STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057828	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Facility Reported Incident Investigation FRI of 5/9/25 IL193544	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.690b) 300.690c) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes	S9999		

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

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S9999	Continued from page 1 or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements were not met as evidenced by: Based upon interview and record review the facility failed to ensure that a descriptive summary of actual occurrence was documented in the progress notes and failed to notify IDPH (Illinois Department of Public Health) of serious injury within regulatory requirements for one of three residents (R1) reviewed for falls. R1's (5/9/25) right femur x-ray states lucency across	S9999		

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S9999	Continued from page 2 the intertrochanteric neck and lesser trochanter concerning for an acute intertrochanteric femoral neck fracture. R1'S (5/9/25) initial facility incident report states Type of Incident: Serious Injury from Known Origin. Description of what happened: (8:00am) CNA (Certified Nursing Assistant) towards the end of providing pericare to resident in bed on the last time that CNA turned the resident towards her, CNA inadvertently overturned resident's right leg. In the CNA's attempt to prevent resident from rolling out of bed, CNA turned resident's leg back to bed preventing a fall. Immediately after peri care, while resident was being dressed, resident complained of right hip pain. The Attending Physician who was in the building at that time, was informed and gave orders for an x-ray to the right femur and right knee. X-ray results showed acute right intertrochanteric femoral neck fracture. Final report to follow. IDPH was notified via email on 5/13/25 (4 days after the incident). R1's (5/9/25) final facility incident report states Type of Incident: Witnessed Fall - with injury. Upon further investigation, on 5/9/25 around 8:00am, CNA 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. The CNA reported to the Nurse. IDPH was notified via email on 5/17/25 (8 days after the incident). R1's (5/9/25) progress note states the aide witnessed resident attempting to roll off the bed and 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. [falling out of bed onto the floor was excluded]. On 6/5/25 at 11:48am, surveyor inquired about the regulatory requirement for reporting serious injuries V2 (Director of Nursing) stated "You have 24 hours from the time you get notification of the injury to report to IDPH. The follow-up is due within 5 days." Surveyor inquired about R1's (5/9/25) initial and final reports submitted to IDPH V2 responded "They was late being reported. I (V2) was not notified of a actual serious	S9999		

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S9999	Continued from page 3 injury so as soon as I found out about it, we (facility) reported it." Surveyor inquired when R1's x-ray was performed V2 replied "Actually, the x-ray was done on the 9th at like 6 or 7:00 on a Friday night" and affirmed it was on the date the incident occurred. The incident reporting policy (revised 7/31/24) states it is the policy of the facility to ensure that all reportable incidents as stipulated in the Section 300.690 state regulation, are reported to the state agency. The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. (C)	S9999		