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	IL6014534	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PALOS	11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463

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S 000	Initial Comments Annual Certification and Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

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Based on interviews and record reviews the facility failed to follow their policy and procedures for care planning and fall prevention by not implementing previously established fall interventions based on all available information for a resident readmitted to the facility with a history of repeated falls and by not implementing personalized fall interventions or ensuring all available sources of information were utilized to identify and implement effective fall interventions for a resident who was admitted to the facility after being hospitalized from a fall that resulted in multiple significant injuries. This failure applies to two of four residents (R7 and R56) reviewed for falls and resulted in R56 experiencing a fall that resulted in a thigh bone fracture.

Findings include:

R7 is an 83-year-old male with a diagnoses history of Metabolic Encephalopathy, Right and Left Side Pain from Back to Legs, and restless leg syndrome who was admitted to the facility 07/23/2024.

R7's admission hospital records dated 02/21/2024 documents he had a history of frequent falls, he was admitted to the hospital after a fall at home, he had previous hospital admissions related to falls in the last few years, he has severe lumbar spine fusion and complains of pain, per family member he has been having more frequent falls as of late, and can be transferred to rehabilitation; the plan for recurrent falls included recommendation of subacute rehab; IDT (Interdisciplinary Team) recommendations also included Bed/Chair alarms, caregiver within arm's reach when out of bed, establish a toileting schedule and ADL (Activities of Daily Living) routine, non-skid socks,

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use of bedside commode, shades up during the day, lights off and shades down at night, and minimizing overnight disruptions.

The facility's Fall Log reviewed 11/18/2024 documents R7 had falls on 10/22 at 11:40 AM and 10/26 at 9:25 PM

R7's progress note dated 10/23/2024 documents a certified nursing assistant made writer aware that R7 was observed sitting on the floor. Writer and staff went into resident's room to assess resident. Resident stated he was trying to move to the other bed because his bed had a hole in it, and he slid down on the floor.

R7's Fall Risk Management Assessment dated 10/26/2024 documents his bed alarm was going off in his room, staff immediately responded, and he was observed lying on the floor; R7 reported he didn't fall but slipped off the bed as he was trying to go to the other bed.

R7's Current care plan initiated 07/23/2024 documents he is at risk for falls related to a history of falls, potential medication side effects, poor safety awareness, disease process such as acute respiratory failure with hypoxia, sepsis, aspiration pneumonia, cognitive impairment, acute metabolic encephalopathy, Coronary Artery Disease, Benign Prostatic Hyperplasia, chronic Urinary Tract Infections, Hypertension, Diabetes Mellitus, Acute Kidney Injury, and A fibrillation. R7's care plan interventions did not include Bed/Chair alarms, caregiver within arm's reach when out of bed, establishing a toileting schedule and ADL (Activities of Daily Living) routine, non-skid socks, use of bedside commode, shades up during the day, lights off and shades down at night, or minimizing overnight

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disruptions. R7's Bed alarm intervention was not implemented until 10/22/2024 and the intervention of frequent rounding and asking if he needs assistance or toileting were not implemented until 10/26/2024.

R56 is a 42-year-old male with a diagnoses history of Cirrhosis of Liver, Emphysema, Non-traumatic Brain Hemorrhage, Stage 4 Chronic Kidney Disease, Sarcoidosis, Epilepsy, Hepatic Encephalopathy, History of Falling, Multiple Fractures of Ribs, and Bone Disorder who was admitted to the facility 07/12/2024.

The facility's Fall Log reviewed 11/18/2024 documents R56 had a fall with injury 07/12/2024 at 10:39 PM.

R56's Admission Summary progress note dated 7/12/2024 documents patient has arrived at facility via stretcher around 2pm. Writer noted upon assessment patient has multiple bruises all over the body, left ear sutures, and bruising around left eye. Patient is currently in bed, with bed in the lowest position, call light within reach, ice water at bedside; at 11:03 PM it was documented that Writer was notified by certified nursing assistant of patient being on the floor. Upon assessment the writer observed the patient sitting upright at the bedside, as the writer asked the patient what happened his nose started to bleed. The patient had pain rating 10/10 with limited range of motion to the left leg, the patient was extremely confused.

Facility Incident Report dated 07/18/2024 documents R56 had an unwitnessed fall 07/12/2024 at 10:10 PM and was admitted to the hospital with an acute right femoral shaft fracture; On 07/12/2024 at approximately 10:10 PM a

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certified nursing assistant observed patient sitting on the floor of his room, he was observed by nurse sitting upright on his buttocks on the floor by his bed, he was observe with minimal bleeding from nose and was unable to move his right leg, when asked what happened he reported he was trying to get up and use the bathroom, he did not activate the call light for assistance, he was last seen by the nurse before the incident at approximately 9:35 PM sleeping in bed with his call light in reach and bed in the lowest position.

On 11/18/24 01:29 PM V26 (Family Member) stated, R56 fell when he first came to the facility, and she doesn't think they did the proper intake when he was admitted. V26 stated, the facility didn't get enough information about R56's needs. V26 stated, R56's other roommates had a better intake process and were better accommodated. V26 stated, she doesn't know how R56 fell but his bed was not equipped with sensors or railings, and his room was far back in the facility at the very end. V26 stated, after R56 fell they added railings to his bed, moved his room closer to nurses station, and added a motion sensor to his bed. V26 stated, when R56 fell he fractured his femur (thigh bone) and hasn't been able to receive therapy. V26 stated, R56 has been discouraged and depressed, has become withdrawn and believes a lot of it has to do with the injury.

R56's medical records did not include any information obtained from V26 (Family Member) on the day he was admitted regarding his needs based on his risk of falls and history of falls.

R56's hospital report dated 07/24/2024 documents he was recently admitted to the hospital from 06/29/2024 - 07/12/2024 for

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traumatic subdural hematoma and sub arachnoid hemorrhage (bruising and bleeding near the brain), nasal bone fracture, abnormally low blood cells post bone marrow biopsy and having subsequent worsened confusion.

R56's Minimum Data Set section for Functional Abilities dated 07/12/2024 marked as completed at 3:11 PM documents he required supervision and touching assistance with bed mobility and substantial/maximal assistance with transfers.

The facility's census report documents when R56 was admitted on 07/12/2024 his room was located in an area that was not close to the nurses station and when he was readmitted to the facility on 07/24/2024 he was placed in a room right outside the nurses station area.

R56's physician order history documents 2 quarter side rails to aide with bed mobility and transfers were not ordered until 07/24/2024.

R56's Current care plan initiated 07/12/2024 documents he is a high risk for falls due to traumatic subdural hemorrhage, calculus of kidney, stroke, acidosis, right ankle joints and right foot, stage 3 Chronic Kidney Disease stage, sarcoidosis, epilepsy, acute kidney failure, insomnia, and right hip fracture with interventions implemented 07/12/2024 including ensure that his frequent visitors are aware of the use of assistive and adaptive devices; he has periods of forgetfulness and would like staff to frequently reorient him to his surroundings; he would prefer to keep all needed items like water pitcher, tissue box, urinal, etc., within reach; he would prefer to keep the bed in the low position for safety; he would like Physical Therapy and Occupational Therapy to evaluate and treat him as ordered to

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increase his strength and mobility and prevent further falls; and he would like staff to provide him with a safe environment: even floors, free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; side rails as ordered, and handrails on walls. R56's care planned interventions of a bed alarm to alert staff when he attempts to get out of bed unassisted, or so staff can assist him and prevent falls and the two quarter side rails to aide with mobility and transfers were not implemented until 07/24/2024. R56's care planned interventions of reminding him to ask for assistance; reorienting him on how to use the call light, and if necessary, toileting him to prevent unassisted attempts to go to the toilet were not implemented until 11/09/2024.

On 11/20/24 at 1:02 PM V2 (Director of Nursing) stated, initial fall assessments are done upon admission. V2 stated, if a resident has a known history of falls on admission based on information obtained from the resident, the resident's family, or the hospital this information would be including in the admission's assessment. V2 stated, any information obtained from those sources should be included on the admission or baseline care plans. V2 stated, any past medical history of fall interventions should have been incorporated in R56's care plan once he was readmitted to the facility in July 2024. V2 stated, he believes V26 (Family Member) was present and interviewed when he was admitted to the facility and possibly any available information regarding falls would have been obtained from her.

On 11/21/24 at 10:33 AM V32 (Physician) replied, yes when asked by surveyor if fall interventions should be personalized to R56's needs. V32 stated, he saw R56 soon after his arrival prior to

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his fall and V26 (Family Member) was at bedside at this time. V32 stated, he believes there was some concern with R56's neurological status related to his sarcoidosis, and this may have led to him attempting to get out of bed. V32 stated, R56 suffers from a rare illness, and it may have been difficult to anticipate his particular needs and the appropriate precautions needed to be implemented prior to him coming to the facility for the first time. V32 stated, fall interventions are a personalized approach for each patient and should be tailored to the debilities that each patient comes with.

On 11/21/24 at 11:32 AM V1 (Administrator) stated, the room R56 was located in on admission is not right near the nurses station and is towards the end of the hall. V1 stated, room R56 is currently located in is closer to the nurses station and is right outside of it.

On 11/21/24 at 12:29 PM V2 (Director of Nursing) stated, R56's bed rails were not in place when he fell 07/12/2024. V2 stated, bed rails would not be added until an assessment is done, and consents were given. V2 stated, there was no reason rails could not be applied for R56 on admission, however there was no indications if bed railings were needed or not for R56 and no information was provided by V26 (Family Member) of him needing bed railings. V2 agreed it is not necessary for V26 to initiate the use of bed railings, and railings could be used for mobility or if the staff noticed that the patient was struggling with positioning however there was nothing indicating this during the brief amount of time R56 was admitted prior to his fall.

The facility's Fall Occurrence Policy received 11/21/2024 states:

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S9999	Continued From page 9 "It is the policy of the facility to ensure that residents are assessed for risk for falls and that interventions are put in place." "A Fall Risk Assessment form will be completed by the nurse or the Falls Coordinator upon admission." "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 Minimum Data Set was done." "If a resident had fallen, the resident is automatically considered as high risk for falls. Therefore, the nurse does not have to fill out the Fall Risk Assessment to determine if the resident is high risk for falls or not, after the resident had fallen." "The Falls Coordinator will add the intervention in the resident's care plan." "The interventions will be reevaluated and revised as necessary." The facility's Care Planning Policy received 11/21/2024 states: "It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations. Based on the State Operations Manual F656 regulation a comprehensive care plan must be developed after the comprehensive assessment of the resident." "The baseline care plan at a minimum should include initial goals based on admission orders, physician orders, and therapy services." (A)	S9999		