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	01/04/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the established comprehensive care plan for 1 of 3 residents (R1) to ensure safety during bed mobility and ADL (Activities of Daily Living) care and failed to communicate the resident's fall risk status. Specifically, facility staff failed to provide the required level of assistance and supervision mandated by the care plan, which led to a fall resulting in significant injury of a Humerus Fracture. A facility incident report dated 9/12/2025 reads in part, On 9/12/25 while CNA (V3) was providing ADL (activities of daily living) care to the resident when the fall occurred the CNA had (R1) laying on her left side, the CNA had one hand on her rib cage area to stabilize the resident while she was washing her with the other hand when the resident started to roll out of the bed the CNA attempted to stop the fall but was unsuccessful. The CNA notified the nurse on duty. The nurse on immediately assessed the resident. (R1) complained of pain to the right shoulder area and the nurse noted a laceration above the right eye. A cold compress was applied to the right eye. (R1) was sent 911 to hospital ED. (R1) returned from hospital ED with diagnosis of a fracture of the right humerus without any surgical interventions and a laceration above the right eyes and Steri-strips applied.R1 is an alert and oriented predominantly Polish-speaking [AGE] year old with diagnoses listed in part but not limited to type II Diabetes, Fracture of the upper end of Right Humerus, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Anxiety Disorder and History of Falls. Care Plan dated 5/12/25 reads in part, (R1) is at high risk for falls due to history of falls, impaired mobility, weakness, comorbidities include Heart Failure, Hypertension, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, Respiratory Failure, History of Deep Vein Thrombosis, Left Humeral Fracture. Interventions: Bed in low position, Encourage to transfer and change positions slowly, Frequent toileting, Have commonly used articles within easy reach. Low bed. R1's MDS (Minimum Data Set) dated 9/16/25 section GG for Functional Abilities/Self Care showed: Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. R1 was noted to be Dependent on staff to conduct this task. On R1's Care Area Assessments (CAA) Summary Section V of the MDS, R1 was triggered for Fall risk for every MDS assessment upon admission on [DATE] through current MDS. Review of R1's Care Plan revealed the resident was identified as a high fall risk and required extensive assistance of at least one staff member for bed mobility and incontinence care. However, on the date of the incident, V3 the agency CNA assigned to the resident failed to follow these interventions by removing her hands and physical support from the resident while the resident was in a side-lying position.On 1/2/26 at 1:10 PM, V3 Agency CNA, said, I haven't been back there awhile (referring to facility). My agency hasn't put me back there but I remember that incident. I was taking care of this lady (R1) and had her on her side. I had one hand on her shoulder and my other hand was cleaning her up because she had a massive BM (bowel movement). She (referring to R1) just reached for her bedside table (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or something on it. I don't know what she was reaching for to be honest. I think she just wanted some security or something but she just rolled over and fell off the bed. Surveyor asked about any bed rails, V3 said, No there were no rails on the bed for her to hold on to so I'm not sure why. I didn't understand her she didn't speak English. It was the first time I took care of her so I don't know if she ever fell before. Surveyor asked if anyone endorsed any information about R1's care needs to her, V3 said, No, no one told me anything about her. Like I said it was the first time I took care of her and no one told me anything about her and I didn't know if she was a fall risk. Surveyor asked if she had any training on fall prevention, V3 stated, No. I don't remember getting any.On 1/2/26 at 2:50 PM V4 LPN said, V3 told me that when she turned her (R1) over to clean her I think she turned her too far and so she fell out of the bed. 911 was called and I don't recall seeing a side rail. Of course if there were side rails, she may not have rolled out of the bed. The Agency CNA said that she just turned her as she was cleaning her. The aide didn't tell me anything about the resident reaching for anything at the bedside table. Surveyor asked about R1, V4 said, She was not a fall risk as she's never fallen out of the bed, so no she's not a fall risk. The whole time I've had her, she's never fallen. I was never told she was high risk for falls and she has never fallen in the room or anything like that. I know cognitively she is forgetful, but she is pretty with it. She speaks broken English but she understands me. I've never seen a communication board and have never had to use one for her.On 1/2/26 at 2:00 PM, V5 Agency LPN said, I'm her nurse today (Referring to R1) but I'm with Agency. All i can tell you is that she is alert oriented x 3 and she can make her needs known. I think family is involved too. Surveyor asked if R1 was at risk for falls, V5 said, No she's not a fall risk but yes I did hear about her falling awhile ago but I wasn't here when she fell. Surveyor asked about any facility in-service training, V5 said, I don't get any in-service training from here, my Agency does all that. (could not tell surveyor about fall preventative measures or fall prevention when asked about R1 as she did not consider the resident was a fall risk).

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(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	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 ensure that 1 of 3 residents (R1) reviewed for accidents was free from accident hazards and received adequate supervision and assistive devices to prevent an avoidable fall. Specifically, the facility failed to ensure an agency CNA (V3) was oriented to R1's high fall risk status. This failure resulted in R1 sustaining a displaced humerus fracture, head laceration with active bleeding requiring sterile-strips, and facial contusions. R1 is an alert and oriented predominantly Polish-speaking [AGE] year old with diagnoses listed in part but not limited to type II Diabetes, Fracture of the Upper End of Right Humerus, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Anxiety Disorder and History of Falls. A facility incident report dated 9/12/2025 reads in part, On 9/12/25 while CNA (V3) was providing ADL (activities of daily living) care to the resident when the fall occurred the CNA had (R1) laying on her left side, the CNA had one hand on her rib cage area to stabilize the resident while she was washing her with the other hand when the resident started to roll out of the bed the CNA attempted to stop the fall but was unsuccessful. The CNA notified the nurse on duty. The nurse immediately assessed the resident. (R1) complained of pain to the right shoulder area and the nurse noted a laceration above the right eye. A cold compress was applied to the right eye. Nurse notified the doctor and orders were give to send out to the ED Emergency Department for evaluation. (R1) was sent 911 to hospital ED. (R1) returned from hospital ED with diagnosis of a fracture of the right humerus without any surgical interventions and a laceration above the right eyes and Steri-strips applied. During the investigation it was noted that the resident prefers to use the edge of the bed or the night stand to support herself for comfort during ADL care, and it was noted that she would benefit from a wide bed and siderails for support during care.A review of R1's care plans refutes facility's conclusion shifting blame to the resident as no documented evidence was found that R1 preferred to be at the edge of the bed or to use the night stand for support during ADL care and was not consistent with either the resident's interview and staff interviews. Care Plan dated 5/12/25 reads in part, (R1) is at high risk for falls due to history of falls, impaired mobility, weakness, comorbidities include Heart Failure, Hypertension, Hyperlipidemia, COPD, Respiratory Failure, Osteoporosis, Gout, Dementia, History of Deep Vein Thrombosis, Left humeral fracture. Interventions: Bed in low position, Encourage to transfer and change positions slowly, Frequent toileting, Have commonly used articles within easy reach. Low bed.On January 2, 2026 at approximately 10:40 AM, R1 was observed awake in bed and with the bed raised waist high and with no fall mats or other fall prevention measures in place. Two State Surveyors conducted an interview with R1 regarding her most recent fall. Because R1 is predominantly Polish-speaking, the state surveyor utilized the Polish-speaking surveyor to interpret and ensure accuracy. During this interview, R1 consistently stated that while the agency CNA (V3) was providing care, the CNA took her hands off the resident to reach for an item. The resident reported that because the CNA let go and there were no side rails in place, the resident rolled out of the bed and struck the floor. Furthermore, R1 did not mention any such preference to be at the edge of the bed while being changed or to use her nightstand as support.R1 said, I fell out of the bed when a CNA was changing my diaper. The CNA didn't hold me when she was changing me, and I rolled out of bed and fell. The bed was high up I think because I broke both my shoulders. My shoulder hurt a lot after the fall and they still hurt today. My hands hurt and shake too. I cannot hold things in my hands like I used to before the fall. They put up this bed railing (pointing to the rail) so maybe I won't fall now, but they never put it up before I fell.A post fall incident statement dated 9/15/25 taken by (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the facility's business office manager (V10) interpreted for R1 reads: Interview with R1 with staff member (V10) to translate stated, They were changing me when they turn me I went over the side of the bed and was on the floor. I wasn't reaching for anything. The bed is much more comfortable and I have more room to move yes I feel safer in this bed with the side rails.V4 LPN nurse on duty at the time of the incident confirmed in an interview on January 2, 2026 at 2:50 PM that upon entering the room immediately following the incident, R1 was on the floor with active bleeding from the head. V4 further stated that the Agency CNA never mentioned the resident reaching for anything at the time of the incident, which contradicts a later allegation made by the CNA that the resident's own actions caused the fall.On 1/2/26 at 2:50 PM V4 LPN said, I was training someone at the time of the incident and I was called to the room by V3 (Agency CNA) and the resident was on the floor and she had some bleeding while she was laying on her back. V3 told me that when she turned her (R1) over to clean her I think she turned her too far and so she fell out of the bed. 911 was called and I don't recall seeing a side rail. Of course if there were side rails, she may not have rolled out of the bed. The Agency CNA said that she just turned her as she was cleaning her. The aide didn't tell me anything about the resident reaching for anything at the bedside table. Surveyor asked about R1, V4 said, She was not a fall risk as she's never fallen out of the bed, so no she's not a fall risk. The whole time I've had her, she's never fallen. I was never told she was high risk for falls and she has never fallen in the room or anything like that. I know cognitively she is forgetful, but she is pretty with it. She speaks broken English but she understands me. I've never seen a communication board and have never had to use one for her.Furthermore, the (V1) Administrator's claim that a subsequent re-interview showed the resident preferred the bed in the lowest position was directly refuted by the consistent testimony provided by the resident to the two State Surveyors. R1 explicitly denied making any statement regarding a low-bed preference and maintained the fall was due to the CNA's failure to provide support. Medical records confirm the resident sustained a humerus fracture, head trauma with bleeding, and facial contusions as a direct result of this lack of supervision and lack of knowledge of resident's fall risk status and care needs.On 1/2/26 at 1:10 PM, V3 (Agency CNA) stated it was her first time to care for R1 and admitted , No one told me anything about her history or that she was a high fall risk. She claimed the resident reached for an object, causing the fall however a statement R1 provided the nurse at the time, R1 denied reaching for anything and that she just rolled over because V3 did not keep her hands on her at all times to keep her from rolling out of the bed, nor were there any side rails for her to grab onto to prevent her from rolling out of the bed. On 1/2/26 at 1:10 PM, V3 Agency CNA, said, I haven't been back there awhile (referring to facility). My agency hasn't put me back there but I remember that incident. I was taking care of this lady (R1) and had her on her side. I had one hand on her shoulder and my other hand was cleaning her up because she had a massive BM (bowel movement). She (referring to R1) just reached for her bedside table or something on it. I don't know what she was reaching for to be honest. I think she just wanted some security or something but she just rolled over and fell off the bed. Surveyor asked about any bed rails, V3 said, No there were no rails on the bed for her to hold on to so I'm not sure why. I didn't understand her she didn't speak English. It was the first time I took care of her so I don't know if she ever fell before. Surveyor asked if anyone endorsed any information about R1's care needs to her, V3 said, No, no one told me anything about her. Like I said it was the first time I took care of her and no one told me anything about her and I didn't know if she was a fall risk. Surveyor asked if she had any training on fall prevention, V3 stated, No. I don't remember getting any.On 1/2/26 at 2:00 PM, V5 (Agency LPN) said, I'm her nurse today (Referring to R1) but I'm with Agency. All I can (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	tell you is that she is alert oriented x 3 and she can make her needs known. I think family is involved too. Surveyor asked if R1 was at risk for falls, V5 said, No she's not a fall risk but yes I did hear about her falling awhile ago but I wasn't here when she fell. Surveyor asked about any facility in-service training, V5 said, I don't get any in-service training from here, my Agency does all that. (could not tell surveyor about fall preventative measures or fall prevention when asked about R1 as she did not consider the resident was a fall risk). Following the fall, R1 was transferred to the Emergency Department. Medical records from the hospital confirm the resident sustained a displaced fracture of the right humerus, multiple abrasions and a contusion to the left temporal region of the head. On 1/2/26 at 2:18 PM, V9 Nurse Practitioner wrote in part in the progress notes, Patient had a recent fall and returned back from the hospital on 9/22/25. FX of R (Fracture of Right)shoulder seen on imaging. patient has sling on now. patient has hematoma and bruising of Right eye and right side of face, CT head was negative according to records. Orthopedics consulted, pain management, and rehabilitation. Patient to follow up with ortho outpatient. Patient was stabilized and sent back to facility. V9 NP could not be reached for interview during this investigation. On 1/2/26 at 12:57 PM, Surveyor requested V1 administrator to provide a fall prevention policy but was provided instead with a Fall Occurrence policy. When requested for an actual policy and procedures that addressed fall prevention and how facility communicated this training to nursing staff, V1 said through email, That is the only policy. The Fall Occurrence Policy dated 6/30/25 reads 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 and reevaluated and revised as necessary. A fall Risk assessment form will be completed by the nurse or Falls Coordinator upon admission, readmission , quarterly, significant change and annually. Those identified as high risk for falls will be provided fall interventions. An Interim Falls Care Plan may be started but a Falls Care Plan is necessary and required after the State required MDS was done. If a resident had fallen, the resident is automatically considered as high risk for falls.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 1 of 3 residents (R1) received care from staff with documented competency and training. Specifically, the facility assigned an agency CNA to provide direct care for R1 without first validating that the staff member possessed the necessary clinical skills or had been oriented to R1's specific safety needs, including fall risk status and required levels of assistance. As a result, the facility failed to ensure that R1 was provided care by a staff member with verified qualifications to perform the assigned duties. R1 is an alert and oriented predominantly Polish-speaking [AGE] year old with diagnoses listed in part but not limited to type II Diabetes, Fracture of the upper end of Right Humerus, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Anxiety Disorder and History of Falls. A facility incident report dated 9/12/2025 reads in part, On 9/12/25 while CNA (V3) was providing ADL (activities of daily living) care to the resident when the fall occurred the CNA had (R1) laying on her left side, the CNA had one hand on her rib cage area to stabilize the resident while she was washing her with the other hand when the resident started to roll out of the bed the CNA attempted to stop the fall but was unsuccessful. The CNA notified the nurse on duty. (R1) complained of pain to the right shoulder area and the nurse noted a laceration above the right eye. A cold compress was applied to the right eye. (R1) was sent 911 to hospital ED. (R1) returned from hospital ED with diagnosis of a fracture of the right humerus without any surgical interventions and a laceration above the right eyes and Steri-strips applied.On 1/2/26 at 1:10 PM, V3 Agency CNA, said, I haven't been back there awhile (referring to facility). My agency hasn't put me back there but I remember that incident. I was taking care of this lady (R1) and had her on her side. I had one hand on her shoulder and my other hand was cleaning her up because she had a massive BM (bowel movement). She (referring to R1) just reached for her bedside table or something on it. I don't know what she was reaching for to be honest. I think she just wanted some security or something but she just rolled over and fell off the bed. Surveyor asked about any bed rails, V3 said, No there were no rails on the bed for her to hold on to so I'm not sure why. I didn't understand her she didn't speak English. It was the first time I took care of her so I don't know if she ever fell before. Surveyor asked if anyone endorsed any information about R1's care needs to her, V3 said, No, no one told me anything about her. Like I said it was the first time I took care of her and no one told me anything about her and I didn't know if she was a fall risk. Surveyor asked if she had any training on fall prevention, V3 stated, No. I don't remember getting any.On 1/2/26 at 2:00 PM, V5 (Agency LPN) said, I'm her nurse today (Referring to R1) but I'm with Agency. All I can tell you is that she is alert oriented x 3 and she can make her needs known. I think family is involved too. Surveyor asked if R1 was at risk for falls, V5 said, No she's not a fall risk but yes I did hear about her falling awhile ago but I wasn't here when she fell. Surveyor asked about any facility in-service training, V5 said, I don't get any in-service training from here, my Agency does all that. A review of the facility-provided orientation documentation for the agency CNA V3 involved in R1's fall (dated 10/2024) revealed a perfunctory approach to training. Over two dozen training topics, including fall prevention and safety protocols, were marked only with a single continuous vertical strike-through line followed by the CNA's signature. The document lacked instructor initials for individual tasks, dates of specific competency completion, or any evidence that the CNA's skills were actually observed or validated by facility leadership. This failure to effectively verify the CNA's competency in safety protocols resulted in the staff member being assigned to care for a high-risk resident without confirmed knowledge of the facility's (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety standards.On 1/2/26 at 12:57 PM, Surveyor requested V1 administrator to provide a fall prevention policy but was provided instead with a Fall Occurrence policy. When requested for an actual policy and procedures that addressed fall prevention and how facility communicated this training to nursing staff, V1 said through email, That is the only policy. The Fall Occurrence Policy dated 6/30/25 reads 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 and reevaluated and revised as necessary. A fall Risk assessment form will be completed by the nurse or Falls Coordinator upon admission, readmission , quarterly, significant change and annually. Those identified as high risk for falls will be provided fall interventions. An Interim Falls Care Plan may be started but a Falls Care Plan is necessary and required after the State required MDS was done. If a resident had fallen, the resident is automatically considered as high risk for falls.The facility's training program failed to provide staff with a proactive fall prevention framework. A review of the facility's education modules revealed the absence of a fall prevention policy; instead, staff were only trained on a fall occurrence policy which detailed procedures to follow after a resident had already fallen. Consequently, the facility failed to ensure that the agency CNA was equipped with the necessary preventative competencies and safety protocols required to maintain the safety of R1 during high-risk for falls and ADL care.