nursing Assistant's job description documents in part, underneath duties and responsibilities: d. assisting with and/or performing the shaving, oral hygiene, nail trimming, toileting, etc. of the resident. 2. Assists in and performs specific techniques of personal care under the direction of the professional staff. (A)	S9999		