

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2025
NAME OF PROVIDER OR SUPPLIER  Heather Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34072</p> <p>Based on observations, interviews, and record reviews, this facility failed to follow its abuse policy and keep its residents free from abuse. This failure resulted in two residents (R2 and R3) having in a verbal altercation that escalated to a physical altercation before staff intervention out of three residents reviewed for abuse in a sample of 3. R3, with a history of physical aggression, hit R2 in the left eye with his fist. R2 sustained a laceration, bruising, and swelling to left eye.</p> <p>Findings include:</p> <p>On 4/16/25 at 2:30 PM, R2 was observed to have left eye swollen shut with ecchymosis (bruising), abrasions above and below left eye.</p> <p>On 4/16/25 at 2:30 PM, R2 stated that R3 has always given him problems. R2 stated that he was getting some more juice after lunch on 4/10, and R3 started yelling at him that he can't have more juice. R2 stated that he told R3 he wasn't the boss. R2 stated that he figured R3 wanted more juice so he threw his cupful of juice on R3 with his right hand. R2 stated that R3 then hit him in the left eye.</p> <p>On 4/16/25 at 1:00 PM, R3 stated that on 4/10 he was sitting outside dining room by the windows. R3 stated that he just finished eating lunch. R3 stated that staff had moved meal carts and drink cart out of dining room and placed them near where he was sitting. R3 stated that R2 had just finished his lunch and self-propelled in wheelchair to the drink cart. R3 stated that the CNA (certified nurse aide) informed R2 not to get drink by himself from cart. R3 stated that R2 started cussing at CNA. R3 stated that he observed R2 spilling drink onto floor while pouring it into his cup. R3 stated that he told R2 to be careful because he was spilling juice on floor. R3 stated that R2 started cussing at him. R3 stated that R2 then threw his cup of juice at his face and upper chest. R3 stated that he reacted by swinging left fist and hitting R2 in the face. R3 stated that staff separated them.</p> <p>On 4/17/25 at 10:50 AM, V5 LPN (licensed practical nurse) stated that V5 heard a commotion while in a resident's room. V5 stated that V5 exited the resident's room to see what was happening and heard R3 state why you threw that on me to R2. V5 stated that R3 had hit R2 prior to her exiting the resident's room. V5 stated that when she came out R2 was moving back in his wheelchair so she pulled him further away from the situation. V5 stated that both residents went to their rooms. V5 stated that R2 informed her that R3 hit him because he threw juice on R3. V5 observed R2's left eye swollen and with laceration below the eye.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 11:10 AM, V7 CNA stated that V7 was assigned to R3 on 4/10/25. V7 stated that V7 was providing care to another resident, did not hear anything.</p> <p>On 4/17/25 at 11:20 AM, V6 CNA stated that V6 was assigned to R2 on 4/10/25. V6 stated that V6 was providing care to another resident, did not hear anything.</p> <p>On 4/17/25 at 1:20 PM, V4 (housekeeping) stated that on 4/10/25 V4 was cleaning the residents' dining room. V4 stated that V4 heard R3 telling R2 not to mess with the food carts. V4 stated that V4 observed R2 getting juice off of the cart. V4 stated that V4 observed R2 throw cup of juice at R3. V4 stated that R3 hit R2 in the eye. V4 stated that afterwards R3 went his way. V4 stated that the nurse was passing medications to another resident at the time of the incident.</p> <p>R2:</p> <p>R2's BIMS (brief interview of mental status), dated 2/3/25, notes R2's score is 15 out of 15. R2 is cognitively intact and able to make needs known.</p> <p>R2's risk assessment, dated 11/9/24, notes R2 has a history of abuse towards someone.</p> <p>R2's medical record notes R2 with history of verbal and physical aggression as evidenced by: on 7/15/23, R2 was involved in a verbal altercation with peer. On 9/23/24, R2 was exhibiting socially inappropriate behavior. On 9/27/24, R2 threatened physical aggression and was verbally aggressive to staff member.</p> <p>R2's abuse care plan, initiated 3/28/2023, notes R2 is at risk for abuse related to a diagnosis of major depressive disorder and history of verbal aggression. On 4/10/25, R2 was involved in an altercation, conflict with a peer. On 9/27/24, R2 threatened physical aggression and was verbally aggressive with a staff member.</p> <p>R3:</p> <p>R3's BIMS (brief interview of mental status), dated 3/21/25, notes R3's score is 15 out of 15. R3 is cognitively intact and able to make needs known.</p> <p>R3's risk assessment, dated 3/9/25, notes R3 has a history of abuse towards someone.</p> <p>R3's medical record notes the following:</p> <p>On 9/30/24, R3 became argumentative when staff was redirecting him during smoke time. R3 began swearing and ranting about being in a facility, having to wait for a cigarette. R3 presented with anger and hostility. R3 proceeded down the hall and began arguing with a resident laying in bed in his room. R3 removed himself from the wheelchair and began walking toward the resident while displaying visibly aggressive behavior.</p> <p>On 12/9/24, R3 was displaying abnormal behavior yelling and making delusional statements, getting upset with peer who was on the line for cigarette break.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24, R3 was on the smoking patio where he stated a peer was talking to him and he told the peer to stop talking to him, at which time the peer hit him in the jaw, and R3 hit him back.</p> <p>On 1/27/25, R3 was threatening physical aggression towards a peer.</p> <p>R3's behaviors care plan, dated 12/16/24, notes R3 may get angry easily. R3 has difficulties managing his anger/frustration as evidenced by aggressively walking towards others, threatening harm, and arguing with a peer.</p> <p>R3's behaviors care plan, initiated 1/27/25, notes R3 has the potential for physical aggression towards others. Poor impulse control.</p> <p>R3's identified offender care plan, initiated 2/20/25, notes R3 has been assessed as a potential risk towards other residents.</p> <p>This facility's abuse investigation involving R2 and R3 was reported to the State Surveying Agency on 4/10/25 at 3:22 PM. The initial reports notes no physical contact made between R2 and R3. Staff interviews: V4 stated that he was cleaning the dining room and R2 was trying to go to the food carts after everyone was through eating. R2 initiated a conversation with R3. R2 said something R3 didn't like, R2 threw cup of juice on R3, R3 jumped up and hit R2. Both residents were in wheelchairs, both were by small elevator across from R2's room. V4 stated that R3 left and went to his room. V4 stated that R2 went to his room. V4 stated that he was coming out of the dining room when all of this happened. V4 stated that they heard the commotion, none of the staff came over. The nurse came over to R2 to get his statement. V5 stated she came out of another resident's room and heard R2 and R3 arguing. V5 stated that she heard R3 say 'why you throw that on me'. V5 stated R2 and R3 were moving away from each other. R2 stated that he was getting juice and R3 came over and said 'you ain't supposed to do that' and R2 responded 'who made him the boss and he threw the juice on R3. R3 stated that R2 was pouring juice in his cup. R3 stated that he told R2 be careful, you shouldn't be doing that. R3 stated that it got to the point where R2 poured his juice on R3 and R3 ended up swinging at R2. R3 stated that is when staff intervened.</p> <p>This facility's abuse policy, dated 03/2025, notes this facility affirms the right of our residents to be free from abuse.</p>		