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	05/08/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect resident's right to be free from abuse. This deficient practice affects one resident (R6) of three residents reviewed for abuse. This failure resulted in R6 having right leg shin bruising/hematoma.Findings Include:Facility Reported Incident to State Agency dated 3/22/26, reads in part: On 3/22/26 @ 8pm, R6 reported that V15 (CNA) kicked her in her leg and pulled her hair. V15 was removed from the building immediately. Notified attending physician, and emergency contact. Police Department was called and is in route.R6 is an [AGE] year-old female resident with diagnoses of Metabolic Encephalopathy, and Unspecified Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.On 5/6/26 at 9:30AM, observed R6 in bed watching television. R6 is alert and oriented and reported that on the day of the reported abuse, R6 entered the elevator, one person standing by the elevator control panel. The staff member flung her wheelchair and the staff member kicked R6 on her right leg. R6 stated she immediately reported the incident when R6 came out of the elevator. On 5/6/26 at 10:15PM, V12 (CNA) stated V12 heard R6 making allegations of abuse from other staff members but did not witness any physical abuse to R6 at that time. When R6 came back upstairs, out of the elevator V12 recalls seeing resident with her hair disheveled and messy after coming out of the elevator.On 5/6/26 at 11:00AM, V14 (Assigned Nurse for R6) stated V14 was called by the first-floor nurse to come and see R6 on the first floor and that R6 was upset and yelling. V14 went down and R6 reported to V14 that R6 was physically assaulted inside the elevator by V15. V14 stated she conducted a complete body assessment to R6 and noted a small red discoloration and slightly swollen area on R6's right leg shin area.On 5/6/26 at 11:30AM, V15 (CNA) stated that V15 does not recall if R6 was in the elevator. V15 stated that her mind was preoccupied when she went in the elevator due to some questioning by one staff member prior to V15's break. V15 used the elevator down to go downstairs and sit on her car for her break, then returned half an hour later and V15 was instructed to go wait outside and there was an allegation of abuse against her. V15 was asked if V15 recalls R6 riding the elevator with V15 and V15 stated To be honest, my mind was preoccupied with all the questions that was asked by my coworker that I did not notice if R6 was in the elevator or not. I spaced out. I do not recall any interaction with R6 in the elevator.On 5/6/26 at 11:56AM, V1 (Administrator) stated the abuse allegation was reported to her by V2 (Director of Nursing), V1 initiated the investigation and reported this allegation to State Agency. V1 stated that R6 reported to the nurse that a CNA kicked her and pulled R6's hair in the elevator. Described as big CNA and black female. Facility watched the video and observed V15 get in the elevator after R6 entered the elevator. R6 reported the staff was already in the elevator. And the video showed V15 came in after the R6 got in. First floor they exited @ 7:27PM CNA exited the elevator and walked towards the lobby. R6 did not exit the elevator until 35 seconds later after V15 exited. When R6 got out of the elevator, R6 calmly rolled down the hall, not frantic. Camera was not able to view what happened inside the elevator. Just CNA going inside the second elevator after R6 entered and then V15 leaving the elevator seconds later on the first floor.Shower sheet dated 3/22/26. Body diagram facing forward noted and documented that R6 to have right leg circled, (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	described as bruise hematoma to shin.On 5/6/26 at 2:35PM V1 and V2 stated that there is no documentation they can provide that documented that R6 had any bruising or hematoma prior to this reported incident.Police Report dated 3/22/26 reads in part: Everything listed and described below including all conversation are in somebody and not verbatim please refer to body camera footage for more in depth and specific details. Any consistencies are unintentional.Local Police Department we're dispatching for the report of a battery through a patient by a staff member which reportedly happened an hour earlierUpon arrival V14 (Nurse), V14 informed the police that R6, who V15 described as being alert and oriented x4, explaining R6 had no Alzheimer's of psych issues, had alleged that R6 had been assaulted by a CNA. V14 said that upon checking R6, bruises were found on her were green in color, which V14 indicated they were fresh. V14 said the hematoma appeared to have grown larger since V14 first saw it. V14 also advised that R6 suffered redness to the back of her head, advising that R6 said her hair was pulled. V14 said these injuries were not on r6 prior to the incident. Police interviewed R6 and in summary: learned from R6, R6 being flung in her wheelchair. R6 described her as being pushed by the CNA in her wheelchair from the front of elevator to the rear elevator doors. R6 advised R6 then yelled at V15 (CNA) calling her Son of a b*tch. R6 advised V15 then turned around and V15 lifted her leg and kicked R6 on the leg. V15 also punched R6 in the face/head (forehead area). It is believed that this physical altercation took place inside the elevator. As later R6 described getting on the elevator on the 2nd floor and got off the first floor where R6 reported the incident to staff. R6 advised that R6 looked in the mirror, however she didn't notice marks on her face. R6 informed me that the marks to the back of her head were old, explaining that they did not occur from this incident. R6 explained that R6 doesn't bruise easy advising that based on her injuries, R6 must have been kicked hard.In the parking lot, found V15 and V15 stated she was informed that V15 was being accused of an abuse allegation. V15 upon returning on her break she was asked to leave. Police informed V15 of the allegation and V15 advised that she had no idea about any of that. On 5/6/26 at 11:56AM, V1 (Administrator) stated that video copy was sent to the police department link provided to facility. Per V1, video cannot be retrieved at this time. It was sent to the police provided link and if needed copy, the police may be able to provide it to State Agency surveyor.Abuse Policy with a revised date of 1/29/26 reads in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegation these guidelines include compliance with the (7) seven federal components of prevention and investigation.

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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 observations, interviews, and record reviews, the facility failed to implement fall care plan interventions for fall-risk residents. This applies to 2 of 3 residents (R4 and R8) who were reviewed for falls and injuries in a sample of 10.The Findings include:1.R4 is a [AGE] year-old male admitted on [DATE] with mild cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. R4 was admitted with an admitting diagnosis including bipolar and a neoplasm of the tongue.On 5/5/26 at 10:05 AM, R4 was observed on his bed with no floor mat on his right side, and a folded floor mat was observed on his left side leaning against the bedside drawer.On 5/5/26 at 10:10 AM, V19 (Certified Nursing Assistant) entered R4's room and stated, I was about to give R4 a shower as today is his shower day. I will put the floor padding back after his shower.A review of the fall care plan documented interventions, including a floor mat on the right side of R4's bed.A review of the incident note dated 2/2/26 documented an unwitnessed fall with a right forehead bruise.A review of the health status note dated 2/3/36 documented that R4 had another fall and was found on the floor on 2/3/26 with no injury.2.R8 is an [AGE] year-old female admitted on [DATE] with severe cognitive impairment as per the MDS dated [DATE].On 5/6/26 at 9:55 AM, R8 was observed in her wheelchair, biking with a nonfunctioning chair alarm with her wheelchair. On 5/6/26 at 9:56 AM, V19 stated, The chair alarm is not working. It needs a new battery.On 5/6/36 at 10:08 AM, V20 (Restorative Director) replaced R8's chair alarm battery, and it started working.On 5/6/26 at 10:34 AM, V2 (Director of Nursing/ DON) stated that it was everyone's responsibility to test the chair alarm. Our staff is supposed to implement fall interventions to avoid further falls and injuries.A review of the fall log and health status note dated 4/23/26 documented a fall for R8 on 4/23/26 with no injury.A review of the fall care plan includes interventions, such as a chair alarm to alert staff when a resident attempts to get out of bed unassisted, so staff can assist the resident and prevent falls.A review of the Fall Occurrence policy, revised on 6/30/25, documents the policy statement: It is the policy of the facility to ensure that residents are assessed for fall risk, that interventions are put in place, and that interventions are reevaluated and revised as necessary.