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	04/09/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow policy procedures, failed to transcribe physician's orders, failed to follow physician orders, failed to notify the wound care director of resident's skin integrity impairment, failed to ensure that staff were aware of required LALM (Low Air Loss Mattress) settings, failed to ensure that the LALM was on the right setting (while in use), failed to ensure that the LALM was on (while in use), failed to implement preventive interventions, and/or failed to ensure that treatments were administered for two of three residents (R1, R2) reviewed for pressure ulcers. These failures resulted in R2 developing the following (facility acquired) pressure ulcers: sacrum (stage 3), right heel (stage 3), left heel (stage 3), right buttock (stage 2), and left elbow (unstageable). R2's left elbow and left heel developed necrosis. Findings include: 1.) R2 was admitted to the facility on [DATE].R2's diagnoses which include dementia, transient ischemic attack, cerebral infarction, type II diabetes mellitus, (2/19/26) pressure ulcer of sacral region - stage 3, (3/2/26) pressure ulcer of right buttock - stage 2 and (3/12/26) pressure ulcer of left elbow - unstageable.R2's (3/3/26) functional assessment affirms the resident is dependent on staff for rolling left and right.R2's (3/3/26) risk assessment for skin integrity impairment determined a score of 10 (high risk).R2's care plan includes (9/29/25) Resident has an ADL (Activities of Daily Living) self-care performance deficit related to dementia, impaired cognition, incomplete performances, and history of stroke. Dependent on staff for care, interventions: assist with ADL tasks as needed. (3/3/26) Actual alteration in skin integrity due to sacral pressure ulcer, right heel, left heel pressure, interventions: low air loss mattress, turn and reposition every two hours and as needed. R2's (4/2/26) Physician Wound Assessment states preventive measures in place: no direct pressure on bony prominences. Heel protection with pillows or heel devices. Sacral (stage 3) reported 2/19/26 not resolved 1.3 x 1.2 x 0.3cm (centimeters), intact skin 90%, granulation 10%, exudate: serosanguineous, moderate. Clean with NS (NS) primary dressing: (brand name) paste, open to air. [Treatment has been changed on 4/2/26]. Right heel (stage 3) reported 2/19/26, 4 x 3.8 x 0, granulation 100% exudate: none. Left heel (stage 3) reported 2/19/26, 2.8 x 3 x 0, granulation 100%, exudate: none. Left elbow reported 3/12/26, 1.4 x 1.3 x 0cm, necrotic 100% black. Adverse factors affecting wound healing process: bed offloading, heels offloading, turning schedule, incontinence, muscle weakness. Team communication: dressings changed and discussed with the treatment nurse. Staff and nursing assistants educated about prevention, repositioning, and wound care. R2's POS (Physician Order Sheet) includes (2/17/26) Low Air Loss Mattress. (3/30/26) (brand name medicated) wound dressing paste apply to sacral topically every dayshift (and as needed) cleanse area with NS (Normal Saline), apply (brand name medication), cover with alginate then secure with island dressing. (3/30/26) (brand name medicated) wound dressing paste apply to right/left heel topically every dayshift Monday, Wednesday, Friday. Cleanse area with wound cleanser, apply adaptic and (brand name medication), cover with alginate then secure with foam dressing. (3/30/26) Betatine solution 10% apply to left elbow then apply protective dressing every Monday, Wednesday, Friday and PRN (as needed). [R2's 4/2/26 sacral treatment order per physician wound assessment - was excluded].R2's (April 2026) TAR (Treatment Administration Record) affirms (brand name medicated) (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound dressing paste: apply to sacral topically every dayshift cleanse area with NS, apply (brand name medication), cover with alginate, secure with island dressing - was documented 4/3/26-4/5/26 and 4/7/26 therefore the incorrect treatment was applied for several days. [R2's 4/2/26 sacral treatment orders were excluded].R2's (3/3/26) BIMS (Brief Interview Mental Status) affirms resident was unable to complete the interview.On 4/6/26 at 1:50pm, surveyor attempted to interview R2, however a verbal response was not received. R2 was lying atop of a LALM which appeared to be firm and not fluctuating. The LALM control device was crammed between the mattress and foot of bed, placing additional pressure on the mattress. R2 was lying on her left side with wedge cushion behind her back, her feet were not elevated, and she was not wearing heel protectors/boots.On 4/6/26 at 2:05pm, V4 (Registered Nurse/RN) affirmed that she's (V4) assigned to R2. Surveyor inquired about R2's current LALM settings. V4 stated, I (V4) don't know because wound care came early and I'm (V4) not sure what they're (wound care) setting it. V4 removed R2's LALM control device from between the mattress and foot board (as requested) and placed it on the bed. The weight setting was 550 pounds. Surveyor inquired about R2's current weight. V4 responded, She (R2) would be less than 200. Surveyor inquired if R2's LALM was set on 550 pounds. V4 replied, Yes however failed to change the setting at this time. Surveyor inquired if R2 has any wounds. V4 stated, She (R2) has wounds on the feet. I think the heels and the sacrum is healed now. R2's sacrum was notably pink and appeared to be healing (scarring with granulation tissue). There was no treatment and/or cream on the sacral wound. V4 removed R2's heel dressings (kerlix and adaptic) which were not secured with foam dressing as ordered. R2's left heel was necrotic with red bleeding skin encircling the wound. R2's right heel skin appeared sheared off. On 4/6/26 at 2:09pm, surveyor inquired about R2's LALM settings. V6 (Wound Care Nurse) stated, It should be set to her (R2) weight, it's a little bit more than that. It's 550 and it's supposed to be according to her weight. Surveyor inquired if R2's mattress is set on 550, which is too high, what's the concern? V6 responded, It's too firm. Surveyor inquired about R2's heel wounds. V6 replied, She (R2) have 2 pressure wounds they were closed but last Thursday (4 days ago) they were open, so we (facility) changed the treatment to adaptic and calcium with honey. Surveyor inquired if R2's heels were recently debrided. V6 stated, I (V6) don't think he (Wound Physician) did it last Thursday, that was the last time seeing it. We (staff) cleaned it and applied the dressing. Surveyor inquired about R2's preventive measures to prevent further heel breakdown. V6 responded, She had booties, I'm (V6) not sure if they were moved. Surveyor inquired about the appearance of R2's left heel. V6 replied, I see some necrotic tissue.On 4/7/26 at 12:53pm (the following day), R2 was lying in bed while V4 (RN) was feeding her (R2). R2's LALM device was still crammed between the mattress and footboard. Surveyor inquired about the settings on R2's LALM. V4 removed the device from between the mattress and foot board, and it was noted to be off. Surveyor inquired why R2's LALM was off while the resident was in bed V4 stated Maybe the housekeeper messed with it, she (housekeeper) was just in here. Surveyor inquired if R2's LALM was currently on. V4 responded, It's not on right now. A note was observed on R2's LALM device with 105.2 handwritten. Surveyor inquired about the 105.2 note placed on R2's LALM device. V4 stated, That's her (R2) weight therefore R2's (4/6/26) LALM 550-pound setting - was incorrect.On 4/7/28 at 12:59pm, V11 (Restorative Nurse) entered R2's room and V4 advised that R2's LALM wasn't working. V11 inspected R2's LALM device and stated This if off, is it plugged up? and affirmed that it was unplugged.On 4/7/26 at 4:12pm, surveyor inquired about R2's wounds. V9 (Wound Care Director) stated, She (R2) had breakdown on her sacrum area and her feet as well (left elbow was excluded). They (staff) put in interventions for her supplements, like (protein supplemental drink). We (staff) ordered her (R2) an air mattress and she definitely has treatments. Surveyor inquired about preventive interventions for R2's feet wounds. V9 responded, We've been offloading she's been using pillows or heel lifts like booties [neither of which were in use for R2 on 4/6/26]. On 4/9/26 at 12:15pm, surveyor inquired about potential harm to a resident if a LALM is on the incorrect setting and/or off - while in use. V12 (Medical Director) stated, If it's the wrong setting it doesn't work as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	intended, and they (residents) have a potential to develop a wound if it is not working at all. Surveyor inquired about potential harm to a resident if wound care treatments are not followed. V12 responded, If the treatment is not implemented as recommended then the wound may not get better. Surveyor inquired about potential harm to a resident if treatments are not applied. V12 replied, If the treatment is something ordered and it's not done there is a problem with that, and the potential for the wound getting better may be reduced.2.) R1's diagnoses include altered mental status, malignant neoplasm of brain/breast/lung, adult failure to thrive, hemiplegia and hemiparesis.R1's (1/26/26) functional assessment affirms resident requires partial/moderate assistance with rolling left and right. R1's (4/2/26) risk for skin integrity impairment assessment determined a score of 10 (high risk).R1's (2/22/25) care plan states resident has alteration in skin integrity related to left elbow blister. Potential for further alteration in skin related to incontinence, weakness, right side hemiplegia, decreased mobility, non-ambulatory and weight loss. Interventions: barrier cream to areas exposed to moisture/incontinence. Inspect skin daily with care. Wound care consultation as ordered.R1's POS (Physician Order Sheets) include (3/27/26) Skin check completed every Tuesday and Saturday. (3/27/26) Wound consult. (4/4/26) Betadine solution 10% apply to left elbow every Monday, Wednesday, Friday and as needed. (3/27/26)(brand name) wound dressing external paste apply to buttocks topically every day and as needed for skin condition. On 4/6/26 at 1:40pm, V3 (Certified Nursing Assistant/CNA) affirmed that she's (V3) assigned to R1. Surveyor inquired if R1 has any skin integrity impairments. V3 stated, On her (R1) bottom it looks like it's healing; I (V3) just cleaned her up. Surveyor inquired about R1's skin integrity impairment. V3 responded, It's like a dot, I can't really explain. R1's (4/2/26) Physician Wound Assessment (4 days prior) includes left elbow 4 x 3 x 0.1cm (centimeters) 100% scabbing [buttock wound was excluded].On 4/6/26 at 1:43pm, R1 was lying in bed - on her back. V3 removed R1's incontinence brief (as requested) and a small circular open area (stage 2) was noted on the right buttock however wound treatments were not observed. On 4/7/26 at 4:07pm, surveyor inquired where resident skin assessments are documented. V9 (Wound Care Director) stated, When they (resident) first come in they will have it in a skin progress note or on the initial nursing assessment. We (staff) don't do the weekly skin assessment because the doctor comes in weekly and they would be in the miscellaneous notes. Surveyor inquired about R1's buttock wound. V9 responded, She (R1) doesn't have a buttock wound, she did when she first came in, but we (facility) healed it a while ago. The only wound she has is from an IV infiltrate in the left forearm. I only have her down for left forearm, they're (staff) supposed to notify me (V9), notify the family and notify the doctor if there's a wound and obtain a order. V9 subsequently reviewed R1's medical records and stated, She (R1) gets (brand name cream) that they ordered a couple days ago for her (R1) [NAME].The (3/2/24) prevention and treatment of pressure injury and other skin alterations policy states identify the presence of pressure injuries and/or other skin alterations. Implement preventive measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. The (03/2024) low air loss mattress policy states the Director of Nursing or designee is responsible for identifying residents who require the use of a low air loss mattress. Residents who have been assessed as in need of a low air loss mattress will have a mattress set up for their use. The Maintenance Supervisor, Housekeeping Supervisor of designee will be responsible for the set-up of the low air loss mattress for the residents. [staff responsible for LALM settings are excluded].

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to document meal intake, failed to provide meal within reach, and/or failed to provide required feeding assistance for two of three dependent residents (R1, R2) reviewed for nutrition. These failures resulted in R2's significant weight loss (-15.6% within 1 month) and R1's significant weight loss (-7.9% within 1 month).Findings include:1.) R2's diagnoses include obesity, dementia, transient ischemic attack and cerebral infarction.R2's (3/3/26) functional assessment affirms substantial/maximal assistance is required for eating.R2's (9/29/22) care plan states resident has an ADL (Activities of Daily Living) self-care performance deficit related to dementia, impaired cognition, incomplete performances, history of stroke, and poor oral intake. Dependent on staff for care, interventions: assist with ADL tasks as needed. The resident requires nutritional support secondary to weight loss, poor oral intake, and dementia. Total assistance is needed with meals, interventions: Set up resident's tray and provide assist or cueing for meals as needed. R2's POS (Physician Order Sheets) include (3/2/26) No added salt diet, pureed texture. (1/29/26) (brand name supplemental ice cream) twice a day for nutritional supplement give with lunch and dinner. (2/20/26) (brand name supplemental drink) 2.0 - 120ml (milliliters) with meals for nutritional supplement. R2's (1/29/26) Nutrition Assessment states total assistance is needed with meals. Significant weight change in the past 3 months? Yes. Significant weight change in the past 6 months? Yes. Variable intakes 0-100% per meal monitor documentation. R2's (March 2026) meal intake documentation affirms nothing was documented (entries were blank) on 3/7 (lunch), 3/9 (dinner), 3/10 (lunch), 3/15 (breakfast & lunch), 3/22 (breakfast & lunch), 3/28 (breakfast, lunch & dinner), and 3/29 (breakfast, lunch & dinner). 13 meals were not documented. 0 (indicating 0-25% intake) is documented 36 times.R2's (April 2026) meal intake documentation affirms nothing was documented 4/2 (dinner) and 4/6 (lunch), 0 was also documented for 9 of 19 entries therefore most of the meal intakes were 0-25%. On 4/9/26 at 2:18pm, surveyor inquired what blank entries indicate on the meal intake documentation. V2 (Director of Nursing) stated, They indicated that the CNA (Certified Nursing Assistant) did not chart on that shift. R2's (3/3/26) BIMS (Brief Interview Mental Status) affirms resident was unable to complete the interview. On 4/6/26 at 1:50pm, surveyor attempted to interview R2 however a verbal response was not received. On 4/6/26 at 2:05pm, surveyor inquired if R2 can feed herself. V4 (Registered Nurse/RN) responded, No, no, no, we (staff) assist her. On 4/7/26 at 12:53pm, V4 (RN) was observed feeding R2 the (brand name supplemental ice cream), however the plated meal was covered with the lid. Surveyor inquired if R2 ate the meal. V4 stated, She's (R2) taking juice and this (brand name supplemental ice cream), she also likes this applesauce too. V4 removed the lid from R2's plate (as requested) and the mashed potatoes and pureed vegetables were untouched. The pureed meat appeared as if only one (1) bite was removed. Surveyor inquired why R2 wasn't fed the plated meal. V4 responded, She just wants 2 spoons, and she said no more however made no attempt to offer R2 the mashed potatoes or vegetable at this time. R2's weights are as follows: (3/5/26) 124.8. (4/2/26) 105.3 (-19.5 pounds) therefore 15.6 % loss within 1 month. 2.) R1's diagnoses include altered mental status, malignant neoplasm of brain/breast/lung, adult failure to thrive, hemiplegia and hemiparesis.R1's (1/26/26) functional assessment affirms the resident requires supervision or touching assistance with eating. R1's care plan includes (2/8/25) resident has an ADL functional performance deficit related to right side hemiplegia, weakness, and brain cancer, interventions: offer assist at mealtimes. (2/28/25) Resident requires nutritional support secondary to weight loss, diagnosis of lung cancer with metastasis, failure to thrive, and major depressive disorder, interventions: assist with meals as needed. Monitor for changes in ability to feed self.R1's POS includes (1/11/26) general diet, mechanical soft texture. (12/19/25) (brand name supplemental ice cream) with dinner for nutritional supplement. (1/19/26) (brand name supplemental drink) 2.0 with meals (90ml) for nutritional supplement. (4/3/26) (brand name supplemental drink) with breakfast and (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	lunch for nutritional supplement. R1's (4/2/26) Nutritional Assessment states significant weight change. Variable intakes 0-100% per meal monitor documentation. Able to feed self with limited to total assistance as needed. Current weight 115 pounds (4/1/26) Significant weight loss noted: -7.9% x 1 month, resident was 124.8 (3/5/26). R1's (March 2026) meal intake documentation affirms nothing was documented (entries are blank) on 3/1 (breakfast & lunch), 3/8 (dinner), 3/9 (dinner), 3/11 (breakfast & lunch), 3/18 (dinner), and 3/29 (dinner) therefore 8 meals were not documented.R1's (1/26/26) BIMS (Brief Interview Mental Status) determined a score of 14 (cognition intact). On 4/6/26 at 1:34pm, R1's lunch tray was on a table - near the foot of bed (out of reach). R1 was lying in bed. The right side of R1's bed was against the wall, and a thick floor mat was in front of the bed - impeding access to the tray. R1's tray was inspected and appeared to be untouched. The following items were on the tray: diced peaches (with the lid on), mighty shake (unopened), juice (cup full), bread (bagged), and the plate with mechanical soft potatoes, vegetables, meat (covered with the lid). Surveyor inquired if R1 received assistance with lunch today R1 stated No. On 4/6/26 at 1:40pm, V3 (CNA) was observed (seated) at the Nurse's station and affirmed that she's (V3) assigned to R1. Surveyor inquired if R1 requires feeding assistance V3 replied Yes. Surveyor inquired who's responsible for feeding R1, V3 stated Whoever passes trays on the floor. Surveyor inquired if V3 was responsible for feeding R1 today V3 responded I (V3) did dining room, I'm (V3) not sure who fed her (R1) for lunch. I didn't talk to the CNA that fed her yet. Surveyor inquired what time lunch is served on R1's unit V3 replied This unit is served around 12:30 (over 1 hour ago). R1's (4/6/26) meal intake documentation affirms the breakfast and lunch entries are marked 0.On 4/26/26 at 1:43pm, V3 inspected R1's lunch tray (as requested) and stated, I (V3) guess they (staff) didn't come around to feed her. Surveyor inquired where R1's lunch tray was placed. V3 responded It's away from the bed. On 4/7/26 at 12:37pm, surveyor inquired if R1 can feed herself V10 (CNA) stated Yes and no but the majority of the time, no. Surveyor inquired if R1 can use her right hand. V10 responded She can use the left, I (V10) don't know what happened with the other one. Surveyor inquired who's supposed to feed residents that require assistance? V10 replied If you're assigned to the floor, you're supposed to feed the resident.On 4/9/26 at 12:20pm, surveyor inquired about potential harm to a resident that requires feeding assistance - if feeding assistance is not provided V12 (Medical Director) stated The patient can lose weight and/or can get sick. Surveyor inquired about potential harm to a resident if intake is usually 0-25% at meals V12 responded Then the patient is going to be losing weight or becoming dehydrated.The (09/2020) feeding a resident policy states residents who need assistance will be fed a well-balanced meal, by a nurse, CNA, or in individual who has completed a state approved feeding course. Document on meal monitor sheet as applicable and/or report to the nurse if resident refused meal or had minimal intake or had difficulty swallowing or chewing meal.