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	04/03/2026

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 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 the fall care plan interventions in place for at-risk fall residents. This applies to 3 of 3 residents reviewed for falls in a sample of 6.The findings include:1.R3 is an [AGE] year-old female admitted on [DATE] with moderate cognitive impairment as per the MDS dated [DATE].On 3/31/26 AT 10:15 AM, R3 was on her bed with V9 (R3's Daughter) at her bedside. V9 stated, Nobody knows how R3 had a hip fracture. My mom doesn't walk, and we don't know how the injury happened. They didn't always have the bed alarm activated.On 4/1/26 at 9:15 AM, R3 was on her bed, and R3's bed alarm was not working. Upon notification, V10 (Restorative Nurse) checked the bed alarm and stated, We have to change the battery.On 4/1/26 at 9:50 AM, observed that R3's bed alarm was not working, with a new battery installed and not blinking. On 4/1/26 at 9:50 AM, V11 (R3's Nurse) checked the bed alarm and stated, The bed alarm is not working/blinking. I am going to change the whole alarm set. The problem could be with the padding, battery, or alarm system itself.On 4/1/26 at 10:07 AM, V11 had changed the whole bed alarm set and was working. V11 stated that the alarm should always be working, as R3 is at high risk of falls.A review of the R3's fall care plan interventions includes a bed alarm to alert staff when the resident attempts to get out of bed unassisted, so staff can assist the resident and prevent falls.2.R5 is an [AGE] year-old female admitted with severely impaired cognition as per MDS dated [DATE].A review of the fall risk assessment dated [DATE] documented that R5 is at risk for falls due to impaired cognition and impaired mobility.On 3/31/26 at 9:27 AM, observed R5 get out of bed, walk unsteadily, and go to the bathroom. The bed alarm was not going off.On 3/31/26 at 9:30 AM, V12 (Environmental Service Director) stated that the alarm should be set to go off when the resident gets up.A review of the R5's fall care plan interventions includes a bed alarm to alert staff when the resident attempts to get out of bed unassisted, so staff can assist the resident and prevent falls.3.R6 is a [AGE] year-old female admitted with severely impaired cognition as per MDS dated [DATE].A review of the fall risk assessment dated [DATE] documented that R6 is at high risk for falls due to impaired mobility, history of falls, and impaired cognition.On 4/1/26 at 9:40 AM, R6 was observed on an elevated bed with a bed remote hanging from the posterior side of the footboard and a call light touch pad inside the bedside drawer.On 4/1/26 at 9:43 AM, V13 (CNA) brought the call light touch pad accessible to R6.On 4/1/26 at 9:45 AM, V14 (Nurse) stated, R6 is on fall risk, and the bed should be in the lowest position, and the call light should be within his reach.A review of the R6's fall care plan interventions includes keeping the bed in a low position, keeping commonly used articles within easy reach, and reinforcing the need to call for assistance.A review of the facility presented the Fall Occurrence Policy (revised on 6/30/25), which states that it is the facility's policy to ensure that residents are assessed for fall risk, that interventions are put in place, and that interventions are reevaluated and revised as necessary.2. Those identified as high risk for falls will be provided with fall interventions.

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

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	04/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to acquire and administer prescription medications to residents. This applies to 1 of 3 residents reviewed for pharmacy services in a sample of 6The findings include:R1 was an [AGE] year-old male admitted on [DATE], having mild cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. R1 was admitted with an admitting diagnosis including left femur fracture, Parkinson's disease, and bone density disorder.A review of the Physician Order Sheet (POS) documented that R1 was ordered with his hallucination medication Nuplazid 34 milligrams once a day, starting on 3/2/26.A review of R1's Medical Administration Record (MAR) for 03/2026 documents that R1 didn't receive his hallucination medication (Nuplazid) on 3/2/26, 3/3/26, and 3/4/26.A review of the POS indicates that the hallucination medication was discontinued on 3/4/26.On 4/1/26, the facility presented a statement from V4 (Registered Nurse for R1 on 3/4/26) stating that it was a clerical error that Nuplazid medication was administered on 3/4/26. The statement also documented that this medication was not available, was never administered to R1, and was discontinued by V5 (R1's attending Physician) on 3/4/26.On 4/2/26 at 3:45 PM, V7 (R1's concerned party) stated, I was staying with him most of the time. R1 was in need of his hallucination medications. But they didn't administer that during his stay with the facility.On 4/1/26 at 1:30 PM, V2 (Director of Nursing / DON) stated, We never administered R1's hallucination medication (Nuplazid). The resident was admitted on [DATE], and this is a specialty medication from the Veterans Affairs (VA) hospital. The nurse made a mistake by documenting that the medication was given to R1 on 3/4/26. We never received that medication. It was not given on 3/4/26.On 4/2/26 at 2:23 PM, V2 added, This is a specialty medication, and not all pharmacies carry this medication. Normally, we should get our medications from the pharmacy within 8 hours.On 4/2/26 at 3:00 PM, V5 (Pharmacist) stated, Nuplazid is not a specialty medication, but requires high-cost approval. We sent an email and voice message to V2 requesting this approval. We did not receive the approval, and hence it wasn't delivered to the facility.