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	04/24/2025

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** 50036 Based on interview and record review, the facility failed to implement effective fall interventions and supervision for a dependent resident assessed as a high risk for falls. This failure affected one resident (R2) of four residents reviewed for falls. This failure resulted in (R2) having a fall, being sent out to the emergency room , and sustaining a laceration to right eyebrow requiring 3 sutures. Findings include: R2 is a [AGE] year-old resident initially admitted to the facility on [DATE] with diagnoses including but not limited to: Functional quadriplegia, atrial fibrillation, bradycardia, and hypertensive heart disease with heart failure. R2's Minimum Data Set (MDS) section C0500 dated 2/18/2025 documents Brief Interview for Mental Status (BIMS) Score = 15 which suggests cognition is intact. MDS section GG0130 dated 2/18/2025 documents resident is dependent on staff for the following areas: eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Care plan with initial date of 2/20/2025 but revision date of 2/23/2025 documents Focus: R2 is high risk for falls due to weakness, functional decline, co-morbidities such as functional quadriplegia, DM-II (Diabetes Mellitus type 2), AFIB (Atrial fibrillation), hypertensive heart disease, HLD (hyperlipidemia), depression, anemia, BPH (benign prostatic hyperplasia) without UTI (urinary tract infection), neuropathy. Goal: R2 will be free of falls through the next review date. Interventions: I prefer to keep all needed items like water pitcher, tissue box, urinal, etcetera, within reach. o I prefer to keep the bed in the low position for safety. o I would like staff to keep furniture in locked position during transfers and nursing care. (continued on next page)

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

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	04/24/2025

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.	o Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance. R2's Progress note dated 3/27/2025 documents: Note Text: Called Hospital to follow up patient status. Patient admitted diagnosis: head Laceration. Bed hold. R2's Progress note dated 3/27/2025 documents in part: Situation: 1. The change in condition, symptoms, or signs observed and evaluated is/are: Patient had a fall. He is on Eliquis 5 mg BID. Has wound on right eyebrow area. 2. This started on: 03/27/2025. 2f. Describe symptoms or signs: Had a fall incident today. Patient c/o (complaint of) pain in both arms. He also had a wound on right eyebrow. 8c. Is there any bleeding noted from the injury? Yes 8c1. If there is a bleeding, choose one of the following: Scant Recommendation: Appearance 1. Summarize your observations and evaluation: Patient has wound on right eyebrow area and c/o pain in both arms after a fall incident. He is on Eliquis 5 mg BID. He was sent to the hospital ER (emergency room) via 911 for further evaluation and management. 3. Additional information on the change in condition: Patient was sent out to ER by 911. MD (medical doctor) and family were notified. R2's Progress note 3/27/2025 documents in part: Incident Summary: Summoned to patient's room by V8 Certified Nursing Assistant (CNA). R2 is observed lying on the floor by his bed. R2 is positioned on his stomach with face turned to left side. There's a chair close to R2's head. Assigned CNA (V8) said she was cleaning patient (R2) and left patient for a second to get more supplies as patient kept on passing stools. Before V8 CNA got back, she heard patient (R2) fell from the bed. R2 c/o (complains of) pain in both arms. Also, noted a wound on his right eyebrow area with small amount of bleeding. R2 remains alert and oriented x4. No loss of consciousness noted during the incident. Patient is on Eliquis 5 mg BID. 911 called for immediate transfer to ER (emergency room). MD (medical doctor) and patient's family notified. R2's Hospitalist History and physical dated 3/27/2025 documents in part: The patient presented to the hospital after mechanical fall out of bed at nursing home. He got a laceration to his right eyebrow which was repaired in the ER. Tetanus was updated. Imaging was negative for any acute injury. Him and his sister stated there feeling that he is neglected at the current nursing home, and they would like to be placed any new nursing home. R2's Laceration repair procedure note from hospital dated 3/27/2025 documents in part: appropriate position and anesthesia around the laceration was obtained by infiltration using 1% lidocaine without epinephrine. The area was then cleansed using alcohol. The laceration was closed with 3-0 Prolene using interrupted sutures. There were no additional lacerations requiring repair. The wound area was then dressed with gauze. The patient's tetanus status was updated with a tetanus booster. Total repaired wound length 2.5 cm. Other Items: Suture count: 3 (continued on next page)

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	04/24/2025

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.	On 4/22/2025, at 9:39 AM, V8 (CNA) stated the night R2 had a fall, I was doing rounds. I went in to change R2. I was cleaning R2 up, he was on his side. R2 kept having a bowel movement. I asked if R2 was ok and went to the door because my linen cart was by the door. I went to grab more linen and R2 was on the floor. I had left R2 on his side, on the bed. R2 was comfortable on his side. R2 was laying on his side before I walked off and he was fine. R2 did not use any side rails. R2'a bed was not to the floor, but it was not high. I did not raise the bed to do care. I left the bed at the level it was in when I came in. R2's bed was about my hip level. R2 could move his one arm the right arm. R2 could move his legs a little bit but could not move them a lot. I can't even tell you how R2 fell . I know I left R2 in a safe position. R2 was laying on his side for a while as I was cleaning his back. My cart was right by the door, and everything happened so quick. By the time I came back in R2 was on the floor. I did not hear R2 fall. I just heard R2 tell me he was on the floor. R2 did not tell me he was slipping or anything. No one else was in the room when this happened. We do not carry radios or anything. There were three CNAs on that hall that night. I let the nurse know. I stepped to the door and called for V9 Registered Nurse (RN). We (V9 and I) cleared the way for the ambulance to come get R2. We (V9 or I) did not move R2 or put him back in the bed. The ambulance people came and got him off the floor. I did not realize R2 was bleeding until the ambulance came and picked him up. R2 was bleeding from his eye. I think it was the right side. R2 always complains of pain. R2 was not screaming or anything like it was something new. R2 pretty much just laid there talking normal. On 4/22/2025, at 11:29 AM, V9 Registered Nurse (RN) stated, I was working the night R2 had his fall at the end of March. I was at the nurse's station. My CNA (V8) was in the hallway. V8 said, can you come here. R2 is on the floor. V8 said, I was changing the patient and he kept passing stool and I left for a second and V8 said she heard him fall from the bed. When I walked in R2 was on the floor, so I called 911, I did not even move R2. Ambulance came right away within a few minutes. At first, I could not see if R2 was bleeding. R2's right side of his face was on the floor. When 911 got there I seen R2 had about an inch long cut on right eyebrow area that was bleeding a minimal amount. It was shallow. R2 was complaining of pain on the left arm. When I went in the room and seen R2 on the floor the bed was waist high. R2 did not have any bed rails on his bed or half rails that I know of. If I were to be changing the resident and needed more supplies, I would make sure the patient is on his back, the bed is lowered, and make sure resident is safe before I leave the room. I would explain to resident that I need to get supplies and I will be right back in a few seconds. On 4/22/2025, at 2:33 PM, V3, Director of Nursing (DON) stated, if a staff member was changing someone and needed more supplies the staff member could put on the call light and get help. In the situation with R2 the linen cart was right outside the door, I would not expect them (staff) to leave a resident to go all the way to the linen closet. I would expect staff to leave resident in a safe manner ensuring their safety before leaving them briefly for supplies. When asked what a safe manner would be V3 stated, a safe manner would be ensuring resident is not at the edge of the bed, put bed in low position, make sure call light was still in reach. When asked what position the resident should be placed in, V3 stated, I guess the position of the patient depends on the patient. When asked specifically for R2's situation as a quadriplegic what would the safest position be for R2 be, V3 stated R2 was a quadriplegic so his safest position would have been on his back. (continued on next page)

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	04/24/2025

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.	On 4/23/2025, at 11:25 AM, V1, Administrator stated, my expectation of staff when leaving a resident briefly to get supplies would be that they are left in a safe position. When asked what would constitute a safe position, V1 stated a safe position would be comfortable, center of the bed, and bed lowered. When asked what position the resident should be left in such as on side or on back, V1 stated the position the resident should be in would depend on their orders. Like if a resident has orders to turn every 2 hours, we would follow the doctors' orders. When asked what position should a resident be left in if the staff is just stepping away briefly to get supplies, V1 stated just for staff to step away briefly the optimal position could be on the back. When asked for this particular resident R2 who had quadriplegia and could not fully move legs, what would optimal positioning for this resident be if staff needed to walk away briefly to get supplies, V1 stated optimal positioning for this particular resident R2 would have been on his back due to his quadriplegia. If there is a fall, we do in servicing right away. I know we did in servicing for the date in question. Fall Prevention Program Guideline Policy with review date of August 5, 2022, documents in part: Policy Statement: Fall prevention program guidelines shall be implemented to promote safety of all residents in the facility. This program shall include measures to determine the individual needs of each resident by assessing the risks for fall and the implementation of evidence-based prevention interventions. Procedure 2. Safety interventions shall be initiated and implemented for each resident identified at risk for fall. 3. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained. 6. Interventions shall include staff, family and resident education, programs, purchase of equipment or other environmental-related alternatives to prevent the resident from falling. 7. An individualized evidence-based plan of care shall be created to reflect fall prevention interventions which could be but not limited to: h. Residents shall be observed to ensure the resident is safely positioned in bed or chair. Provide care as assigned in accordance with the plan of care. j. Education and communication of resident care to staff. m. provide assistance with activity of daily living to include toileting as needed. ADL (Activities of Daily Living) Care Guidelines Policy with reviewed date of August 5, 2024, documents in part: ADL care is provided for each resident in the facility in accordance to the resident's comprehensive assessment and care plan in order to identify, evaluate, and intervene to, maintain, improve or prevent and avoidable decline in ADL's. (continued on next page)

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	04/24/2025

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.	Interpretation and Implementation 2. Nurses and CNAs (certified nursing assistants) are trained in providing general/routine ADL care to the residents. The facility has an active program of restorative nursing services which is developed and coordinated through the resident's care plan. 4. ADL nursing care is performed daily for the residents based on the comprehensive assessment, plan of care, physician orders as well as ADL documentation on varios shifts. Such care may include as appropriate but not limited to: g. Incontinent care and bowel and bladder training as indicated; and i. Other ADL support and assistance in accordance to the restorative nursing assessment and/or comprehensive resident assessment