

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0023945		(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, Illinois, 60426			
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S0000	Initial Comments		S0000				
	Annual Licensure Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.1210a)						
	300.1210b)						
	300.1210d)3)6)						
	300.2210b)2)						
	300.2900j)2)						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. Section 300.2900 General Building Requirements j) Hazardous Areas, Fire Extinguishers and Miscellaneous 2) There shall be at least one approved fire extinguisher in all basements, furnace rooms, and kitchens, laundry rooms and beauty shops. In addition, there shall be on each floor of the building, extinguishers located so a person will not have to travel more than 50 feet from any point to reach one. They shall be inspected annually and recharged when necessary. The date of checking and recharging shall be recorded on a tag attached to the extinguisher. This REQUIREMENT is not met as evidenced by: 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		S9999				

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S9999	Continued from page 2 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 pilon fracture, a severe fracture involving the distal tibia. Findings include: R162 was admitted on 12/17/25 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.		S9999				

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S9999	Continued from page 3 Elopement risk assessment dated 12/18/25 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 put on since his admission to facility. On 3/4/26 at 2:36PM, R162 said he got the fire extinguisher off his unit, walked past the nursing station down to the dining room where the window by the vending machine was cracked open. R162 said he busted/hit the window with the fire extinguisher and jumped out. R162 said he landed on the ground face down. R162 said he was in extreme pain of hundred out of a one to ten pain scale with 10 being the worst pain. R162 said he was feeling frustrated and stressed. R162 said he had been feeling that way for a while. R162 said he informed staff members, but they did not help him. R162 said, when he jumped out of the window, he was mentally, physically and emotionally confused. On 3/4/26 at 3:07PM, tour of second floor dining room with V5 (Maintenance). The windows at the facility are a set of three windows with the two outer windows that can be opened, and the middle cannot. The windows have two glass panes, and the middle windows have blinds in between the panes. There is a latch to lock the window and a hand crank to open the windows. There should be a limiting chain on the window to prevent it from opening all the way. Observed the window that R162 jumped out. The outer windowpane had pieces of broken glass stuck inside the window frame and the inner windowpane had been replaced. The latch had three screws in place to prevent it from opening. The hand crank was removed. Another window in the same dining room was observed with no hand crank but was able to be opened when pushed. There was a limiting chain in place. The fire extinguisher case on R162's hallway, that was utilized had a piece of plastic plexiglass on the door with a small piece of glass within the case. The fire extinguisher was missing the pull pin tag. All the other fire extinguishers on R162's floor had glass windows and pull pin tags. On 3/5/26 at 10:10AM, V4 (Maintenance) said he recalls having to fix and clean up a broken window on second floor dining room in January. V4 said they replaced the one side of glass and placed screws around the lock to		S9999				

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S9999	Continued from page 4 prevent it from opening. V4 said on the same day he also replaced the glass insert for the fire extinguisher case on the second floor. V4 said it was replaced with plexiglass because the glass was broken. On 3/5/26 at 4:00PM, V24 (Nurse) said he was R162's nurse for the day. V24 said R162 was an elopement risk. Observation of the facility elopement report binder did not include R162's picture, face sheet or elopement information. V24 said, R162's elopement information was not in the 1st floor unit elopement binder. V24 said, R162 resides on the 1st floor unit. On 3/6/26 at 10:46AM, V32 (Social Service) said, if a resident has a history or suicide or self-harm it should be care planned upon admission and quarterly. On 3/11/26 at 10:47AM, V22 (Behavior Health Counselor) said she does not recall who the Certified Nursing Assistant/CNA was that informed her of R162 pacing with his coat and bag in hand. V22 said the CNA informed her about R162 because she thought R162 was exit seeking. V22 said R162's pacing with his coat and bag in hand was exit seeking behaviors. Social services note dated 12/27/2025 documents: Writer (V22) was informed by CNA that resident (R162) was pacing with his coat and a bag in his hand. Writer approached resident to find out what he wanted to do. Resident stated that he feels like he is forty years old and not at a good point in his life. Writer advised resident to attend group and seek staff for assistance when needed. Staff will continue to monitor. R162's sign-in sheet for groups are as follows 2/12/26 (Basic Conversation), 2/25/26 (A Better Me), 2/26/26 (Basic Conversation) and 3/4/26 (Basic Conversation). There were no other group sign in sheet provided for R162 during this survey. On 3/13/26 at 12:04PM, V49 (Nurse) said R162 was calm and stated he wanted to leave. V49 said she questioned R162 as to why he wanted to leave. V49 said he did not know why he wanted to go. V49 said she asked R162 did he have something mental going on in his head. V49 said R162 replied he wanted to harm himself. V49 said she called the doctor who gave an order for R162 to go out to the hospital. V49 said R162 was at the nursing station and said he was just joking about harming himself. R162 refused to go to the hospital because he said he was just joking when he reported he wanted to harm himself. V49 said, she called the doctor back to		S9999				

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S9999	Continued from page 5 update the doctor about R162's refusal. V49 said R162 was given snacks, juice and was allowed to call his daughter twice while V49 was waiting on the doctor's return call. V49 said the doctor called back at the end of her shift and was updated about R162's refusal. V49 said she was instructed if R162 was calm he did not have to be discharged to the hospital. V49 said she was instructed to monitor R162. V49 said R162 was monitored every fifteen minutes for three days. V49 said R162 was calm. V49's Progress note dated 12/28/2025 (12:49pm) documents: Resident (R162) saying he wants to leave, social service made aware, resident kept under 1:1 supervision. V49's Progress note dated 12/28/2025 (6:42pm) documents: Resident came to the nurse's station verbalized "I want to leave", writer asked resident where he wants to leave, he said "I just want to go I don't want to stay here. Where is the social worker?" Writer informed resident that social worker had left for the day and he was encouraged to call his family and talk to them in order to calm him down, he call his seven year old daughter and was laughing on the phone, hang up the phone and went to his room. V49's Progress note dated 12/28/2025 (7:50pm) documents: Resident came back to the nurse's station again saying "I want to go" and verbalized desire to harm himself during the interaction with staff saying "I want to leave or I will harm myself" the statement was taken serious resident was assessed for safety appears so calm not agitated denied having a specific plan or means to harm himself, resident placed on close observation for safety, resident's room checked for any harmful object there was none found, resident encouraged to verbalized his feelings he keeps saying "I just want to leave" remains under supervision. V49's Progress note dated 12/28/2025 (8:02pm) documents: Resident's doctor called made aware, she gave order to transfer resident to Hospital for observation, resident is under supervision by the nurse's station heard what doctor said he verbalized "I am not going to the hospital, I just want to leave here" staff provides emotional support while still under supervision. Writer called the DON (Director of Nursing) made aware, resident at this time still sitting by the nursing station under supervision writer had another conversation with resident. He said "I just want to go, I don't want to harm myself" calm relaxed and communicating with staffs, ate his snack with a cup of juice, took his bedtime medication, resident said "I		S9999				

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S9999	Continued from page 6 don't have plan to harm myself. I don't want to go to the hospital" with a smile on his face. Resident is still under supervision. Doctor notified twice to make aware of resident refusing to be transfer to hospital awaits call back. On 3/6/26 at 11:19AM, V19 (CNA) said, R162 looked sad. R162 was walking back and forth like he did not want to be at the facility. R162 said he wasn't feeling good. V19 said, she felt like R162 needed more monitor than she could provide because his sad look and pacing made her feel uneasy. V19 said R162 needed one to one (1:1) monitor. V19 said R162 verbalized he wanted to leave the facility prior to his jumping out of the window but not on the day of the actual incident. V19 witness statement date 1/6/26 documents: R162 got up and said, he wasn't feeling well, wanted to go to the hospital. R162 reported not feeling well. We went to the day room and we heard a sound. They (facility) already knew he had issues and R162 needed a 1:1. On 3/6/26 at 11:35AM, V20 (Nurse) said, she heard R162 had history of self-harming behavior prior to his incident but did not read R162's medical chart. V20 said, she normally works with R162. R162 paces at night. V20 said, the night of the incident, R162 had his coat on and a bag on his shoulder. V20 said, R162 did not wear a coat or have a bag on the other nights she worked with him when he was pacing. V20 said, residents with a history of self-harming behaviors without an active plan should be monitored every hour. Incident report dated 1/6/26 documents: R162 was pacing the unit throughout the night. When writer V20 (Nurse) notices he was walking back and forth, she asked the CNA to look in the dining room and she didn't see him. V20 then went to look in his room and he wasn't there. We checked all rooms on the units. V20 went to the dining room to look again and noticed the window in the dining room was broken. We looked down and R162 was lying on the ground trying to crawl away. 911 called. Predisposing Physiological Factors: Poor safety Awareness. Predisposing Situation Factor: ambulating without assist. Resident last observed – date time: pacing unit. Notes: Contributing factors include poor safety awareness related to the hospital preliminary evaluation suggests the resident behavior and memory lapse may be related to possible psychosis. On 3/6/26 2:09PM, V38 (Nurse Practitioner) said he felt R162 was trying to leave the building. V38 said he would expect staff to provide one on one monitoring for a resident when displaying behaviors like pacing and		S9999				

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S9999	Continued from page 7 voicing wanting to leave the facility. V38 said he would expect staff monitoring until behaviors subsided or can give an (PRN) as needed medication. If they are exhibiting aggressive behaviors, they can try to give an (PRN) as needed medication or send them to the hospital. R162's ambulance run report dated 1/6/26 documents: Clinical Impression: Pain, acute due to trauma. Signs and Symptoms Leg pain, Altered mental status, Back pain, Neck Pain. Injury: Falls- Fall from, out of or through window- fifteen (15ft) – Nursing Home -1/6/26. Blunt Trauma. (Name of crew) dispatched to assist with nursing home patient who jumped out a window. Crew dispatched to assist for the nursing home patient (R162) who jumped out of a window. Hospital paperwork dated 1/6/26 documents: R162 brought in by the ambulance from nursing home for complaint of fall out of window. Per emergency medical service (EMS), R162 threw a small dresser out the window on the second (2nd) story of a building and dove out the window after it, EMS reported 162 landed on his left leg. Upon arrival R162 complained of neck pain, back pain, left leg pain, swelling noted on left ankle. Ortho at bedside splinting R162's ankle currently. Complaint: Trauma Fall. Nursing note 1/6/26 documents: R162 was admitted for diagnosis of closed displaced Pilon fracture of left tibia. (A severe, often comminuted (shattered) break at the bottom of the left tibia (shinbone) involving the ankle joint's weight-bearing surface). "A"		S9999				