STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145173	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Health Care Center	15600 South Honore Street Harvey, IL 60426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to notify a physician of a resident (R2) fall until about six hours later when R2 began complaining of new pain for one out of three residents reviewed for physician notification in a total sample of three. Findings Include: R2 is a [AGE] year old with the following diagnosis: history of falling, muscle weakness, and multiple fracture to the right ribs. A Nursing note dated 11/13/24 at 1:11PM documents the nurse was notified by the wound care aide that R2 was complaining of exaggerated pain to the right side. R2 stated while being transferred to the wheelchair during the morning get up, balance was lost and subsequently R2 fell to the floor. The nurse was not aware of the incident prior to R2 reporting it. The nurse practitioner was notified and sent R2 out for further evaluation. A Nursing note dated 11/13/24 at 8:41PM documents R2 returned back from the hospital with a diagnosis of closed fracture of multiple ribs. The Hospital Records dated 11/13/24 document R2 came to the hospital with a chief complaint of fall. R2's emergency department diagnosis is listed as close fracture of multiple ribs, unspecified laterality. The x-ray of the ribs documents there are questionable fractures involving the interior aspect of ribs eight, nine, and ten on the right. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 1:58PM, R2 stated R2 had a fall last month while being transferred causing R2 to break ribs on the right side. R2 was not aware how many of the ribs were fractured. R2 reported a CNA (V8) tried to transfer R2 from the bed to the wheelchair but dropped R2 and R2 fell on the floor next to the bed. R2 reported R2 has the left arm and leg locked due to arthritis so R2 can stand and pivot to the wheelchair only. R2 stated R2 normally will talk the staff members through how to properly transfer R2 but V8 refused to listen to R2. R2 reported R2 sat on the side of the bed and V8 grabbed R2 under the left arm to stand R2 up. R2 said, It happened so fast. I don't really know what caused the fall, but I was up then I was down on the floor. R2 denied being slid down V8's leg and denied asking to be put on the floor. R2 stated when R2 began falling, V8 let go it R2. R2 denied having pain right away but told a staff member a couple hours later R2 began to feel pain in the side. R2 reported V8 and another staff member (V10 - CNA) got R2 back up in the wheelchair after the fall. R2 mental status was assessed and R2 reported the location, type of building, president, and R2's birth date correctly. R2 stated the date was 12/2/24. On 12/4/24 at 11:36AM, V8 (CNA) stated V8 went to get R2 up for the day around 5AM. V8 reported during a transfer R2's leg began to spasm and R2 requested to be lowered to the floor. V8 stated V8 then went to get another CNA to get R2 up off the floor. V8 reported after R2 was back in the wheelchair, V8 told V11 (Nurse) that R2 was lowered to the floor. V8 stated a nurse should be made aware of a fall as soon as it happens. On 12/4/24 at 11:50AM, V9 (Nurse) stated around 12PM a wound tech told V9 that R2 was complaining of pain to the right side. V9 reported assessing R2 and R2 told V9 that R2 fell in the morning but did not report it earlier because R2 did not want to get anyone in trouble. V9 stated V13 (DON), V1 (Administrator), and V14 (Nurse Practitioner) were notified immediately of what happened. V9 reported V14 ordered R2 be sent to the hospital for evaluation and fracture were discovered on x-ray. V9 stated R2 normally has pain but has never complained of side pain before. V9 reported a physician needs to be notified of a fall so they can decide what to do with their care. On 12/4/24 at 2:04PM, V10 (CNA) stated V8 asked V10 for assistance getting R2 off the floor because R2 needed to be slid down to the floor during a transfer. V10 reported entering R2's room and R2 was lying in the ground. V10 stated V10 and V8 picked R2 up under the arms and got R2 back into bed. V10 denied telling a nurse about the fall because V10 assumed V8 already told a nurse. V10 reported falls need to be reported the nurse immediately so they can assess for any injuries. On 12/4/24 at 2:18PM, V11 (Nurse) stated V8 told V10 that R2 almost fell and was slided to the floor during a transfer. V10 reported going into R2's room and R2 was sitting in a wheelchair and only complained of R2's normal pain. V11 stated V8 nor R2 used the word fall when describing the incident. V11 reported was not aware at the time but this incident should have been considered a fall at the time it happened because R2 went down to the floor. V11 stated even though V8 slid R2 down to the floor it still needed to be considered a fall. V11 reported a physician and the DON need to be notified of a fall immediately after it occurs so they can tell the nurse what needs to be done next. On 12/5/24 at 9:49AM, V13 (DON) stated by definition a change in plane is considered a fall so this incident should have been considered a fall by staff and reported. V13 reported staff that were present at the time of the incident didn't consider what happened to be a fall so it was not reported immediately. V13 stated this incident happened in the sometime in the early morning hours of the night shift (5AM-6AM) and it was reported to V14 around 12PM when R2 began complaining of pain. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 5:01PM, V14 (Nurse Practitioner) stated V14 was not notified right away because staff did not considered the incident to be a fall at first. V14 reported R2 made contact with the floor so this should have been considered a fall from the time it happened. V14 stated once R2 began complaining of pain and explained the incident then V14 was notified what happened by staff. V14 reported V14 should be notified of a fall immediately to determine what course of treatment needs to be provided to the resident. The Care Plan dated 11/13/24 documents R2 at risk for injury: a fall occurred. Interventions include to assess R2 to identify any injuries from the fall and to follow facility post fall policy regarding monitoring for signs and symptoms of injury. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score as 15 (no cognitive impairment). Section GG of the MDS indicates R2 has upper and lower extremity impairments on both sides and uses a wheelchair. R2 needs substantial/maximal assistance for bed mobility and transfers. This means the helper does more than half the effort. The helper lifts or hold the trunk or limbs and provides more than half of the effort. Per V1, the facility does not have a post fall policy staff can reference for what steps to take after a fall.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to utilize a gait belt during a transfer for a resident (R2) that requires substantial/maximum assistance for one out of three residents reviewed for falls in a total sample of three. This failure resulted in R2 suffering three fractured ribs after falling to the floor during the transfer. Findings Include: A Nursing note dated 11/13/24 at 1:11PM documents the nurse was notified by the wound care aide that R2 was complaining of exaggerated pain to the right side. R2 stated while being transferred to the wheelchair during the morning get up, balance was lost and subsequently R2 fell to the floor. The nurse was not aware of the incident prior to R2 reporting it. The nurse practitioner was notified and sent R2 out for further evaluation. A Nursing note dated 11/13/24 at 8:41PM documents R2 returned back from the hospital with a diagnosis of closed fracture of multiple ribs. The Hospital Records dated 11/13/24 document R2 came to the hospital with a chief complaint of fall. R2's emergency department diagnosis is listed as close fracture of multiple ribs, unspecified laterality. The x-ray of the ribs documents there are questionable fractures involving the interior aspect of ribs eight, nine, and ten on the right. On 12/3/24 at 1:58PM, R2 stated R2 had a fall last month while being transferred causing R2 to break ribs on the right side. R2 was not aware how many of the ribs were fractured. R2 reported a CNA (V8) tried to transfer R2 from the bed to the wheelchair but dropped R2 and R2 fell on the floor next to the bed. R2 reported R2 has the left arm and leg locked due to arthritis so R2 can stand and pivot to the wheelchair only. R2 stated R2 normally will talk the staff members through how to properly transfer R2 but V8 refused to listen to R2. R2 denied a gait belt was used during the transfer. R2 reported R2 sat on the side of the bed and V8 grabbed R2 under the left arm to stand R2 up. R2 said, It happened so fast. I don't really know what caused the fall, but I was up then I was down on the floor. R2 denied being slid down V8's leg and denied asking to be put on the floor. R2 stated when R2 began falling, V8 let go it R2. R2 denied having pain right away but told a staff member a couple hours later R2 began to feel pain in the side. R2 reported V8 and another staff member (V10 - CNA) got R2 back up in the wheelchair after the fall. R2 mental status was assessed and R2 reported the location, type of building, president, and R2's birth date correctly. R2 stated the date was 12/2/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/4/24 at 11:36AM, V8 (CNA) stated V8 was working the night shift and was getting R2 up around 5AM. V8 reported R2 needs a one person assist and is able to stand and pivot to the wheelchair. V8 stated V8 got R2 sitting up on the side of the bed and had R2 stand up and go to pivot to the wheelchair which was placed next to the bed. V8 reported while R2 was pivoting, R2 got leg spasms and could no longer move. V8 stated V8 asked R2 if R2 wanted to be set back down on the bed or on the floor, and R2 said R2 wanted to be set down onto the floor. V8 stated V8 slid R2 down V8's leg and laid R2 down on the floor. V8 reported going to get another CNA to help R2 up off the floor. V8 stated V8 then told V11 (Nurse) what happened. V8 reported R2 is alert and oriented times three. V8 stated both CNA's got R2 up off the floor by picking R2 up under R2's arms. V8 reported a gait belt should be used with every transfer. V8 stated a gait belt should be placed snuggly around the resident's lower chest area and the finger method should be used to test if it is on tight enough. V8 denied R2 reporting any pain after being lowered to the floor. The surveyor then asked how R2 ended up with fractured ribs if R2 was gently lowered to the floor, and V8 was unable to answer this question. When the surveyor asked V8 to describe a step-by-step process of how R2 was transferred that day the eight did not mention putting on a gait belt. The surveyor had to directly ask if a gait belt was placed on R2 to which V8 replied, yes. On 12/4/24 at 11:50AM, V9 (Nurse) stated a wound care aid reported to V9 that R2 was having pain on the side. V9 reported V9 went to assess R2 and R2 told V9 that R2 had a fall, but R2 did not want to report it earlier because R2 did not want to get anyone in trouble. V9 denied asking R2 what happened during the incident. V9 reported immediately telling V13 (DON) and V1 (Administrator) what R2 told V9. V9 stated V14 (Nurse Practitioner) was then called and R2 was sent out to the hospital for an x-ray. V9 reported R2 did have fractures per the hospital. V9 stated R2 first reported the pain around 12 PM. V9 reported R2 normally complaints of leg pain but pain on the side is new onset pain. V9 stated or two is alert and oriented times three and has the ability to verbalize what happened during the incident. V9 denied being notified by any staff from the previous shift that R2 fell . On 12/4/24 at 12:00PM, V8 then called the surveyor back on the phone and reported that R2 did not have a gait belt on during the fall. V8 stated R2's leg began giving out, and V8 tried to slide R2 down to the floor as best as V8 could. V8 reported staff are always supposed to use a gait belt when transferring residents. V8 was not able to answer why a gait belt was not used during this transfer. On 12/4/24 at 2:04PM, V10 (CNA) stated V10 did not witness the fall, but V8 came to ask V10 to assist with getting R2 back into the wheelchair. V10 reported R2 was lying on the floor when V10 entered the room. V10 stated both CNA's (V8 and V10) picked R2 up under the arms and got R2 back into the wheelchair. V10 denied R2 stating how the fall happened and V10 denied asking how the fall occurred. V10 reported V8 only told V10 that R2 asked to be laid on the floor during the transfer. V10 stated a gait belt should be used for any transfer for safety reasons. V10 reported R2 is a one person assist with transfers and is not able to walk. V10 stated when R2 returned from the hospital, R2 had fractured ribs. V10 denied R2 having a gait belt on when V10 first entered the room. On 12/4/24 at 2:18PM, V11 (Nurse) stated V8 reported to V11 that R2 almost had a fall. V11 reported going to check on R2 and R2 was sitting in the wheelchair when V11 entered the room. V11 stated R2 told V11 that R2 got weak in the legs and R2 told V8 to sit R2 on the floor. V11 reported R2 was given scheduled pain medication at that time but did not report any other pain. V11 denied V8 or R2 using the word fall when describing what happened. V11 stated anytime a resident is on the floor, it is to be considered a fall. V11 reported V13 educated V11 on this topic. V11 denied V8 or R2 telling V11 that a gait belt was not being used during the transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/4/24 at 2:25PM, V12 (Wound Care Nurse) stated R2 did not report any pain during wound care treatments that morning. V12 reported the wound care aid was doing rounds in the afternoon when R2 reported pain on R2's side. V12 stated this information was reported to V9, and V9 handled it from there. On 12/5/24 at 9:49AM, V13 (DON) stated during the investigation, the wound aid told V9 that R2 was complaining of pain on R2's side. V13 reported interviewing R2 and R2 told V13 that R2's left leg started giving out so V8 slid R2 down V8's leg onto the floor. V13 stated V8 told V13 that R2 was having leg spasms and V8 slid R2 to the floor per R2's request. V13 stated V8 got another CNA to get R2 up off the floor and then told V11 what happened. V13 reported later R2 did complain of pain for the next shift. V13 stated within the past couple days V8 admitted to the administrator that a gait belt was not being used during the transfer. V13 reported gait belts are part of the CNA uniform and should be worn at all times during their shift. V13 stated staff should never transfer any resident without a gait belt because it is easier to control the resident if something happens if the gait belt is on. On 12/5/24 at 5:01PM, V14 (Nurse Practitioner) stated V14 was told that R2 was lowered to the floor as R2 was being transferred. V14 denied that facility staff notified V14 that a gait belt was not being used during the transfer. V14 reported the hospital x-ray report showed R2 had possible rib fractures so the actual imaging was requested but the hospital has not sent over that imaging yet. V14 stated all residents must have their gait belts on when being transferred for resident's safety. V14 said, That is like CNA 101, when asked when should a resident be wearing a gait belt during transfers. A Nursing note dated 11/18/24 documents R2 is alert and oriented to person, place, and situation with a BIMS score of 15. R2 requires partial to moderate assistance with the wheelchair. R2 reported that while being transferred to the wheelchair, R2 lost balance and fell to the floor on the previous shift. R2 reported pain to the right flank area it was given pain medication and an ice pack. The physician was notified and sent to the hospital. R2's fall is being investigated for increased weakness. A new intervention is to have therapy evaluate and ensure gait belt is used during transfers. The Final Incident Report dated 11/18/24 documents R2 reported being transferred to the wheelchair when R2 begin to have leg spasms and the leg started to give out. R2 stated that because of this the CNA (V8) attempted to lower R2 to the floor, which caused an unintentional change in plane resulting in a fall. Per V8, R2 was unable to assist with the transfer as typical and began having leg spasms. As a result of R2 not being able to continue to assist with the transfer, V8 had to lower R2 to the floor. It is coded that R2 require substantial/maximal assist, which was the type of assistance given at the time of the transfer. R2 has not had any previous falls involving a transfer. R2's fall is attributed to gait imbalance, and anticipated change in the ability to transfer and weakness. A head to toe assessment was completed after R2 complained of pain to the right link area. R2 was sent to the emergency department for x-rays and returned with a diagnosis of right intercostal rib fracture. The Fall Risk assessment dated [DATE] document score of a five indicating R2 is at risk for falls but not considered a high fall risk. A score of 12 or higher indicates a high fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Restorative Nursing assessment dated [DATE] documents R2's priority restorative programs are transfers and bed mobility/walking. The transfer program indicates the goal is R2 will tolerate staff assistance into getting in and out of the wheelchair. R2 has maintained the ability to perform ADLs. There is no documented decline in R2's mobility. The Care Plan dated 4/18/23 documents R2 has an ADL self-care performance deficit secondary to weakness, being a fall risk, pain due to leg wound, and history of falls. An intervention includes to provide the needed level of assistance and support to complete activities of daily living. This care plan also documents R2 is at risk for falls secondary to history of falls, weakness, bilateral lower extremity wounds, pain, and poor balance. R2 requires assistance from staff for transfers due to decrease muscle strength and weakness. Interventions include to explain the task prior to starting. Give simple step-by-step directions for transfer to assist R2. R2 will stand pivot and transfer with maximum assist from the bed to the wheelchair. The intervention documented after the fall on 11/13/24 is to place the gait belt under the fractured ribs. The Care Plan dated 11/13/24 documents R2 at risk for injury: a fall occurred. Interventions include to assess R2 to identify any injuries from the fall and to follow facility post fall policy regarding monitoring for signs and symptoms of injury. The Care Plan dated 11/14/24 documents R2 has limited transfer skills. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score as 15 (no cognitive impairment). Section GG of the MDS indicates R2 has upper and lower extremity impairments on both sides and uses a wheelchair. R2 needs substantial/maximal assistance for bed mobility and transfers. This means the helper does more than half the effort. The helper lifts or hold the trunk or limbs and provides more than half of the effort. The policy titled, Management of Falls, dated 08/2020 documents, .6. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. The policy titled, Gait Belt/Transfer Belt, documents, To assist with a transfer or ambulation. A gait belt will be used with weight bearing residents who require hands on assistance .2. The gait belt is securely clasped around the resident's waist unless contraindicated. The policy titled, Transfer Techniques, dated 02/2022 documents, Purpose: To safely transfer the resident from bed to chair or from one location to another. Transfer from bed to wheelchair .5. Have resident sit on the edge of the bed with feet crossed and resting on the floor. He/she may use this as an opportunity to practice sitting balance. Put on gait belt and shoes .7. Place gait belt around resident's waist unless contraindicated.