STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004139	A. BUILDING: _____ B. WING _____	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HEALTH CARE CENTER	15600 SOUTH HONORE STREET HARVEY, IL 60426

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2393228/IL158856	S 000		
S9999	Final Observations Statement of Licensure Findings 1 of 2 Violations 300.610a) 300.1210b) 300.1210d)2 300.1210d)5 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents receive care consistent with professional standards of practice to prevent avoidable pressure ulcers from developing; failed to follow their policy for wound prevention by failing to provide the necessary treatment and services to prevent and promote healing of a facility developed pressure ulcer for 1 of 3 (R109) residents reviewed for pressure ulcers in the sample of 32. These failures resulted in R109 sustaining a clinical stage 3, facility-acquired pressure ulcer to the right hip. Findings include:	S9999		

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S9999	Continued From page 2	S9999		

R109 is a 81-year-old male admitted to the facility on 06/23/2022. R109 was hospitalized on 04/18/2023 and is not currently in the facility. R109 is a cognitively impaired resident with diagnosis including but not limited to: Unilateral Primary Osteoarthritis to Right Knee; Fusion of Spine to Thoracic Region; History of Falling; Spondylosis of lumbar Region; and Cognitive Communication Deficit.

MDS (Minimum Data Set) assessment dated 06/30/2022 completed upon admission, shows R109 does not present with any pressure ulcers. R109 requires extensive assistance of two+ person physical assist with bed mobility.

R109's Braden scale assessment dated 06/23/2022 reads that R109 is at moderate risk for developing pressure ulcer.

Facility records showed no care plans to prevent the development of any pressure ulcers nor was any care plan developed after the formation of the facility-acquired pressure ulcer.

Per record review, R109 has facility acquired stage 3 pressure ulcer to the right hip measuring 5.5cmx4.5cmx0.1cm".

On 4/26/2023 at 2:51 PM Surveyor interviewed V13 (Registered Nurse/ Wound Care Coordinator), V13 stated, "R109 has facility acquired wound, it was noticed on 4/12/2023. Upon initial assessment on 04/12/2023, the pressure ulcer measured 5.5cmx4.5cmx0.1cm. The family was made aware, we explained the treatment and protocol. Recommended treatment was Santyl ointment and Opti foam. R109 was able to move, so he was not enrolled in turning

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S9999	Continued From page 3 program". V13 further indicated that one of R109's interventions to prevent pressure ulcer was air mattress; however, it was ordered after his pressure ulcer was discovered. Staff also used skin barrier ointment as a standard protocol. On 4/26/2022 at 03:53 PM Surveyor interviewed V16 (Wound Care Nurse Practitioner), V16 stated, "R109 developed stage 3 pressure ulcer to right hip. It was reported to me on 04/12/2023. I measured it at 5.5cmx4.5cmx0.1cm, it was 70% necrotic at the time. I debride it and it was staged at 3. Santyl and foam dressing were prescribed to be applied daily. When I saw R109, he was laying on his right side. R109 needed assistance with repositioning and couldn't turn himself". V16 further clarified that he didn't see R109's pressure ulcer again because R109 was transferred to the hospital on 04/18/2023. "Prevention and Treatment of Pressure Injury and Other Skin Alterations" dated 04/2021 reads in part, "Identify residents at risk for developing pressure injuries. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through the individual program plan. Based on individual Braden Scale Assessment, implement measures according to the Pressure Injury/Prevention Algorithm". (B) 2 of 2 Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6	S9999		

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S9999	Continued From page 4 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 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	S9999		

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S9999	Continued From page 5 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. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and assistive devices to prevent accidental falls and injuries for two of four (R11, R109) cognitively impaired residents reviewed for accident hazards in a sample of 32. This failure resulted in R11 sustaining a left humerus (arm) fracture that required emergent transfer to the hospital for medical treatment; and R109 sustaining a head laceration that required emergent transfer to the hospital for medical treatment. Findings include: 1. R11's medical records showed he is a 65-year-old and cognitively impaired resident with a past medical history not limited to falls, gait and mobility abnormalities, difficulty in walking, lack of coordination, and weakness. R11's fall report dated 01/09/2023 showed R11 was found sitting on the floor by V18 (Licensed Practical Nurse) and he was "holding his left arm yelling out it hurt". R11 was sent emergently to the hospital and admitted on 01/09/2023. New intervention showed to round on resident at a "minimum of 2 hours". R11's orthopedic initial consult dated 01/10/2023 showed R11 was diagnosed with a left humerus	S9999		

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S9999	Continued From page 6 (arm) fracture. R11's Nurses Note dated "1/10/2023 15:05" showed R11 remained in the hospital status post fall on 01/9/22 "which resulted in the resident being admitted". R11 sustained a "displaced fracture of the distal humerus of his left arm, but no operation is needed according to the Surgical physician". On 04/25/2023 at 10:54 AM, observed R11 lying in bed, partially on his left side wearing a hospital gown. Bed position was knee high level and not low to the floor. R11 was positioned near the edge of the bed with both feet hanging off the side of bed. No fall mats were observed on the floor or within R11's room. On 04/26/23, observation period made by surveyor on 1 West and 1 East units from 09:20 AM to 11:35 AM with the following noted. At 09:25 AM, observed R11 lying in bed on his back near the edge of the bed wearing a hospital gown with both legs hanging off the side of bed from his knees down. Bed position was knee high level and not low to the floor. No fall mats were observed on the floor or within R11's room. Observed call light clipped to the bottom sheet at the head of R11's bed and not within resident's reach. At 11:30 AM, observed R11 lying in bed on his back near the edge of the bed with both legs hanging off the side of bed from the knees down. Bed position was at waist high level and not low to the floor. Observed call light clipped to the bottom sheet at the head of R11's bed and not within resident's reach. On 04/26/2023 at 1:40 PM V9 (Restorative Nurse) said R11 is a fall risk due to history of falls and behaviors. V9 said R11 was placed on	S9999		

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S9999	Continued From page 7	S9999		

"2-hour rounding after the fall in January". She added that R11 was placed in a "high low bed to the ground when in bed, or as low as it will go". V9 then said, "as a team, we double check staff are checking on all residents, especially high fall residents every two hours" and R11 does not have fall mats due to "how his room is, and res has been okay without them".

On 04/26/2023 at 3:58 PM, V18 (Licensed Practical Nurse) said she was working the day of R11's fall incident. V18 said when she entered R11's room, he was sitting on the floor holding his arm and complained of left arm pain. V18 then said upon assessment, R11's left arm was "deformed looking" so she called the physician who ordered a "stat" (immediately) x-ray of his arm. V18 added that the x-ray results showed a fracture and R11 was sent "911" (emergent) to the hospital.

On 04/26/2023 at 04:20 PM, V25 (Certified Nursing Assistant) said on the day of R11's fall, she went to his room and saw him sitting in a chair. V25 said that she told R11 she needed to weigh him but needed to get someone to help stand him up. V25 said when she returned to the room with V18 (Licensed Practical Nurse), R11 was sitting on the floor and holding his left arm and said he fell. V25 was unable to identify any fall preventions for R11.

R11's quarterly fall risk assessment dated 2/09/2023 showed R11 to be "at risk" for falls.

R11'S fall care plan dated 02/22/2023 reads in part: R11 is at risk for falls related to history of falls with interventions to assure he is in view of staff when out of bed (12/22/2020), promote placement of call light within reach (11/21/2017),

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S9999	Continued From page 8 round on resident at a minimum of 2 hours, toileting and offering him snacks and water (01/10/2023). No staff were observed entering R11's room or rounding on him during surveyor's observation period on 04/26/2023 from 09:20 AM to 11:35 AM on 1 West. 2. R109 is an 81-year-old male admitted to the facility on 06/23/2022. R109 was hospitalized on 04/18/2023 and is not currently in the facility. R109 is a cognitively impaired resident with a history of falls and diagnosis listed in part with: Unilateral Primary Osteoarthritis to Right Knee; Fusion of Spine to Thoracic Region; History of Falling; Spondylosis of lumbar Region; and Cognitive Communication Deficit. R109's fall risk assessment dated 2/28/2023 showed R109 to be "at risk" for falls. On 04/18/2023 R109 was found on the floor by the staff with bleeding to the face. V109 was sent to the hospital on 04/18/2023 and diagnosed with a laceration to the forehead that required stitches. Hospital records dated 04/18/2023 read in part, "R109 seen on 04/18/2023, Upon emergency department arrival noted laceration to the forehead and previous lacerations from other falls. Assessment and plan: History of fall; forehead laceration, stitched". On 04/24/2023 at 11:00 AM Surveyor interviewed V23 (R109's family member), V23 said that whenever he came to visit R109 the bed was 2.5 - 3 feet off the ground and no fall matts were present on the floor.	S9999		

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S9999	Continued From page 9 On 04/26/23 at 12:23 PM Surveyor interviewed V9 (Registered Nurse/Fall Coordinator). V9 said that R109 had two most recent falls. V9 stated, "I investigated both of R109's falls on 04/16/2023 and 04/18/2023, both were unwitnessed. On 4/16/2023 he was trying to transfer from the wheelchair into the bed and ended up falling. R109 was sent out to the hospital for further evaluation; he suffered abrasion to the face. The second fall was on 4/18/2023. R109 attempted to reposition himself in the bed and had fallen out of bed. R109 suffered laceration on the forehead. Staff provided wound care and sent R109 out to the hospital". On 04/27/2023 at 01:46 PM Surveyor interviewed V24 (Licensed Practical Nurse), V24 stated, "R109 fell in the evening on April 16th, 2023. He just used a washroom and we put him back in the wheelchair. Shortly after, I was passing evening medications and I found him on the floor. I assessed R109 and put him back in the wheelchair. R109's right eyebrow had some bleeding, I put pressure onto the wound and 911 was called. R109 went to the hospital, where he received 4 sutures and was brought back to the facility on the same day. I immediately called V22 (R109's family member) and told him what happened. I called V22 again when I got an update from the hospital. On April 18th, 2023, R109 was sleeping during my morning rounds. As I was passing morning medications, the CNA came to me and told me that R109 fell again. I went to the room and saw R109 laying on the floor. His face was laying on the nightstand. R109's right eyebrow reopened, and he had additional cut on the right cheek. I called 911 again and R109 was send to the hospital. I called the V22 again to notify him of the incident".	S9999		

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S9999	Continued From page 10 R109'S fall care plan dated 07/05/2022 reads in part, "Monitor for changes in gait or ability to ambulate; Monitor resident for tolerance and endurance; Use proper fitting, non-skid footwear". Care plan did not include any additional interventions previous to the falls that R109 suffered on 04/16/2023 and 04/18/2023 even though R109 was cognitively impaired and assessed as a fall risk resident. On 04/26/23 12:23 PM V9 (RN/Fall Coordinator), "I investigated both falls on 04/16/2023 and 04/18/2023, both were unwitnessed falls. The resident had to be redirected multiple times, on 4/16/2023 he was trying to transfer form his wheelchair into the bed and ended up falling. He was evaluated, vitals were done. He did not call for help. His wheelchair was locked. When resident was in bed, they were fall matts. DON, guardian and MD was notified. He was sent out to the hospital for further evaluation. He suffered abrasion to the face. The second fall was on 4/18/2023. The resident attempted to reposition himself in the bed and had fallen out of bed. He did not call for help. Staff assessed him and assisted him back to bed. Resident suffered laceration on the forehead. Staff provided wound care and sent out to the hospital. Fall mats were paced on the floor, bed was in the lowest position and call light was within resident's reach". Management of Falls policy dated 08/2020 reads in part the following: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall	S9999		

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S9999	Continued From page 11 incidents and/or injuries to the resident. Procedure: 3. Develop a plan of care to include goals and interventions which address resident's risk factors. 4. Provide assistive devices for mobility, hearing and vision as appropriate for resident. 6. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. Routine Resident Checks policy dated 09/2020 reads in part the following: Policy Interpretation and Implementation: 1. To ensure the safety and well being of our residents, a resident check will be made at least every two (2) hours throughout each 24-hour shift by nursing service personnel. 2. Routine resident checks involve entering the resident's room to determine if the resident's needs are being met. On 04/26/2023, facility presented a two page in-service attendance record dated 04/25/2023 for "Falls and Fall Interventions". (B)	S9999		