Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

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 03/13/2026
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interview and record review, the facility failed to provide adequate supervision and maintain a safe environment for one resident that had a diagnosis of schizophrenia, anxiety, and depression, with a documented history of self-harming behaviors and exit-seeking behavior. The facility failed to prevent the resident from accessing a fire extinguisher, which was used to break a second-floor window and exit the building without staff knowledge. This affected one of three residents (R162) reviewed for supervision. As a result, R162 exited through the second-floor window, landed face down outside the facility, and sustained a left leg [NAME] fracture, a severe fracture involving the distal tibia. Findings include:The Immediate Jeopardy began on 01/06/2026 when R162 broke a window in the dining room with a fire extinguisher and jumped out of a second story window (fifteen feet) without facility staff knowledge. R162 landed face down sustaining a [NAME] fracture. V1(Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 3/6/26 at 4:33PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 3/7/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the interventions implemented.R162 was admitted on [DATE] with the diagnosed of Schizophrenia, Anxiety and Depression. Brief interview for mental status dated 12/18/25 documents a score of thirteen which indicates cognitively intact.Hospital Behavioral Health Integrated Assessment 12/16/25 documents: R162 reports that he has self-harm in the past. R162 was unable to recall the last time he self-harmed. Identified patient's perspective: R162 said, he was in the emergency department because it was cold outside, homeless and feeling depressed, R162 stated, he has never had thoughts of taking his own life, but he has had thoughts of harming himself. R162 stated that he has self-harmed in the past by hitting himself. R162 states the last time he self-harmed was a while ago, he was unable to provide any further information about when he last self-harmed.R162's baseline care plan dated 12/17/25 does not document anything about Anxiety, Depression, Schizophrenia or history of self-harming behavior. R162's care plan dated 12/17/25 documents the following: Receiving (name of medication) psychotropic medication. To manage behavior or mood issues of: Related to diagnosis of was blank. Interventions dated 12/17/25 include Document mood and behaviors as needed as they occur; Lab work per MD order; Monitor and report signs and symptoms of side effects to physician as needed.R162 is at risk for abuse related to diagnosis of Schizophrenia. Date Initiated: 12/18/2025 interventions: Encourage resident to process her feelings, fears, problems, etc. (Blank) times per week in 1:1 session with therapist or staff during periods of increased stress/depression/anxiety Date Initiated: 12/18/2025; Encourage/re-assure/re-direct/repeat as needed; Encourage resident to participate in activities.Elopement risk assessment dated [DATE] documents: R162 was NOT at risk for elopement.On 3/3/26 at 1:59PM, R162, who was assessed to be alert and oriented to person, place and time, was observed with a cast on his left lower leg. R162 was hesitant to report how the incident happened and how he ended up in a cast. R162 said he had a mental breakdown and a fall. R162 would not report exactly when the incident happened, or which staff were involved. R162 said the cast was (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow facility policy and infection prevention standards of practice by not conducting contact tracing, failing to immediately conduct testing, implement isolation orders and doffing Personal protective equipment prior to exiting an isolation room after two residents (R1 and R11) and one staff member (V8-Certified Nursing Assistant) tested positive for COVID-19 resulting in resident and staff exposure to COVID-19. This failure has the potential to affect a total of 155 residents at the facility. Findings Include:R11 was admitted to the facility on [DATE] with a diagnosis of ataxia, major depressive disorder, type II diabetes, and hypertension.R11's progress notes document on 3/2/26 that R11 sustained a fall and was sent to the hospital. R11 returned to the facility on 3/2/26 with a diagnosis of covid-19.R11's after visit summary dated 3/2/26 documents under diagnosis Covid-19.R11's census documents: 8/26/25 - 3/2/26 R11 room was on unit XYZ. 3/2/26 -3/3/26 R11 was moved to the second floor and 3/3/26 R11 was moved back to the unit XYZ.On 3/5/26 at 11:27AM, V3 (Infection Preventionist) said they were informed that R11 had tested positive for Covid 19 after a fall that resulted in hospital stay on 3/2/26. R11 returned to facility on 3/2/26. V3 said they reviewed any staff that came into close contact with R11. R11's roommate was tested but no other residents were tested as possible close contacts for R11. V3 said R11 was on unit XYZ, ambulatory in the unit, goes to outpatient group therapy and eats in the common dining room. V3 said no other residents were tested on R11's unit.Facility policy Acute Respiratory Illness Policy Review dated 2/2025 states: Contact tracing in response to a single new case of covid 19: complete contact tracing to identify residents who had close contacts and staff who had higher risk exposure to the newly identified case of covid19. Test all residents and staff identified as close contacts or who had higher risk exposure on day 1, day 3 and day 5. R1 was admitted to the facility on [DATE] with a diagnosis of bipolar, shortness of breath, and congestive heart failure.R1's census sheet documents: 2/28/26-3/4/26 R1 was on the XX floor.R1's progress notes dated 3/2/26 documents: R1 complaints of coughing for the past 2-3 days. R1 noted with wheezing back lower lungs. Positive phlegm with cough and stat chest x-ray ordered. Progress note dated 3/3/26 documents: R1 was out in day program when chest x-ray services came. They will come back in the evening upon R1's return from day program. Progress note dated 3/4/26 documents resident complaints of shortness of breath. Resident was sent to emergency room with chest x-ray results received with possible tuberculosis. Progress note dated 3/4/26 at 11:03PM documents: report received from hospital that R1 is Covid positive. Resident transported back into the facility. New orders received to initiate contact/droplet isolation.R1's physician order sheet dated 3/4/26 documents contact/droplet isolation. There were no other orders for isolation prior to 3/4/26.R1's hospital record dated 3/4/26 documents under diagnosis: Covid19. R1 presented to the emergency department at 5:28 AM on 3/4/26 with shortness of breath and cough and had a chest x-ray that apparently showed active tuberculosis though R1 has no history of tuberculosis. R1 stated that he has been having fevers, chills, shortness of breath and cough with brown-tinged sputum over the past week. SARS-CoV2 RNA testing was positive. R1 was discharged from the emergency department with a diagnosis of COVID-19 on 3/4/2026 at 10:52 PM. On 3/5/26 at 3:38PM, V3 (Infection Preventionist) said cough would be considered a symptom of respiratory disease and was unable to provide any acute respiratory testing prior to R1's hospitalization. V3 said we have not tested any residents on the XX floor. I will check with the consultant to see if we need to test the XX floor.R1's medical record did not document any testing for any acute respiratory viruses.Facility policy Acute Respiratory Illness Policy Review dated 2/2025 documents: Specimens for respiratory outbreaks should be collected immediately after the onset of the illness to identify the cause of the illness. When a resident shows signs of an acute respiratory illness, the following actions will be taken: initiate contact and droplet precautions, conduct a rapid antigen test for covid 19.3. On 3/5/26 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 11:27AM, V3 (Infection Preventionist) said she was notified on 3/2/26 that V8 (Certified Nursing Assistant/CNA) was positive for covid. V3 said they also were informed on 3/2/26 that R11 had tested positive after a fall that resulted in hospital stay. V3 said there were no other residents or staff with covid19. V3 said an outbreak would be 3 cases within 72 hours. On 3/5/26 3:38PM, V3 said there are now three cases of covid, and she was informed today that R1 tested positive. V3 said they still are not considered in an outbreak. V3 was unsure if R1 was back in the building.Facility policy Acute Respiratory Illness Policy Review dated 2/2025 documents: Outbreaks are now defined as and must be reported if three or more residents and/or staff in a facility, who within 72 hours of each other have: Acute Respiratory Illness (ARI) and/or Positive point of care test or laboratory-positive test for a single virus, and at least one of the cases is a resident. Outbreak closure still occurs after fourteen days have passed without additional cases. Testing Plan: Covid 19, influenza, RSV and other respiratory illnesses all have similar and overlapping symptoms. When an outbreak of acute respiratory illness is suspected, testing to determine the etiology of the disease is essential to determine the appropriate precautions needed to control the outbreak and if indicated to implement timely treatment.4. On 03/04/2026 at 3:15 PM V6 (Licensed Practical Nurse/LPN) and surveyor visited R11. R11 was in a two bed room and R11's bed was closest to the door (referred to as bed one). The bed by the window was empty (referred to as bed two). Signage on the door stated, Droplet Precautions and Contact Precautions. Personal Protective Equipment (PPE) was available and donned in the hallway. Upon room entry, the privacy curtain was pulled across the door entryway requiring V6 to move the privacy curtain to enter the room. Garbage receptacles were positioned between bed one and bed two in the middle of the room on the wall opposite the beds in the room. After visiting R11, V6 began to doff PPE in R11's room between bed one and bed two (then requiring V6 to walk past R11 and move the privacy curtain to exit the room). As V6 began to doff the isolation gown, surveyor stopped V6 and questioned V6 about the risk of infection spread if PPE is doffed in the room and V6 then walks past R11 and touches the privacy curtain before exiting the room. V6 stated You are right. It doesn't make sense. V6 moved the trash receptacle to just inside R11's entry/exit door and then doffed PPE. On 3/4/2026 at 3:25 PM V7 (LPN) was interviewed about the donning/doffing process in R11's room. V7 stated We take off PPE (personal protective equipment) in the room near the trash receptacle and then walk out. V7 stated All of the PPE comes off before we leave the room. V7 clarified that that means that the gown, gloves and mask all come off in the room before staff walk out. V7 stated that is the process that V7 and the Certified Nursing Assistants (CNAs) have been following today. V6 was present and asked if the trash receptacle has been between bed one and bed two all day. V7 stated yes. Surveyor asked to speak with the infection prevention nurse. V6 called V3 (Assistant Director of Nursing and Infection Prevention Nurse). V3 presented to the unit and observed R11's room. V3 stated I have told the staff that they should remove their PPE as close to the exit as possible. V3 confirmed that the trash receptacle should not be placed between bed one and bed two because it requires staff to walk past bed one and R11 before exiting the room. V3 stated Maintenance sets up these isolation rooms and nurses don't think that they can move anything. I have educated the nurses. I will reeducate them. 5. On 3/6/2026 at 9:50 AM V27 (Housekeeper) was observed in room ABC with the door open. A Droplet Isolation sign was on the door. The resident (R1) stood in the room and said to the surveyor I have COVID. V27 was observed wearing a surgical mask, gown and gloves. No N-95 or face shield was donned. V30 (Resident Care Coordinator/Nurse) was in the hallway and surveyor asked V30 to observe V27 in the room. V30 stated That is not correct. V27 was called to the entry of the room by V30. V27 stated that the resident is on droplet isolation. V27 stated That means there is something contagious in that room. I should have had an N-95 on. I don't have one on because I didn't look through the drawers (pointing to the personal protective equipment (PPE) three-drawer cart outside of the room). V30 pointed to a face shield on top of the PPE cart and V27 added And a face shield. I should have a face shield on. I wasn't paying close enough attention. Surveyor asked V27 why the PPE is important. V27 stated It's (continued on next page)

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	important that I don't catch what they have or spread it to anyone else. V27 doffed the gown and gloves in the doorway and then looked for hand sanitizer in the PPE cart. After opening and closing all three drawers in the PPE cart, V27 stated that there was no hand sanitizer available in the PPE cart. V30 was present throughout the interview and got hand sanitizer from the nurses' station for V27. V30 stated I agree that was inadequate. I will follow up with the Infection Control Nurse and the Administrator now. On 3/6/2026 at 1:56 PM R11 was observed sleeping in bed one of a two-bedroom room. Bed 2 was empty. Signage on the door stated, Droplet Precautions and Contact Precautions. Garbage receptacles were observed to be positioned between bed one and bed two in the middle of the room on the wall opposite the beds in the room. V37 (Licensed Practical Nurse) was interviewed. V37 stated that she has taken care of R11 today and has been in and out of R11's room three to four times today. V37 stated that (CNAs) have also been in the room providing care throughout the day. V37 explained that the signage on the door reminds staff that R11 has a diagnosis of COVID and requires isolation. That means that staff need to wear personal protective equipment (PPE) before going into the room. V37 stated that there is a trash can in the room and when staff finish providing care, they remove their PPE in the room and then exit the room and sanitize their hands. V37 stated All PPE comes off in the room. I stand in front of the trash can. The trash can is between bed one and bed two. V37 and surveyor then spoke with V3 (Infection Prevention Nurse) and asked about the process of PPE removal for residents on contact isolation. V3 stated Staff must remove their PPE as close to the door as possible. When V37 told V3 that the trash cans are between bed one and bed two and staff are removing PPE between bed one and bed 2, V3 stated That is not the correct process. V3 took paper out of V3's desk and stated I can be creative. I am going to cut and x and put it on the floor so nurses know where the trash can goes. V37 stated I wish I would have known that. I have been taking care of R11 all day. I have been in and out of that room at least four times today. I learned something today. It makes sense that we don't want to spread infection.On 3/5/26 at 3:38PM, V3 stated We will retest all of that staff on the XYZ unit on Friday especially since they were taking PPE off in the room. My concern is that they are exposing themselves because they weren't taking off PPE at the door. I told them that the garbage can should have been moved.Policy titled Infection Prevention and Control Program last revised 9/20/2024 stated in part that the mission of the program is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. It is the policy that this facility's Infection Prevention and Control Program (IPCP) is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. Facility 671 documents 155 residents at the facility.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to follow its call light policy and ensure call light cords were within reach for 6 residents (R74, R78, R81, R121, R144, and R161) out of 10 residents reviewed for call light accessibility in a sample of 50.Findings include:On 3/3/26 at 10:15 AM, R161 was observed lying in bed. R161's call light cord was observed on the floor next to wall, not within reach.On 3/3/26 at 10:16 AM, 144 was observed lying in bed. R144's call light cord was observed to be twenty inches in length; not within reach.On 3/3/26 at 10:20 AM, R121 was observed lying in bed. R121's call light cord was observed dangling on floor, not within reach.On 3/3/26 at 10:25 AM, R78 was observed lying in bed. R78's call light cord was observed on the floor behind R78's nightstand, not within reach.On 3/3/26 at 10:35 AM, R81 was observed sitting in wheelchair on the left side of R81's bed. R81's call light cord was observed dangling through R81's bedframe at the head-of-bed on the right side of the bed, not within reach.On 3/3/26 at 10:38 AM, R74 was observed lying in bed. R74's call light cord was observed dangling on floor, not within reach.On 3/6/26 at 12:30 PM, V2 (Director of Nursing) stated that call lights should be placed within resident's reach at all times.The facility's call light, use of, policy, dated 09/2020, notes in part, be sure call lights are placed within resident reach at all times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance at least every two hours for four residents (R10, R98, R115, and R145) dependent or require maximum assistance of staff for incontinence care out of four residents reviewed for ADLs (Activities of Daily Living) in a sample of 50. Findings include: On 3/3/26 at 10:18 AM, R115 was observed ambulating in the halls. R115's sweatpants was observed to be wet in the buttocks, groin, and upper thighs.R115's MDS (Minimum Data Set), dated 12/8/25, notes R115 is dependent on staff for toileting. R115's BIMS (Brief Interview of Mental Status) score is 5 out of 15, severe cognitive impairment.On 3/5/26 continuous observations were made from 10:10 AM until 1:57 PM on the third unit for R10, R98, R115, and R145. R10 was observed sitting in reclining chair in the resident common area. R98 was observed sitting in wheelchair in dining room. R145 was observed sitting in wheelchair in the dining room.On 3/5/26 during continuous observations, R115 was observed ambulating in halls or sitting in resident common area. During this time, R115 was not checked by staff for incontinence care.On 3/5/2026 at 1:47 PM R145 was wheeled to the hallway by V10 (Activity Director). On 3/5/2025 at 1:54 PM, V11 (Certified Nursing Assistant/CNA) walked past R145 and V10 and stated Are you still waiting for me because I am not rushing and laughed as she reentered room XXX. On 3/5/2026 at 1:57 PM, V11 wheeled R145 into her room. V11 stood in front of R145 and lifted her from the wheelchair to the bed. V11 asked R145 to pee in the diaper before she took it off. V11 removed R145's pants which V11 stated were dry on the buttocks. Surveyor palpated the pants and confirmed that they were not wet. V11 then removed the diaper and described it as heavily wet from urine. V11 stated that R145 urinates a lot so her diaper is usually wet. An approximately 1 inch linear indentation of the skin was noted vertically along the proximal left leg. V11 was asked to describe the mark and stated I don't know how to describe it. It looks like a mark from sitting in the wheelchair.R145's MDS, dated [DATE], notes R145 is dependent on staff for toileting. R145's BIMS score is 2 out of 15, severe cognitive impairment.On 3/5/26 at 2:25 PM, R98 was transported to R98's room for incontinence care. R98 was transferred to bed via a mechanical lift device and two staff members. R98 was observed not assisting with care; two staff members were needed to provide care. R98's brief was saturated with urine.R98's MDS, dated [DATE], notes R98 requires maximum assistance of staff for toileting. R98's BIMS score is 7 out of 15, moderate cognitive impairment.On 3/5/26 at 2:40 PM, R10 was transported to R10's room for incontinence care. R10 was transferred to bed using a mechanical lift device and two staff members. R10's chair had a small puddle of urine and a deep indentation on the seat cushion. R10's sling and clothing were observed to be saturated with urine and dripping urine onto R10's bed during the transfer. Two staff members were needed to provide care.R10's MDS, dated [DATE], notes R10 is dependent on staff for toileting. On 3/5/26 at 5:10 PM, V2 (Director of Nursing) stated that staff should be checking and changing residents every two hours and as needed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its advance directives policy and ensure one resident's (R2) wishes for advance directives are documented in the physician orders of three reviewed for advance directives in a sample of 50.Findings include:On 3/6/26 at 10:45 AM, V32 (Social Services) stated that residents are asked upon admission regarding advance directives. V32 stated that if a resident was admitted with a POLST (physician orders for life sustaining treatment) it would be documented on social services initial assessment and uploaded into the resident's electronic medical record. V32 stated that social services would only notify nursing if there was a change to a resident's code status.On 3/6/26 at 12:30 PM, V2 (Director of Nursing) stated that the nurse is expected to ask the resident and/or resident's representative regarding advance directives. V2 stated that this is part of the admission checklist the nurse completes. V2 stated that the nurse is responsible for reviewing the resident's code status with the physician and obtaining an order and entering order into the physician orders section of the resident's electronic medical record.R2's face sheet notes R2 was admitted to the facility on [DATE]. There is no documentation noted regarding advance directives.R2's uniform do-not-resuscitate (DNR) advance directive is dated 1/25/26.R2's initial social services assessment, dated 2/5/26, notes R2 is DNR.There is no documentation in R2's medical record noting an advance directives care plan was initiated.R2's POS (Physician Order Sheet) does not note an order for R2's code status/advance directive.The facility's advance directives policy, dated 11/2022, notes in part, the resident will have a code status order entered in their physician orders in accordance with advance directives on file. Social service director and/or designee will assess if resident has pre-existing advance directives. If so, copies of any/all documents will be uploaded into electronic medical record and documented in the resident's care plan.

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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. Based on interview and record review, the facility failed to notify the physician of diagnostic test results indicating the need for further evaluation for 1 of 3 residents (R159) reviewed for physician notification. The findings include:R159's face sheet shows diagnosis of type 2 diabetes, hypertension, anemia, acromegaly, personal history of transient ischemic attack and cerebral infraction without residual effects, unspecified osteoarthritis. R159's radiology results report dated 11/13/25 denotes in-part pt (patient) states he fell today on R159's head, pain in head, no bruising. Test procedures X-ray of skull, four views of skull with no prior studies. There is no definite displaced or depressed calvarial fracture by plain film. Nondisplaced fracture not excluded. Head trauma/injury not evaluated by plain film. Intracranial pathology not evaluated by plain film. CT is clearly and strongly recommended. Impressions CT is clearly and strongly recommended. R159's progress notes dated 11/13/25 completed by V17(Registered Nurse/RN) denotes in-part at 9:30pm views of the skull with no prior studies. There is no definite displaced or depressed calvarial fracture by plain film. Nondisplaced fracture not excluded. Head trauma/head injury not evaluated by plain film. Intracranial pathology not evaluated by plain film. CT is clearly and strongly recommended This report was relay to the NP (Nurse Practitioner) for review. R159's progress note dated 11/12/25 at 6:48pm denotes in-part the above resident was observed leaning over while, sitting in the wheelchair. The resident's forehead touched the floor due to his height, without him falling out of the wheelchair. The writer assessed the resident stat, the resident denies pain, no injury, no bruising, no swelling, nor redness to the forehead. The writer informed Nurse Practitioner, Director of Nursing, and Plenary Guardian. The resident is on Neuro checks and awaiting a stat X-Ray to the skull. Staff will continue to monitor the residents.Facility failed to present Neuro checks for R159 upon exit of this survey, request made on 3/6/26 at 3:15pm and 4:02pm.On 3/5/26 at 12:46 V18 (Nurse Practitioner/NP) stated the Nurse did not inform her of the X-ray results for R159, she would have given orders for R159 be sent to the hospital for further evaluation. On 3/5/26 at 3:15pm V17 (RN) said he was notified of R159 X-ray results on 11/13/25, V17 said he informed V18 (NP) of R159 Xray results of the skull. V17 said V18 (NP) told him to monitor the R159 for changes and if there's changes to send him to the hospital. V17 said he did not document the orders to monitor R159 for changes and to send R159 out if there are changes noted. V17 said R159 had a fall. V17 said R159 did not fall when he worked with R159. V17 said monitoring R159 for changes would include checking the vital signs and completing neuro checks. V17 said he checked R159 vital twice that shift, but he did not complete any neuro checks for R159. V17 continued to say R159 did not fall when he worked with R159. V17 clarified that V18 (NP) gave him orders to monitor R159. V17 said he did not contact V18 (NP) for clarification of frequency for monitoring nor did he contact V18 (NP) for clarification on what monitoring consist of. V17 continued to say R159 did not have a fall on his shift. V17 said he did not conduct neuro checks for R159. V17 agreeable that Nursing care is 24 hours a day, and that he would have to continue care of a resident that may not have fallen on his shift. 3/6/26 at 11:11am V2 (Director of Nursing) said V17 should have notified the physician of R159 X-ray results. V2 said V17 (RN) has been disciplined previously for failure to notify the physician. Facility policy titled Change of Condition dated 9/20 denotes in-part the purpose: to ensure that the resident physician/ physician on call / NP and responsible party is kept informed regarding the residents change in condition.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their against medical advice policy by not notifying the physician and failing to provide medications for one (R128) resident who left the facility against medical advice for two of three residents reviewed for discharge.Findings include:R128 was admitted to the facility on [DATE] with a diagnosis of type II diabetes with foot ulcer, asthma, bipolar, hypertension and asthma. R128's brief interview for mental status score dated 12/11/25 documents 13/15 which indicates cognitively intact.R128's progress notes dated 3/3/26 at 6:30Pm with a created date of 3/4/2026 07:25:52 documents: Resident left against medical advice (AMA). He was educated on the risks and benefits of continued treatment, verbalized understanding, and elected to leave the facility despite medical advice.R128's progress notes does not document any notification to the physician or nurse practitioner related to R128's leave against medical advice.R128's physician order documents: sertraline, Depakote, Seroquel for bipolar; lisinopril- hydrochlorothiazide for hypertension; metformin for diabetes; gabapentin for frostbite/pain; daily wound treatments to toes related to frostbite.On 3/6/26 at 9:50AM, V26 (Nurse) said she was assigned to R128 on the day he left against medical advice. V26 said she did not call or notify the physician. V26 said she did not give R128 any medications upon discharge. V26 said R128 was wanting to leave prior to her shift and staff were aware.On 3/6/26 at 10:47AM, V32 (Social Service) said social service will have the resident sign against medical advice paperwork upon leaving. V32 said they did not notify any physicians. The nurses are responsible for notifying the physician and providing 2 weeks of medications.V32 said he was not present at the time but recalls R128 requesting to leave earlier in the day.On 3/11/26 at 10:44AM, V33 (Social Service) said she was present at the time of R128 left the facility. V33 said she assisted R128 to sign the against medical advice paperwork. V33 said she did not complete any other assessments at time of discharge. V33 said she did not notify any physician of R128's leaving. V33 was unsure if the R128 received any medications upon discharge.On 3/11/26 at 3:20PM, V2 (Director of Nursing) said when residents leave against advice, staff should provide a couple days of medications. V2 said staff should inform the doctor and document in the progress notes that they were notified. V2 was unsure of any other documents should be completed or given to resident upon leaving against medical advice.Facility AMA release leaving against medical advice policy dated 7/2025 documents: When a resident or the residents legal representative expresses the desire to leave the facility before the attending physician had discharged the resident. Notify the physician /nurse practitioner; notify administrator; notify director of nursing; notify case manager.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure Enoxaparin Solution Injection Solution Prefilled Syringe. Injection 0.4ml was available for administration as prescribed. This affected one of three residents (R86) reviewed for available medication.Findings Include:R86's brief interview for mental status dated 12/11/25 documents a score of fifteen which indicates cognitively intact. R86's physician order sheet dated 12/19/2024 documents: Enoxaparin Solution Injection Solution Prefilled Syringe. Inject 0.4ml subcutaneously two times a day related to chronic embolism and thrombosis of unspecified deep vein of lower extremity. Medication Administration Record dated 3/1/2026- 3/31/2026 documents: Enoxaparin Solution Injection Solution Prefilled Syringe; Wednesday 3/4/26 at 6am, 4pm and on 3/5/26 at 6am documents the number nine (9). Chart code/Follow up code nine (9) =other see progress notes. Electronic medication progress note dated 3/4/26 at 6:03am documents: medication not available, awaiting supply from the pharmacy as medication is being reordered, (4:57pm) medication not available and 3/5/2026 at 6:56am unavailable On 3/4/26 at 10:27am, R86 who was assessed to be alert and oriented to person, place and time, said, the facility runs out of R86's blood thinners at times. R86 said, he goes without his prescribed blood thinner for a day or two periodically. R86 said, the facility ran out of his blood thinners this morning. R86 said, he did not get my blood thinner this morning. On 3/4/26 at 12:22pm during observation of the medication cart. R86's Enoxaparin Solution Injection Solution Prefilled Syringe was not in stock/on hand/or available. V7(Licensed Practical Nurse/LPN) said, she did not administer R86's prescribed enoxaparin solution for the 6:00am morning dose. V7 said, she had to order it. Then V7 verified that she placed the order for the wrong medication, she ordered pantoprazole. Then V7 said, R86's medication did not arrive because there's an ongoing insurance issue. V7 denied informing V2 (Director of Nursing/DON) of the ongoing issue. On 3/11/26 at 1:26pm, V2 (DON) said, she was unaware R86 had any problems receiving his blood thinner. V2 said, she received prior authorization from the pharmacy, and the facility was going to pay for R86's medication. V2 said, then she was trying to determine why R86 was on blood thinner injection when he was mobile. V2 said, if there is an order for the medication to be administered she expects the nurse to ensure the medication is on hand to administer it as prescribed. Pharmacy Prior Authorization Request dated 3/5/26 documents: Is the patient (R86) currently treated with the requested medication. Yes. R86 resides in a long-term care facility, has been on this medication since 2024. Medication Storage/Labeling/Packing of Medication policy dated 5/2025 documents: resident-specific medications are placed in a locked cabinet or cart. Medication administration policy dated 9/2020 documents: Medication will be administered in accordance with the established policies and procedure. Drugs must be administered in accordance with the written orders of the attending physician.

Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their medication storage policy by having opened, used, undated and unrefrigerated medication on the medication cart for two of three residents (R3 and R5) reviewed for medication storage. Findings Include:On [DATE] at 3:36pm, during medication cart audit with V26 (Nurse), R3's Insulin Glargine Subcutaneous Solution Pen-injector dispensed on [DATE] was opened, used and not dated. V26 said, R3's insulin should have been dated after opening to ensure expired medication is not given. V26 said, insulin is good for twenty-eight to thirty (28-30) days after opening. R5's Insulin Aspart (with Niacinamide) was observed on the medication cart, new and not used or opened. Refrigerate until opened was documented on the pharmacy bag that held R5's insulin. V26 said, all unopened, unused insulin pens should be refrigerated until they are opened/used. V26 said, R5's insulin should have been in the refrigerator.Medication Storage/Labeling/Packing of Medication policy dated 5/2025 documents: Medication requiring refrigeration are store in a refrigerator located in a locked room accessible only to licensed staff. Individual residents' medication are stored and labeled according to legal requirements, including requirement of acceptable manufacturing practices.

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 03/13/2026
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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a clean and homelike environment on one of three 3 units reviewed. On the third locked unit, two lounge chairs located in the television room were observed with multiple old, dried stains on the seat cushions and armrests. Findings Include: On 3/4/26 at 10:09am, two filthy lounge chairs with multiple dried irregular shaped circles in the middle of the seat cushion, discoloration, dirt and other stains covering the chair and arm rest were observed in the resident television room on the third (3rd) unit. V6 (Nurse) said, residents sit in those chairs and watch television. V6 said, those chairs have been dirty for a long time. On 3/4/26 at 10:20m, V3 (Assistant Director of Nursing) said, the lounge chairs have stains on the cushion and arm rest. V3 said, some of the stains on the cushion are consistent with dried urine and the other stains are consistent with spills. V3 said, the red stain may be consistent with a red juice spill. V3 said, she would not sit in either lounge chair due to the multiple stains/spills. On 3/4/26 at 10:25am, V41(Housekeeping Director) said, she took pictures a week ago of the lounge chairs and how dirty they looked to see what could be done to clean them. V41 was unable to report where that current picture was, who she gave it to and what the resolution was. On 3/4/26 at 10:30am, R154 was observed sitting on the second lounge chair. R154 was asked how she felt about sitting in a stained chair. R154 refused to speak with surveyor.