Illinois Department of Public Health

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 ______	C 07/11/2021

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

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S 000	Initial Comments Complaint Investigation: 2194119/IL134903	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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.	S9999		

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to safely supervise a resident who fell in his room and was left unsupervised and fell a second time. This failure resulted in R2 found on the floor in his room lying on his right side and sustained a right hip fracture requiring surgical intervention. This applies to 1 of 5 residents (R2) reviewed for safety in the sample of 5. The findings include: On July 9, 2021 at 10:15 AM, R2 was lying in his bed and complained of right hip pain. R2 said he "had a fall on my right hip". R2's Physician Order Sheets dated through July 2021 shows he has diagnoses including fracture of the right femur, contusion of the right shoulder, contusion of the scalp, weakness and dementia. The Minimum Data Set assessment dated May 13, 2021 shows R2's cognition is moderatly impaired and R2 requires assistance with transfers and walking. The Fall Risk Assessment dated June 9, 2021 shows he is at risk for falls related to decreased mobility, post fall, impaired memory/judgement, and history of falls within the past 3 months.	S9999		

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S9999	Continued From page 3	S9999		

R2's current care plan shows he is at risk for falls related to dementia and use of psychotropic medications with interventions including to monitor for safety and ensure resident has a wheelchair.

R2's Fall report dated June 10, 2021 documents V4 (LPN) was called to R2's room by staff. R2 was observed on the floor next to his bed. R2 was alert and responsive, denies pain and range of motion to his upper and lower extremities. R2 was assisted to the wheelchair by staff. Injuries observed at time of incident include a hematoma to the top of the scalp and abrasion to the right arm. Mental status "disoriented." The same report documents "no injuries."

R2's Final Incident report dated June 18, 2021 documents per interviews with staff on June 10, 2021 around 11:00 AM, R2 was observed laying on his left side in his room after an unwitnessed fall. A complete body assessment was done and R2 was noted to have a hematoma to the left side of his forehead ....Range of motion to all extremities with no complaints of pain. R2 was sent to the local hospital for further evaluation due to his hematoma ... ...Facility later received a call from the hospital stating he required emergency orthopedic surgery due to a right hip fracture.

R2's Nursing Home to Hospital Transfer form dated June 10, 2021 documents R2's reason for transfer states, "Fall."

On July 9, 2021 at 11:47 AM, V5 (CNA) said on June 10, 2021 she was in R2's room sitting with his roommate (R4) when R2 got up out his bed unassisted and fell on the floor. V5 said R2 was lying on the floor on his left side. V5 said she

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S9999	Continued From page 4 called for help and V6 (CNA) came. V5 said V6 helped her transfer him into the chair. V5 said she left the room to get bed sheets for R2 because his bed sheets were soiled with urine. V5 said V6 remained in the room with R2 and R4. V5 said when she came back into the room R2 was on the floor again. He was lying on his right side on the floor. V5 said he was bleeding from his right elbow and had a bump to the right side of his head. V5 said they transferred him into the chair and "R2 could not stand up straight." On July 9, 2021 at 12:45 PM, V6 (CNA) said on June 10, 2021, V5 called for help because R2 had a fall and was on the floor. V6 said she helped V5 transfer R2 into the chair. V6 said V5 left the room to get new bed sheets for R2. V6 said R2 was trying to get up from the chair and she was holding down the chair to keep him from getting up. V6 said " I thought (R2) was okay" and she left R2 in the chair to change R4's (R2's roommate) incontinent brief. V6 said she heard a noise and pulled the privacy curtain and saw R2 rocking in the chair side to side. V6 said then R2 fell over in the chair and landed on his right side. V6 said R2's right side of the head hit the dresser. On July 9, 2021 at 12:00 PM, V4 (LPN) said on June 10, 2021 the CNA called me down to the R2's room because he fell. V4 said when she entered the room and R2 was on the floor lying towards his right side. V4 said R2 had a hematoma to the right side of his forehead. V4 said she notified the nurse practitioner and he was transferred to the local hospital. V4 said it was reported to her R2 had a fall the previous day and is a fall risk. On July 9, 2021 at 8:26 AM, V7 (RN) said	S9999		

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S9999	Continued From page 5 residents who are a fall risk should be monitored closely. If a resident has a fall staff should remain with the resident for safety until the nurse comes to assess the resident. On July 9, 2021 at 10:48 AM, V2 (DON) said R2 was sent to the hospital on June 10, 2021 for a fall. V2 said he was admitted with a hematoma and sepsis. V2 said the hospital called and said R2 had a fall at the hospital and sustained a hip fracture. V2 said she did not have any evidence R2's fall was at the hospital. V2 said residents at risk for falls should be monitored for safety. R2's hospital records dated June 10, 2021 shows he was admitted to the hospital with diagnoses including fall at nursing home, scalp hematoma, sepsis and pneumonia. R2's CT Head report dated June 10, 2021 shows right frontal tissue swelling. R2's hospital consultation note dated June 11, 2021 documents R2 presented to the hospital following an unwitnessed fall at the nursing home. R2 reports pain to the right hip and shoulder since the fall, R2 has significant pain to right hip and points to the distal femur as well. Right shoulder with bruising and pain with range of motion to the right lower extremity ... .unwitnessed fall at nursing home associated with a right femoral neck fracture ....and required surgical intervention. R2's X-ray report dated June 11, 2021 shows a right femoral neck fracture with overlap and varus angulation. The facility's Management of Falls Policy dated August 2020, states, "The facility will assess	S9999		

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S9999	Continued From page 6 hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions and revise the residents plan of care in order to minimize the risks for all fall incidents and/or injuries to resident. (A)	S9999		