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	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Healthcare & Rehab Ctr	3919 West Foster Avenue Chicago, IL 60625

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 - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to implement effective fall precaution interventions for a resident (R2) identified as a fall risk for 1 (R2) of 3 residents reviewed for fall precautions.Findings Include:R2's Facesheet documents that R2 has diagnoses not limited to: unspecified dementia, carcinoma in situ of bladder, essential hypertension, chronic kidney disease, orthostatic hypotension, mild cognitive impairment of unknown etiology, cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, repeated falls, anxiety disorder, unspecified, age related osteoporosis without current pathological fracture, adult failure to thrive, hyperlipidemia, Alzheimer's disease with late onset, anemia, unsteadiness on feet, history of falling.R2's MDS/Minimum Data Set, dated [DATE], documents that R2 does not score on the BIMS/Brief Interview for Mental Status, indicating that R2 is severely cognitively impaired and has memory problems. R2 requires substantial/maximal assistance with Activities of Daily Living (ADL) Assistance and partial/moderate assistance with mobility. R2 is incontinent of bowel and bladder and ambulates via wheelchair.R2's fall care plan documents in part, R2 has at high risk for falls related to impaired mobility, poor safety awareness d/t (due to) episodes of confusion, hx (history) of fall prior to admission, and recent fall. Date Initiated: 09/15/2025. I prefer to keep the bed in the lowest position for safety. Date Initiated: 09/15/2025. I would like staff to provide me a safe environment. Please provide Floor mats/Floor pads at my bedside if appropriate.R2's fall risk assessment dated [DATE] documents that R2 is at high risk for falls with a fall score of 9.R2's fall risk assessment dated [DATE] documents that R2 is at high risk for falls with a fall score of 17.R2's progress note dated 01/14/2026 at 2:15PM documents At around 2:00 PM, resident wheeled to dining room by staff to participate in activities, resident engaged and enjoyed with staff supervision.R2's progress note dated 01/14/2026 at 10:36PM documents At around 6:00 PM, NOD (Nurse on Duty) spoke with Nurse. Resident will be back in the facility. Resident underwent CT scan of the head/neck. 5 stitches was made at the upper left eyebrow.R2's hospital records dated 01/14/2026 documents that R2 was evaluated in the hospital on [DATE] and diagnosed with a laceration to the forehead requiring 5 sutures.R2's progress note dated 01/14/2026 at 12:00AM documents At around 11:30 PM, resident returned back to the facility from emergency room accompanied by 2 ambulance personnel via stretcher. Resident in stable condition, no sign of distress or pain. Head to toe assessment done, noted with 5 sutures to left eyebrow, no active bleeding noted. CT of the head and neck negative with no significant findings. Neurological monitoring in progress, remains at baseline. PRN (as needed) pain medication administered. Writer called son/POA (Power of Attorney) and left a message to provide update. VS checked and recorded BP (Blood Pressure) 150/68 P (Pulse) 75 T (Temperature) 98.1 R (Respirations) 15 SpO2 (Oxygen Saturation) 98% on room air. Resident made comfortable in bed. Kept clean and dry. Bed placed in lowest position, head of bed elevated. Call light within reach. Will endorse accordingly.R2's Facility Reported Incident dated 01/15/2026 documents that R2 fell in the facility and sustained a laceration on the left eyebrow.On 03/08/2026 at 11:12AM, V5 (Registered Nurse/RN) states R2 fell while sitting in the dining room. V5 states she did not witness R2 fall but (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saw a video on the facility's camera how R2 fell. V5 states it appears from the video that R2 was eating and then became dizzy and fell out of her chair. V5 states she saw on the video that R2 hit her head on the floor and was bleeding. V5 states there were staff members inside monitoring the dining room at that time. V5 states the staff were busy doing other things and was unable to prevent R2 from falling.On 03/08/2026 at 10:35AM, R2 observed located inside the second-floor dining room sitting in a wheelchair. R2 states she fell out of her chair but does not want to discuss the fall. R2 states she does not want to discuss the fall because it was horrible. R2 then states she does not feel well and requests for staff to transport her back to her room.On 03/08/2026 at 11:09AM, surveyor observed R2 in bed. R2's bed in a high position, R2's bed observed to not be in the lowest position. R2 observed in a supine position with head of bed at 45 degrees, R2 noted to be sleeping in bed. R2's bed observed in a high position that reaches surveyor's mid upper thigh measuring approximately 2 feet, 8 inches in height. Surveyor observes that there are no floor mats in place while R2 is in bed.On 03/08/2026 at 12:00PM, V9 (Agency CNA) states she is assigned to care for R2 today. V9 states this is her second time caring for R2 and she is not aware of R2's specific fall precaution interventions. V9 states she is not the person who placed R2 back into bed today. V9 states upon entering R2's room to check on her, V9 noticed that R2's bed was not in the lowest position. V9 states when she checked, R2's bed height reached the middle of her thigh. V9 states from prior experience, she is used to fall risk residents having floor mats in place while in bed. V9 states she started her shift today at 7:00AM and when she arrived, R2 did not have floor mats in place while she was in bed. At 12:05PM, surveyor and V9 now located inside of R2's room. Surveyor observes that R2's bed is not in the lowest position. V9 observed operating R2's bed and lowering R2's bed to the lowest position. R2's bed is now in a position that reaches the middle of surveyor's calf measuring approximately 1 foot in height. V9 states if R2's bed is not in the lowest position and floor mats are not in place, then R2 could fall and injure herself.On 03/08/2026 at 1:23PM, V3 (Fall Coordinator/Restorative Nurse) states she is responsible for inputting the fall interventions into the resident's care plan. V3 states residents' care plans are updated whenever a resident has a fall. V3 states herself, the nurses, and CNA staff are responsible for ensuring that resident's fall interventions are being implemented. V3 states she was made aware that R2 experienced a fall in the facility and was told to go to the dining room. V3 states when she arrived, she saw R2 on the ground and laying on her back. V3 states R2 kept saying, I want to get up. V3 states she observed an injury above R2's left eyebrow. V3 states all fall interventions are expected to be followed once they are put into place for a resident. Surveyor deploys R2's fall care plan on a computer and V3 states R2's care plan does not specify how many floor mats should be in place while R2 is in bed. V3 states the verbiage in R2's care plan pertaining to the floor mats states If appropriate. V3 states she determined that R2 was appropriate to have floor mats in place while in bed. V3 states according to R2's care plan, her bed should be in the lowest position while in bed. V3 states if R2's fall precaution interventions are not implemented, R2 could potentially fall and hurt herself.Facility policy dated 06/30/2025, titled Fall Occurrence documents in part, It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions. The nurse may immediately start interventions to address falls in the unit. The falls coordinator will add the intervention in the residence care plan.