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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145893 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Harmony Palos | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based upon record review and interview the facility failed to revise a comprehensive care plan for three of three residents (R1, R2, R3) reviewed for falls.</p> <p>Findings include:</p> <p>R1's (5/9/25) final facility incident report states on (5/9/25) CNA (Certified Nursing Assistant) was providing peri-care to resident in bed, on the last time that CNA turned the resident towards her, CNA inadvertently overturned resident's right leg which resulted in the resident falling out of the bed and on to the floor. Residents care plan was updated to include assistive device in bed to assist resident with turning and repositioning.</p> <p>R1's (3/1/25) risk for falls care plan excludes the (5/9/25) fall and an assistive device in bed.</p> <p>On 6/10/25 at 11:48am, surveyor inquired if R1's comprehensive care plan includes an assistive device for turning and/or repositioning in bed (as stated on the 5/9/25 incident report) V3 (ADON/Assistant Director of Nursing) accessed R1's electronic medical record and responded No, she does not have side rails.</p> <p>---</p> <p>R2's (5/21/25) incident report includes a fall.</p> <p>R2's (3/20/25) risk for falls care plan (received 6/5/25) excludes the (5/21/25) fall and preventive interventions entered on or after 5/21/25.</p> <p>On 6/10/25 at 11:59am, surveyor inquired about R2's (5/21/25) fall and preventive interventions - post fall V3 (ADON) stated The resident wanted to go to bed, and he (R2) asked the CNA to put him in the bed. The CNA went to go get diapers and the pad to put on the bed and he decided to slide onto the floor and try to crawl to the bed to get in there on his own. So, for the care plan intervention the staff need to visually check on him and make sure that his needs are met. Surveyor inquired when R2's fall care plan was last updated V3 responded That was supposed to have been um initiated on May the 21stand affirmed that R2's care plan was revised on 6/5/25 (survey entrance date).</p> <p>---</p> <p>(continued on next page)</p> | | |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R3's (5/23/25) fall incident report includes Immediate Action Taken: bed rails will be added to bed, bed alarm and floor mats will be added.</p> <p>R3's (5/15/25) risk for falls care plan excludes the 5/23/25 fall and floor mats.</p> <p>On 6/10/25 at 12:10pm, surveyor inquired about R3's (5/23/25) fall and preventive interventions - post fall V3 (ADON) stated The patient have a pressure ulcer on his buttock area, and he tries to move around in the bed, I think he's also visually impaired. He rolled off the bed, so we applied side rails to help reposition himself in the bed. Surveyor inquired if floor mats were added to R3's care plan (as stated on R3's 5/23/25 incident report) V3 responded No, I don't see it on there.</p> <p>The fall occurrence policy (revised 7/26/24) states those identified as high risk for falls will be provided fall interventions. The falls coordinator will add the intervention in the resident's care plan. The interventions will be reevaluated and revised as necessary.</p> |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff turn/reposition residents safely, failed to ensure that staff report resident falls, failed to ensure that staff are aware of resident fall prevention interventions, failed to implement fall prevention interventions, failed to provide supervision, and/or failed to ensure that equipment was functioning properly for three of three residents (R1, R2, R3) reviewed for falls. These failures resulted in R1's (5/9/25) fall with sustained right acute intertrochanteric femoral neck fracture and pain rated 5/10.</p> <p>Findings include:</p> <p>R1 is [AGE] years old with diagnoses which include congestive heart failure, chronic kidney disease, lymphedema, and hypertension.</p> <p>R1's (3/1/25) fall risk assessment determined a score of 15 (high risk).</p> <p>R1's (5/28/25) functional assessment affirms resident is dependent on staff for rolling left and right.</p> <p>R1's (5/9/25) progress note (entered by V11/Agency Licensed Practical Nurse) states the aide witnessed resident attempting to roll off the bed, grabbed her by both legs and pulled her up into the bed. The resident complained of pain and Tramadol PRN (as needed) was given. The medical doctor was in the building and gives orders for an x-ray to the right femur and right knee.</p> <p>R1's (5/9/25) right femur x-ray states lucency across the intertrochanteric neck and lesser trochanter concerning for an acute intertrochanteric femoral neck fracture.</p> <p>R1's (5/9/25) Medication Administration Record affirms pain level was rated 5/10.</p> <p>R1's (5/9/25) final facility incident report (which is incongruent with the progress note) states the CNA (Certified Nursing Assistant) inadvertently overturned resident's right leg which resulted in the resident falling out of bed and on the floor. Residents care plan was updated to include assistive device in bed to assist resident with turning and repositioning [R1's comprehensive care plan - received 6/5/25 excludes an assistive device in bed].</p> <p>R1's (5/28/25) BIMS (Brief Interview Mental Status) determined a score of 8 (moderate impairment).</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>On 6/5/25 at 12:38pm, R1 was lying in bed however an assistive device (ie: side rails, trapeze) for turning and repositioning was not in place. Surveyor inquired about the (5/9/25) incident R1 stated I fell, they (staff) change your diaper and they tell you to roll go ahead keep rolling and that's when I fell on the floor. Surveyor inquired how staff responded when R1 fell R1 replied I think they (staff) just picked me (R1) up and put me back in bed, it happened so fast. Surveyor inquired if staff implemented anything after the (5/9/25) fall V5 (Family) responded There needs to be 2 people when changing her (R1). She (R1) can't move on her own. Surveyor inquired if side rails were placed on R1's bed V5 replied No, I don't see any. Surveyor inquired if R1 requires surgery for the 5/9/25 fracture V5 stated She's (R1) 95, the doctor recommended that and she said no due to her age, it was not in her best interest.</p> <p>On 6/5/25 at 12:52pm, V6 (CNA/Certified Nursing Assistant) entered R1's room to remove the lunch tray. Surveyor inquired about R1's fall prevention interventions V6 stated I help only the CNA to pull her (R1) up and to distribute the food and affirmed that she (V6) was unsure.</p> <p>On 6/5/25 at 1:09pm, V7 (CNA) affirmed that she's assigned to R1. Surveyor inquired about R1's fall prevention interventions V7 stated As of now, we (staff) roll her (R1) with a 2-person assist when we are changing her. She (R1) also has to have a bed all the way lowered [assistive device while in bed was excluded].</p> <p>On 6/9/25 at 9:17am, V2 (Director of Nursing) presented V4's (5/9/25) witness statement as requested (due to inability to reach V4 via phone) which states during morning care on 5/9/25 when I was rolling the resident back over, her leg went over the edge. I grabbed her pant leg and the top of her shirt to prevent her from falling. She did touch the oxygen concentrator with her head, and I told the nurse. She never fell when I took care of her. Surveyor inquired about V4's statement (which was incongruent with R1's) V2 stated she (V4) said to me I (V4) was standing on the side of the bed and one of the legs went over too much so I grabbed her pant leg and shirt so she wouldn't fall out of bed. She said that she never fell out of the bed, but she did bump her head a little bit on the oxygen tank. She also said she (R1) did not complain of any pain. When I (V2) first went into the room (R1) did tell me she (R1) was having some pain. She (R1) was saying that it was taking two people to give her care during the initial contact but only (V4) was providing care so that didn't make sense what she (R1) was saying at that time. I (V2) went back to talk to her (R1) again when we figured out that there was a fracture, that's when (R1) tried to explain everything to (V3/Assistant Director of Nursing) she (R1) explained that she ended up on the floor and said that it took 2 people to get her off of the floor. I was unable to find anyone else that would have gotten her off the floor.</p> <p>On 6/9/25 at 1:31pm, surveyor inquired about R1's (5/9/25) incident V11 (Agency Licensed Practical Nurse) stated The CNA had me (V11) straighten her (R1) up in the bed because she was trying to fall out the bed. She (V4) told me she was trying to fall out the bed and she needed some help, so I (V11) went in there to help her. When I went down to that room the lady (R1) was in the bed. She (R1) said she was having some pain, so I gave her something for pain. V11 also affirmed that she was unaware that R1 fell on the floor.</p> <p>On 6/11/25 at 10:59am, surveyor inquired about potential harm to a resident if staff do not report to the nurse and/or physician that a resident fell and hit their head V13 (Medical Director) stated Multiple things can happen if we don't know about it. They (staff) should notify someone that something happened, if they (residents) fall they may require x-rays and we (staff) need to determine what happened. Falls can get fracture anywhere and if there's head trauma there's a risk of bleeding.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>—</p> <p>R2's diagnoses include specified disorders of muscle and history of falling.</p> <p>R2's (3/20/25) fall risk evaluation determined a score of 5.0 (low risk).</p> <p>The facility incident log affirms R2 fell on 3/28/25, 4/1/25, 5/17/25, and 5/21/25.</p> <p>R2's (5/31/25) functional assessment affirms resident is dependent on staff for toileting and requires substantial/maximal assistance with chair/bed to chair transfer.</p> <p>R2's (3/20/25) care plan includes ADL (Activities of Daily Living) self-care performance deficit and impaired mobility related to generalized weakness and functional decline. Intervention: Transfer: substantial assist x1 staff participation and gait belt.</p> <p>R2's (5/31/25) BIMS determined a score of 15 (cognition intact).</p> <p>On 6/5/25 at 12:56pm, R2 was observed seated in a wheelchair. Surveyor inquired about R2's falls at the facility R2 stated It doesn't matter, what they gonna do? Surveyor inquired if the facility implemented something to prevent additional falls R2 responded They (facility) supposed to be getting me (R2) another wheelchair, but they haven't gotten one yet. Surveyor inquired how long R2 has been waiting for a new wheelchair R2 replied It's been long enough.</p> <p>On 6/5/25 at 1:35pm, the call light was activated (by R2). R2 stated I need somebody to come change me. V7 (CNA) subsequently entered the room, placed a gait belt around R2's waist and proceeded to transfer R2 by herself however R2 was unable to stand up straight (both knees were buckled) therefore R2 was quickly pivoted and plopped onto the bed. R2's pants were soaked with urine and the wheelchair seat was notably wet.</p> <p>On 6/11/25 at 11:45am, surveyor inquired if R2 can stand and/or transfer without assistance V14 (Restorative Nurse) stated He (R2) needs assistance for the transfer, he needs 1-person for assistance. If I'm not mistaken, he needs substantial assistance, technically we consider total dependence is 2-person but he is able to bear some weight and do couple steps. Surveyor inquired if R2 was supposed to receive a modified wheelchair V14 responded I haven't been notified of anything. The high back wheelchair would give him more support that would be helpful. I will go and speak with therapy about it.</p> <p>—</p> <p>R3's diagnoses include cerebral infarction, cognitive communication deficit, and specified disorders of muscle.</p> <p>R3's (5/15/25) fall risk evaluation determined a score of 16 (high risk).</p> <p>The facility incident log affirms R3 fell on 5/21/25 and 5/23/25.</p> <p>R3's (5/19/25) functional assessment affirms resident is dependent on staff for sit to stand and chair/bed to chair transfer.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>R3's (5/15/25) care plan states resident has an ADL self-care deficit and impaired mobility, intervention: Transfer: partial assist x1 staff participation using gait belt and rolling walker. Resident is at high risk for falls, interventions: 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.</p> <p>R3's (5/21/25) incident report states CNA was cleaning up patient, left the room to find nurse. Other CNA observed patient on the floor next to his bed [the fall was unwitnessed].</p> <p>R3's (5/19/25) BIMS affirms that cognitive skills for daily decision making are severely impaired.</p> <p>On 6/5/25 at 1:00pm, R3 was banging his cell phone on the bedside table repeatedly and yelling for help however staff did not respond. R3 was in a wheelchair adjacent the bed with a call light draped over his left arm (antecubital area) and not secured. R3 stated I need to get in bed. I'm worrying about getting in bed, I thought they (staff) were gonna put me in the bed it's been 20 minutes. How long does it take to get someone in bed? Surveyor inquired if R3 pressed the call light R3 responded I can't see the light where's it at? and was unable to find it. Surveyor inquired about R3's falls at the facility R3 replied I guess I was trying to get up. Surveyor inquired about staff response when he fell R3 stated They didn't pick me up right away, it a took a minute to get me up. I been calling for help a long time and I don't get it.</p> <p>On 6/5/25 at 1:06pm, V10 (Registered Nurse Orientee) affirmed that she's assigned to R3 and stated, He's a 2-person assist. Surveyor advised V10 that R3 requested assistance and we subsequently entered R3's room. R3 stated I need somebody to put me back in the bed. Surveyor inquired about the location of R3's call light V10 responded It's right there on your arm so he (R3) can reach it easily so it's available to him. R3 replied Yeah, but I can't see it and affirmed that he's visually impaired. V10 exited the room without providing R3 the call light and did not return - to assist R3 as requested.</p> <p>On 6/5/25 at 1:12pm, V7 (CNA) affirmed that she's assigned to R3. Surveyor inquired about R3's fall prevention interventions V7 stated We usually have the bed at the lowest position, and we have the bed alarm on. Surveyor inquired if R3 requires any additional fall prevention interventions V7 responded No however a chair alarm was observed on R3's wheelchair and provide call light access was excluded. Surveyor inquired about R3's call light V7 stated We usually have his call light attached to his gown. Surveyor inquired if there was a clip on R3's call light to secure it to his gown V7 reached for the call light cord (near the floor), moved the clip near the button and secured it to the gown. Surveyor inquired how R3 is transferred V7 replied He's a 2-people assist. We (staff) can help him stand and guide him to the chair. V8 (Infection Prevention Nurse) entered R3's room to assist with R3's transfer. R3's wheelchair was moved close to the bed however the wheels were not locked, a gait belt was not in use, and a rolling walker (as stated in the care plan) was not provided. As V7 was instructing R3 to stand up V9 stated Wait a minute, we should use a gait belt to get him up. V9 (Restorative CNA) subsequently entered the room placed a gait belt around R3's waist, then instructed him to push up from the chair and grab the walker. Surveyor inquired if the chair alarm (in use) sounded when R3 stood up V9 stated No. Surveyor inquired if R3's chair alarm was working V8 inspected R3's alarm and stated, Is this even on?</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>The fall prevention program guidelines (revised 12/5/21) state a fall risk assessment shall be completed upon admission, re-admission, quarterly, significant change, annually, and after each fall. Safety interventions shall be initiated and implemented for each resident identified at risk for fall. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained. An individualized evidence-based plan of care shall be created to reflect fall prevention interventions which could be but not limited; to place call device within reach at all-times and respond to call light promptly. If a resident has visual defects, the location of the placement of the call light shall be verbalized to those residents. If a resident has any physical or fine motor skill deficiencies, the resident shall be fitted with the appropriate device. May utilize personal alarms when appropriate such as bed alarms, chair alarms and motion sensor alarms. Use of side rails may be considered as a safety measure, mobility aide for self-turning and repositioning. Provide assistance with activity of daily living to include toileting as needed. Use of gait belt and other appropriate transfer devices such as mechanical lifts. Ensure equipment is properly functioning and maintained.</p> | | |