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 04/25/2022

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 FRI of 3/11/2022\IL144944	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 3001210c) 300.1210d)6) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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 implement fall risk interventions for a resident assessed to be at risk for falls, by not maintaining the resident's bed in the lowest position to minimize the risk of injury. This failure applied to one (R2) of four residents reviewed for accidents and resulted in R2 being hospitalized after a fall, for obtaining a cervical spine injury and brain concussion. Findings include: R2 is a 98- year- old male who was admitted to the facility on 8/1/2021, with the following past medical history; chronic obstructive pulmonary disease, dementia in other diseases classified elsewhere with behavioral disturbance, undeferential schizophrenia, essential primary	S9999		

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S9999	Continued From page 2 hypertension, peripheral vascular disease, unspecified injury of right wrist, abnormal weight loss, hyperlipidemia, personal history of pulmonary embolism, etc. R2 had an unwitnessed fall on 3/11/2022 and was sent to the hospital for evaluation. Hospital record dated 3/12/2022 states; This is a 98-year-old gentleman who was admitted to the hospital with unwitnessed fall sustaining traumatic type 11 atlantoaxial rotatory fixation along with facial contusion, now with acute encephalopathy due to brain concussion. Fall risk assessment dated 9/03/2021 scored R2 as an 8 (at risk for fall). Care plan initiated 5/15/2017 states that R2 is noted to be at high risk for falls related to muscle weakness, dementia, use of medication, etc. Fall interventions include always have bed in lowest position while resident is in bed, floor mats while in bed, rounding at a minimum of every 2 hours and prompt, or assist for change in position, reposition away from side rails, etc. Minimum Data Set (MDS assessment dated 12/1/2021 section C (Cognitive) coded R2 with a BIMs score of 00, section G (Functional status) coded R2 as extensive assist with one staff physical assist for all ADL care, and total dependence for bed mobility and bathing. Progress note dated 3/11/2022 documented by V6 (LPN) state the following: Resident was discovered on the floor during rounds assessment revealed swollen face. Further documentation the same day states, Writer called hospital regards to resident admission, The ER Nurse confirmed that resident was admitted With Diagnosis of Contusion.	S9999		

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S9999	Continued From page 3	S9999		

4/19/2022 At 1:38PM, V6 (LPN) said that he recalls R2, he had many falls, but he was the assigned nurse for the last one that resulted in him being sent out to the hospital. V6 said that R2 fell around 5:00AM on that day while he was doing medication pass, the C.N.A informed him that R2 was on the floor. Upon assessment, R2 had a swelling to the left side of his face and could not open his left eye, V6 called the Nurse Practitioner (NP) and got an order to send resident to the hospital. V6 added that R2 is a fall risk, is bed bound and his bed is supposed to be on the lowest position, he cannot recall if he had a floor mat, he might have been on a manual bed because the bed was not super low, was probably up to the knee. V6 said that he saw R2 probably three hours before the fall, he followed up with the hospital and was told that R2 was still under evaluation but would be admitted.

4/19/2022 at 12:59PM, V5 (Maintenance Director) said that the facility has two types of beds, the manually operated and the electric ones, the manual ones stay about 1 foot 25 inches from the ground and that is as low as they can get. V5 was asked what happens to residents that are fall risk and he said that all residents at risk for fall are not supposed to be on the manual bed, they usually put them on the low/electric beds, those ones can go all the way to the ground.

4/20/2022 at 11:42AM, V13 (C.N.A) said that she remembers R2, the day he fell, she did her round 3:30AM, R2 was in the middle of his bed. When she started her final round around 4:00 to 4:30AM, she found R2 on the floor, his bed was not all the way down, it was about the height of her knee. She called the nurse and they helped the resident back to his bed. V13 changed R2 and noted swelling to right side of his face. V13

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S9999	Continued From page 4 said that she saw R2 at about 1:30AM and his bed was not down to the floor at that time either. V13 stated that maybe someone from second shift left it like that, she did not lower the bed, she thought it must have been left like that for a reason. V13 continued to state that R2 might have been a fall risk but she was not too sure; the nurse was supposed to be rounding too, so he could have lowered the bed if he thought it was too high. 4/19/2022 at 2:41PM, V9 (Restorative Nurse) said that a bed can be as low as knee high, but for a fall risk resident, it should not be that high, bed is expected to be in the lowest position and residents are supposed to be checked on every 2 hours and repositioned as needed. 4/20/2020 at 11:00AM, V2 (DON) said that residents that are fall risks have electric beds and they should be down to the floor. R2 was a fall risk, he had a low/electric bed and one of his fall interventions was for the bed to be on the lowest position and floor mat when in bed. Document presented by V2 (DON) titled, Management of Falls (dated 08/2020) states: 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 to minimize the risks for fall incidents and/or injuries to the resident. Under procedure, the document states: assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. (A)	S9999		