| 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 01/04/2026 |
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| HARMONY PALOS | 11860 SOUTHWEST HIGHWAY , PALOS HEIGHTS, Illinois, 60463 |

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| S0000 | Initial Comments<br><br>Facility Reported Investigation for Incident of 9/12/25 2670226- F689, F656, F947 cited. | S0000 | | 01/16/2026 |
| S9999 | Final Observations<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210c)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. | S9999 | | 01/16/2026 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>Statement of Licensure Violations:<br><br>These regulations were not met as evidence by:<br><br>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 and failed to implement safety protocols—including the use of side rails and constant physical contact—during incontinence care. Despite R1's documented history of fractures and inability to maintain balance, the staff member left R1 unsupported, resulting in R1 rolling and falling from a high bed. This failure resulted in a sustained displaced humerus fracture, a head laceration with active bleeding requiring sterile-strips, and facial contusions.<br><br>Findings Include:<br><br>R1 is an alert and oriented predominantly Polish-speaking 84 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.<br><br>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." | S9999 | | |

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| S9999 | Continued from page 2<br><br>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.<br><br>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."<br><br>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.<br><br>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."<br><br>A post fall incident statement dated 9/15/25 taken by 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 | S9999 | | |

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| S9999 | Continued from page 3<br>to move yes I feel safer in this bed with the side rails."<br><br>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 1/2/25 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.<br><br>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 | S9999 | | |

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| S9999 | Continued from page 4<br>for her to grab onto to prevent her from rolling out of the bed.<br><br>On 1/2/25 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."<br><br>On 1/2/25 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).<br><br>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.<br><br>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 | S9999 | | |

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| S9999 | Continued from page 5<br>management, and rehabilitation. Patient to follow up with ortho outpatient. Patient was stabilized and sent back to facility."<br><br>V9 NP could not be reached for interview during this investigation.<br><br>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."<br><br>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."<br><br>(B) | S9999 | | |