STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145995	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archer Heights Healthcare	4437 South Cicero Chicago, IL 60632

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40061 Based on interviews and record reviews, the facility failed to report an allegation of abuse to the Illinois Department of Public Health (IDPH) within two hours of the allegation for one resident (R1) out of a total sample of five residents reviewed for abuse. Findings include: On 9/03/2024 at 10:35 AM, R1 stated about a week and a half to two weeks ago, V12 (Nurse) called R1 a 'crackhead' and threatened to have R1 transferred to a different floor. R1 reported the incident to social services and V1 (Administrator). On 9/03/2024 at 11:05 AM, V1 and V2 (Director of Nursing/Nurse Consultant) stated there were two reportables in the last three months for R1; however, there was no reportable from the incident between R1 and V12. V1 stated R1 had mentioned [R1] was uncomfortable with V12 but did not elaborate further. V1 stated there was an open room on the fourth floor so to avoid further issues, facility transferred R1 from second floor to the fourth floor. During a follow-up interview with V1 at 11:36 AM, V1 stated when facility interviewed V12, V12 stated R1 was referring to someone as a crackhead. In response, V12 used a phrase along the lines of 'you wouldn't like it when someone called you a crackhead, would you?' V1 stated, from what I saw it wasn't an abuse allegation there. On 9/04/2024 at 10:29 AM, V12 stated R1 was talking to V12 when R1 referred to another resident as 'that dope friend over there.' In response to that, V12 said 'wait up, hold on, that's not nice. Why would you call [resident] that? You wouldn't like it if someone called you a dope fiend.' V12 stated R1 then got upset and started saying that V12 was calling R1 a dope fiend. V12 stated, [R1] went from there saying that I was calling [R1] all types of names. [R1] went in and reported me. [R1] reported me to the Administrator and to social services. Social service and [V1] came and talked to me. V12 stated, [R1] reported me to them saying I was calling [R1] names. On 9/04/2024 at 10:57 AM, V19 (Social Services Director) stated, About two weeks ago I was called downstairs as I was leaving out the door. [R1] was stating that [V12] called [R1] a crackhead. [R1] said [V12] just called [R1] a crackhead basically. V19 stated V1 was present for this and V1 and V19 investigated the allegation. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/04/2024 at 1:29 PM, V2 (Director of Nursing/Nurse Consultant) stated verbal abuse is anyone who is changing their tone to a resident, talking down to a resident or using inappropriate language to a resident. If someone is called a crackhead or dope fiend, that would be talking down to the resident. V2 stated if it is reported to staff, the next step is to report it to the abuse coordinator (V1). Facility has two hours to report to IDPH. Facility provided a copy of Facility Reported Incident for R1 and V12. Initial reportable sent to IDPH on 9/03/2024 at 12:47 PM - time of the survey. Facility's Abuse Prevention Program Facility Policy and Procedure (dated 11/18/2016) documents in part: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator. Initial Reporting of Allegations - When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated. This report shall be made immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or resulted in serious bodily injury.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40061 Based on interviews and record reviews, the facility failed to ensure coordination of outside services/appointments and have a complete medical record for R3 for one of five residents reviewed for appointments. Findings include: R3's After Visit Summary from 7/20/2024-7/24/2024 hospitalization documents in part to follow-up with hepatology, primary care, and urology. R3 had the 7/31/2024 and 10/14/2024 appointment. R3's After Visit Summary from 8/23/2024-8/26/2024 hospitalization documents in part instructions to schedule a gastroenterology follow-up visit for EGD (esophagogastroduodenoscopy) on 8/27/2024. There was also an appointment with V26 (Podiatry) on 9/30/2024 at 10:30 AM. On 9/03/2024 at 10:25 AM, V3 (Nurse) was R3's primary nurse. Surveyor asked if R3 had any past appointments or upcoming appointments. V3 stated looked at R3's physician orders in the computer. V3 stated R3 had an appointment on 7/31/2024 but did not know if R3 went to 7/31/2024 appointment. V3 did not know what the appointment was for. V3 also stated that R3 had a future appointment on 10/14/2024 but V3 did not know what it was for or for which medical specialty. R3's Order Summary Report documents in part that R3 had a hospital follow-up on 7/31/2024 at 1:50 PM. It also documents in part that R3 has a return visit with V25 (Gastroenterologist from Hepatology Department at hospital - surveyor acquired V25's title via provided telephone number in the Order Summary Report) on 10/14/2024 at 4:15 PM. On 9/03/2024 at 12:56 PM, surveyor requested a list of R3's future appointments from V2 (Director of Nursing/Nurse Consultant). On 9/03/2024 at 1:19 PM, V14 (Transportation Coordinator/Central Supply) stated role is to set up transportation arrangements for residents' appointments. V14 stated did not have any transportation or appointments listed for R3 in August or September. At 1:25 PM, V14 stated no appointments/transportation set up for R3 in July. V14 stated nursing staff did not inform V14 of any other upcoming appointments this month. On 9/03/2024 at 1:25 PM, V15 (Appointment Scheduler/Medical Records) stated role is to go through the resident's chart and After Visit Summary from the hospital to look for any upcoming or needed appointments. Nurses will also inform V15 of any upcoming appointments via the appointment binders in the units. At 1:46 PM, V15 stated did not have an appointment listed for R3 on 7/31/2024. V15 stated [V15] did not have a record of R3 going somewhere and did not know if R3 went or if R3 refused to go. V15 did not know the purpose of the 7/31/2024 appointment. V15 stated did not see any other appointments for R3 beside the one for 10/14/2024. V15 stated was not aware of a urology appointment recommendation and did not set up an appointment for R3. V15 was also not aware of R3's appointment with V26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/04/2024 at 9:21 PM, V2 stated 7/31/2024 was for an emergency room follow-up that R3's primary can address at the facility (this was not addressed until time of survey). V2 also stated that V15 made the urology appointment for R3 for 12/02/2024 yesterday after speaking with surveyor. V2 stated facility was still trying to review R3's hospital papers and chart to make sure all R3's appointments were accounted for and set up. On 9/04/2024 at 1:29 PM, V2 stated was not sure of V25's title or if it related to the recommended hepatology follow-up. V2 was not sure whether R3 had the EGD done or if R3 followed up with gastroenterology. V2 was also not sure about R3's appointment with V26. V2 stated [V2] and staff were still looking into it. During a follow-up interview at 2:15 PM, V2 stated calling the hospital for R3's appointments and found out that appointments were already set up. At 2:46 PM, V2 wrote that R3's appointment with V26 was scheduled on 8/2/2024. Facility was not aware of this until time of survey. Regarding R3's gastrointestinal appointment for 10/8/2024, V2 wrote Per the hospital, [R3] was to see [R3's] primary to set up this appointment. [R3] would have never been able to have an EGD scheduled until [R3] saw [R3's] primary in the community [retracted] who [R3] did not have any follow up appointments scheduled due to seeing the primary in the nursing facility. This was not addressed until time of survey. On 9/04/2024 at 12:18 PM, V2 wrote that the facility did not have an appointment policy. Illinois Long-Term Care Ombudsman Program's Residents' Rights for People in Long-Term Care Facilities (Revised 11/18) documents in part: Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Facility's 2/22 Medical Record Policy documents in part: To ensure that a complete, accurate and legal record of the resident's care that's maintained contains justification of diagnoses, treatment results. The record is readily accessible systematically organized to provide a medium of communication among health care professionals involved in the residents care and to facilitate retrieval of information. It is the policy of this facility that an organized, accurate and complete written record will be maintained for each resident in accordance with applicable State and Federal guidelines and laws.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to monitor a diabetic resident's foot; failed to assess and report a new skin alteration on a diabetic resident's foot; and failed to provide activities of daily living (ADL) care as assessed for a diabetic resident which affected R2 in the sample of three residents reviewed for improper nursing care. These failures resulted in R2's nurse practitioner (V4) assessing for R2's right lower leg redness and swelling; removing R2's moist right sock to see multiple maggots crawling from R2's right foot wound (base of big toe); and R2 being transferred to the hospital for further evaluation of gangrene infection which required surgical amputation of R2's right big toe. Findings include: R2's Admission Record documents, in part, diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease and with diabetic peripheral angiopathy without gangrene, dementia, hypertension, hyperlipidemia, peripheral vascular disease, retention of urine, difficulty in walking, lack of coordination, and need for assistance with personal care. R2's Minimum Data Set (MDS), dated [DATE], documents, in part, R2's Brief Interview of Mental Status (BIMS) score 15 which indicates R2 is cognitively intact, and R2's Behavior for Refusal of Care with no refusals of care. R2's Functional Ability and Goals (dated 5/17/24 and 7/29/24) documents, in part, the following: Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self and Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear is appropriate for safe mobility are coded as 2 which signifies Substantial/maximal assistance-Helper (staff) does more half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. R2's Mobility documents, in part, a manual wheelchair for R2; and for R2's Sit to stand, Chair/bed-to-chair transfer, and Toilet transfer, R2 is coded as 2 which signifies Substantial/maximal assistance-Helper (staff) does more half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. R2 was discharged to the hospital on 7/30/24, and no longer resides in the facility. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	On 9/3/24 at 12:39 pm, V4 (Nurse Practitioner, NP) stated V4 is R2's nurse practitioner in the facility, works Monday through Friday, and routinely visits R2. V4 stated, The most recent thing I remember was when I was rounding on (R2). I asked, 'How are you?' (R2) said (R2) was going to bathroom and was in (R2's) wheelchair. I saw one leg a little swollen, so I wanted to see (R2's) toes, and then I saw maggots. When asked where was V4 when assessing R2 on 7/29/24, V4 stated it was in R2's room. V4 stated R2 was propelling self via wheelchair to the bathroom. V4 stated on 7/29/24, V4 observed R2's right shin was with redness, shiny. Something was wrong. V4 stated V4 asked R2 about what happened to R2's right leg as V4 was examining R2's leg, and R2 said, Oh, that hurts. V4 stated V4 was alarmed with R2 having pain, so V4 wanted to fully assess R2's right foot and toes with R2 wearing socks. V4 stated, When I open it (sock), just wow (V4 is making motion with V4's hands of an explosion). When asked to explain what V4 means by this, V4 stated, (R2) had on a thicker sock. I opened up the sock, and there's maggots running out from wound on right big toe. V4 stated V4 informed the nurse (V5, Licensed Practical Nurse, LPN), Director of Nursing (former) and V16 (Wound Care Physician Assistant). V4 stated, This was a concern to me. Everyone was made aware immediately. V4 stated on 7/29/24, V4 ordered antibiotics, pain management, maggot medication, and stat laboratory (lab) blood work. When asked about details of what V4 observed on 7/29/24 with R2's right foot, V4 stated, There were maggots, I remember. Maggots, they came from the wound, and I opened up the sock, and they were crawling. They were just there. There were no maggots in the bed. They were inside the sock, crawling. Many of them. When asked about how many maggots did V4 see, V4 stated, 10 or higher. When asked about the characteristics of R2's right big toe wound, V4 stated, It was moist. It looked like when you dipped skin in water for hours without drying it. Foot was swollen. V4 stated the right big toe wound didn't have pus-like discharge, but it was moist. V4 stated the wound was under the right big toe joint and looked similar to a corn callous. V4 stated, The maggots were in there only, eating part of (R2's) foot. It developed from there, the moist part. V4 stated on 7/30/24, V4 assessed R2 in the facility and R2's labs were abnormal, so V4 ordered for transfer to the hospital. V4 stated, I don't want to wait. (R2) could have possible gangrene or osteomyelitis going on. V4 stated R2's white blood cell (WBC) count and C-reactive protein (CRP) count were elevated indicating infection. V4 stated, I was concerned with gangrene with diagnosis and (R2) may need MRI (magnetic resonance imaging). It was a concern for amputation. I sent (R2) to hospital for higher level of care. When asked about care specific for a diabetic resident's skin, especially feet, V4 stated, We do routine foot exam. We have to do it. Podiatrist for cutting the nails. We have a consult for podiatry. When asked about the expectations of staff to assess a diabetic resident's skin, V4 stated, We have to check the skin. Check more on foot for exam. There is a chance of neuropathy or infection. If they (residents) have a sore, then they will not feel the sore. V4 stated, Every day, we need to clean and put new socks on. When asked what V4 expects of staff to be doing to prevent R2 from developing a diabetic wound with maggots, V4 stated, If we (staff) clean (R2) and check (R2's) feet every day. I expect and to change (R2's) socks every. Change every day and open cleaning it. (R2) can help with (R2) upper body, but not bottom part with socks. I don't think (R2) can do that. V4 stated V4 would not expect R2's diabetic wound to ever have a maggot infestation. V4 stated R2's mobility is via a manual wheelchair and R2 propels R2's self in the hallways. V4 stated V4 has never been notified by nursing staff R2 has been noncompliant with wearing socks or shoes while up in the wheelchair. In R2's Progress Notes, dated 7/29/24 at 7:25 pm, V4 (NP) documents, in part, APC (Advanced Practice Clinician) noted with right shin area, below knee redness, edema + (plus), while opening (R2's) sock, noted a lot of maggots crawling, coming from under right great toe small skin area opening, no pus discharge at present, right foot great toe surrounding skin noted moist, macerated, and white skin discoloration. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	In R2's Progress Notes, dated 7/30/24 at 2:42 pm, V4 (NP) documents, in part, F/u (follow up) lab, will Transfer to (hospital) on 7/30/24 (per {V27, Attending Physician}) due to acute right foot ulcer (DM {diabetes mellitus}-2), CRP 224, WBC 34 (prior to IV antibiotic). R2's Hospital Records documents, in part, R2's hospital diagnoses of Right foot wound, Gangrene, and s/p (status post) right hallux (big toe) amputation 7/31/24. On 9/3/24 at 12:09 pm, V5 (LPN) stated V5 is very familiar with R2, and R2 is alert, orientated with periods of confusion and propels self by wheelchair. V5 stated R2 will transfer R2's self to the wheelchair and the toilet, and we (staff) did assist with bathing and bed bathing. V5 stated on 7/29/24, V5 was called back to R2's room by V4 (NP). V5 stated with R2's sock on, R2's foot would get moist, and V4 observed R2's right foot skin (on 7/29/24) as real moist, like (R2's) skin was in water too long. V5 stated R2's right foot wound had white looking drainage, but V5 is not good with (wound) treatments. V5 stated V4 saw R2's foot was swollen and's why V4 had checked on R2's right foot. V5 stated, I didn't see that they (feet) were swollen. V5 stated V4 provided orders that V4 carried out. V5 stated R2's skin don't take too long for breakdown, with (R2) being diabetic and all the other conditions. When asked why it is important for staff to check a diabetics skin, like R2, V5 stated, The same, so they (diabetic residents) don't end up with an amputation, and they don't know they got it, and they are not left untreated. V5 stated with R2 being up and about, it's hard to tell if something is going wrong. It's easier when (R2) is in bed. V5 stated CNA (Certified Nursing Assistants) perform the ADL care, and when CNAs are bathing/showering residents, the CNA will call the nurse to come do a full body skin check. V5 stated shower/bed baths are given twice a week. In R2's Progress Note dated 7/29/24 at 6:24 pm, V5 (LPN) documents, in part, Resident was noted with a small wound to the right foot, great toe, red in color slightly swollen, with small amount of drainage. NP (V4) saw resident and order ABT (antibiotics) and stat labs, CBC, CMP (comprehensive metabolic panel), CRP. Family may aware. On 9/3/24 at 2:49 pm, V5 (LPN) stated R2 wore nonskid socks when R2 propelled R2's self in the wheelchair and did not wear shoes. V5 stated V5 could not recall the exact date of the last time V5 performed a full body assessment for R2 during bed bath or shower. When asked if V5 has received a report from a CNA about R2 having new skin alteration on right foot, V5 stated, No, no report of (R2) skin. V5 stated, If something did happen (to R2), in one or two days, there can be breakdown. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	On 9/3/24 at 12:29 pm, V6 (CNA) stated V6 normally works on R2's floor and is assigned as R2's primary CNA. V6 stated R2 was alert and (R2) needed assistance. V6 stated at times, R2 would refuse showers, and V6 would tell the nurse. When asked how you handle R2's refusal of a shower, V6 stated V6 will tell the nurse, then go back a second time to see if R2 wants it, and if R2 refused again, V6 would tell the nurse so it's documented. V6 stated, (R2) needed assistance. (R2) would be able to get up and go to the bathroom. (R2) needed help to put clothes on. When asked if V6 checked R2's skin on the feet, V6 said yes, and V6 would take the socks off to check. When asked if R2 had a skin alteration on R2's feet recently near the end of July 2024, V6 stated, I saw one. It was near right toe. I told the nurse. V6 stated V6 could not remember which nurse V6 notified. V6 stated V6 could not confirm if the date was 7/29/24 (with new right big toe wound). This surveyor stated survey will view the CNA assignment schedules to confirm if V6 was working on 7/29/24. When asked to describe what V6 observed on R2's right foot on this unknown date late July 2024, V6 stated, Nothing but a little, like it was like a skin tear on the side of her toe. There was redness. No drainage. V6 stated, I took them (socks) off, when I was getting (R2) ready. Assisting to get (R2) up with dressing. V6 stated, I reported (R2's) skin tear to nurse. When asked how often is V6 checking R2's skin, V6 stated, It's a daily thing with care. Facility document dated 7/29/24 day shift (7 am - 3 pm) and titled Daily Assignment Sheet documents, in part, V6 was not working or assigned to R2. V17 was assigned as R2's primary CNA, and V5 (LPN) was R2's primary nurse. On 9/4/24 at 12:25 pm, V17 (CNA) stated V17 works routinely on R2's floor and confirmedV17 was assigned as R2's primary CNA on 7/29/24. V17 stated R2 was a 1 person staff assist for transfer and needed assistance with dressing for ADL care. V17 stated R2 would propel R2's self with R2's feet when in the manual wheelchair and would wear slippers. When asked on 7/29/24, did V17 notice any redness or swelling to R2's right lower extremity, V17 stated, Not I can recall. When asked if V17 checked R2's skin during ADL care on 7/29/24, V17 stated, No, I can't even remember that day. (R2) normally like goes to the bathroom on (R2) own with assist. I can't even remember looking at (R2's) feet. V17 stated V17 will document skin alterations on the shower sheet and report it to the nurse. When asked what is V17 looking for on a resident's skin, V17 stated, To look to see basically any wounds, open wounds or open sores or marks need attention. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	On 9/3/24 at 1:47 pm, V7 (Wound Care Coordinator) stated R2 was a diabetic and V7 had provided R2's last wound care treatment in June 2024 where a left heel deep tissue injury was healed. V7 stated V7 was informed on 7/29/24 by V4 (NP) R2 had a new right foot wound. V7 stated V7 performed R2's wound care treatment on 7/30/24, and R2's right big toe wound was sloughy. Almost all of it. I was thinking how (R2) doesn't feel this. (R2) has diabetic neuropathy. It was yellow tissue. It was a pink crack itself. This surveyor and V7 viewed R2's Treatment Nurse Initial Skin Alteration Review (7/30/24, authored by V7). V7 confirmed the measurement to the right big toe wound was 8 by 11 centimeters (cm). V7 stated the wound was from the right big toe to hallux by ball of the foot. V7 stated, I didn't understand how (R2) didn't feel it. It looked really mangled. V7 stated V7 classified R2's wound as a non-pressure, diabetic wound. When asked what that means, V7 stated it did not come from pressure. (R2) moves (R2's) feet. Nothing is sitting on (R2's feet), so it's not the cause of the wound. V7 stated, This kind of wound does not gradually happen. They (staff) need to watch out for diabetic hands and feet and handle them carefully. (Diabetic residents) with neuropathy, and they (staff) must do the care. Staff see the feet and wash the feet then they would see it (wound). They have to be actually doing it. When asked in V7's professional wound care training, how can a wound be infested with maggots, V7 stated if there is a wound and if wound is lacerated or open, the fly can deposit eggs. V7 stated even if the wound is covered, the fly can sit on top of covering (dressing or sock) and lay eggs 27 layers down to infiltrate the area. When are skin assessments being done by staff (nurses/CNAs), V7 stated, They should have skin checks twice a week with showers. CNA and nurses are responsible. If there's an alteration of skin, nurse will let us (wound care) know. I will use assessment tool. R2's Treatment Nurse Initial Skin Alteration Review, dated 7/30/24, V7 documents, in part, R2's right great toe extending to plantar hallux wound as a non-stageable, non-pressure injury/diabetic, acquired in the facility with the size of wound being 8 cm by 11 cm by unknown depth with small amount of exudate and peri wound area as edematous and macerated. On 9/4/24 at 1:18 pm, V2 (Director of Nursing, DON/Regional Nurse Consultant) stated, Skin should be assessed daily. Staff identify issues during care. CNAs will notify the nurses. If CNA sees something during AM care or PM care, CNA sees the alteration of skin and will notify nurse. When asked how often skin assessments are done, V2 stated, Weekly skin assessments. When asked when a CNA or nurse is assessing a resident's skin, what are they looking for, V2 stated, Open areas, if they see blister or redness. V2 stated bed baths or showers are given weekly, and if the resident refuses, then the staff must figure out which day is a good for an alternate day. V2 stated the treatment nurse (V7, Wound Care Coordinator) collects the paper shower sheets from the floors to review. This surveyor showed V2 the shower sheet for R2 from 7/24/24 with no documentation of what was done (no skin check or bath/shower was checked). When asked what was done for R2 on this date, V2 stated, I don't know. I can't answer. V2 stated when residents refuse care, the resident is educated, and the CNA will alert the nurse. V2 stated social services staff will speak to the resident and the refusal of care will be care planned for. When asked about diabetic resident's skin checks, V2 stated, Again staff should be monitoring overall for skin dryness, redness, excessive moisture. Look at the feet, and the podiatrist is supposed to be seeing them. For diabetics, we want to make sure resident doesn't have skin alteration because of different issues with their health. The toenails are to be clipped. It takes a while for them (diabetics) to heal. V2 stated V2 expects staff to assess everyone, not just diabetics. When asked why it takes longer for diabetics skin to heal, V2 stated, Diabetes affects every organ in the body. Tissue perfusion and not getting oxygen to the organs. Edema which can prevent fluid coming in from intra and extra vascular space which can affect healing as well. (continued on next page)

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	145995	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archer Heights Healthcare	4437 South Cicero Chicago, IL 60632

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F 0687 Level of Harm - Actual harm Residents Affected - Few	R2's Complete Care Plan, with last care plan review date of 8/8/24, documents, in part, a focus of R2 has actual impairment to skin integrity related to comorbidities and medical diagnosis of diabetes mellitus type 2 shows interventions of keep hands and body parts from excessive moisture (initiated 5/11/24) and monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. (the rest) to MD (doctor) (initiated 5/11/24). R2's Complete Care Plan does not include a focus for refusal of care. On 9/4/24, R2's Shower Sheets for July 2024 were requested from V2 and provided to this surveyor by V7 (Wound Care Coordinator). R2's Skin Monitoring: Comprehensive CNA Shower Review, dated 7/17/24, signed by V6 (CNA) documents, in part R2 received a shower with assist. R2's Shower Sheets (titled as Skin Observation Worksheets) dated 7/21/24 documents R2 refused a bath/shower and on 7/24/24, no documentation is observed R2 received a shower and skin check, skin check or a bath/shower was refused. Facility policy dated September 2022 and titled Bath/Shower Schedule documents, in part, Policy: A bath or shower will be given to each resident by a Certified Nurse Assistant one time per week as scheduled and prn, per resident preference. Procedure: 1. Charge Nurse makes schedule for Certified Nurse Assistant to include baths or showers are scheduled for respective date and shift. 2. Bath and shower schedule is posted on each floor. 3. Certified Nurse Assistants give bath or shower as scheduled. 4.If resident refuses bath or shower, the Charge Nurse is notified for intervention, follow-up, and documentation. 5. Certified Nurse Assistants are to notify the Charge Nurse of resident's skin changes noted. 6. Bath/Shower sheets are to be completed by the Certified Nurse Assistant upon each bath/ shower scheduled whether accepted or declined. 7. Bath/Shower sheets will be maintained by the facility for the current and entire last month and then may be discarded. Facility policy dated September 2023 and titled Activities of Daily Living (ADL) documents, in part, Purpose: To preserve ADL function . Interventions may include (depending on an assessment based on individualized need): . Dressing: . Selecting, obtaining, putting on, fastening . and taking off all items of clothing, and putting on and removing . socks and shoes. Facility policy dated November 2022 and titled Foot Care Assessment documents, in part, Policy: It is the policy of the nursing department to perform an assessment of the resident's feet at the time of admission, updated quarterly, and when significant change occurs. Purpose: To identify treatable conditions, prevent infections, provide treatment, and comfort. Facility policy dated October 2020 and titled Pressure Ulcer and Skin Condition Assessment Policy documents, in part, Policy: It is the policy of this facility pressure and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved wound assessment form. Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure, and other ulcers and assuring interventions are implemented. Standards: . 3. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the licensed nurse who will perform the initial assessment. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Facility policy dated 2/1/22 and titled Change in Resident's Condition documents, in part, General: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician/NP and resident's responsible party of a change in condition. Responsible Party: RN, LPN, Social Services. Policy: Nursing will notify the resident's physician or nurse practitioner when: . b. There is a significant change in the resident's physical, mental or emotional status. c. There is a pattern of refusing treatment or medication . e. It is deemed necessary or appropriate in the best interest of the resident. 2. Appropriate assessment and documentation will be completed based on the resident's change in condition or indication. 3. Once the physician/NP has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issue and any physician orders. 4. The communication with the resident and their responsible party as well as the physician/NP will be documented in the resident's medical record or other appropriate documents. 5. The Care Plan for the resident will be updated as indicated. Facility job description (undated) titled Certified Nursing Assistant documents, in part, Job Summary: The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine . Main Duties: A. Support the facility's philosophy of care and strive to achieve its goals and objectives . C. Carry out assignments for resident care including (but not limited to): a) bathing b) dressing . H. Report any changes in resident's condition . to the charge nurse of the unit . M. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. Facility job description (undated) titled Charge Nurse documents, in part, Job Summary: . Care for the clinical nursing needs of residents on his/her wing . Job Requirements: . 2. Excellence in all aspects of quality nursing including exceptional care . Main Duties: A. Support the facility's philosophy of care and strive to achieve its goals and objectives . D. Supervise all aides in performing their duties by checking work closely to ascertain assignments have been completed . F. Make daily rounds on the wing to ensure individual Care Plans are being followed and assess each resident's status in accord with his/her Care Plan . P. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duties . R. At all times abide by policies of the facility and ascertain employees under his/her supervision do the same . U. Prepare . reports, events and observations using the EMR (electronic medical record) system.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40061 Based on interviews and record reviews, the facility failed to ensure accurate medical records for one resident (R1) out of a total sample of six residents. Findings include: On 9/03/2024 at 10:35 AM, R1 stated medical records list R1 with a diagnosis of schizophrenia. R1 stated [R1] does not have schizophrenia and does not know where the diagnosis came from. Facility did not explain which doctor put it on R1's medical records. R1 stated, I don't want people treating me differently you know because they'll see that schizophrenia on my papers and discriminate against me. R1's Admission Record (dated 9/03/2024 1:39 PM) documents in part a diagnosis of Schizoaffective Disorder, Bipolar Type with onset date of 7/10/2024. Reviewed V13's (Psychiatric Nurse Practitioner) 8/06/2024 Psychiatry Note for R1. No mention of schizophrenia. During a telephone interview with V13 on 9/03/2024 at 2:44 PM, V13 stated 'Schizoaffective Disorder, Bipolar Type' is a type of schizophrenia plus bipolar diagnosis. Surveyor read V13's Psychiatry Note from 8/06/2024 over the phone. V13 stated if the note does not indicate schizophrenia, then V13 did not have it as a diagnosis for R1. V13 stated [V13] did not put the Schizoaffective Disorder, Bipolar Type diagnosis on R1's Admission Record. V13 stated [V13] does own personal assessment based on R1's moods and behaviors. V13 reviews R1's social history and gathers the information based on what R1 shares with V13. On 9/04/2024 at 9:21 AM, V2 (Director of Nursing/Nurse Consultant) stated [V2] did not see a schizophrenia diagnosis in R1's hospital intake forms. V2 and facility were trying to figure out where schizophrenia diagnosis came from or who diagnosed R1 with it. V2 stated when interviewing the nurse that put the diagnosis in (V5), V5 stated either hearing it from report or reading it from somewhere. Attempted telephone interview with V5 on 9/04/2024 at 11:23 AM; however, no answer. Reviewed R1's admission packet. R1's 7/10/2024 Admission Report does not document in part a diagnosis of schizophrenia. R1's After Visit Summary (dated 7/10/2024 4:14 PM) does not document in part a new diagnosis of schizophrenia. R1's 7/08/2024 - 7/10/2024 hospital records do not document in part a diagnosis of schizophrenia. R1's 6/28/2024 Notice of PASRR (Preadmission Screening and Resident Review) Level I Screen Outcome did not document in part a diagnosis of schizophrenia. On 9/04/2024 at 1:29 PM, V2 stated facility did not know where schizophrenia diagnosis came from. V2 stated, 'I think the nurse put the wrong one (diagnosis) by accident.' (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Medical Diagnoses (dated 9/04/2024 10:42 AM) document in part a crossed-out diagnosis of Schizoaffective Disorder, Bipolar Type with comment of Incorrect Documentation. Facility's 2/22 Medical Record Policy document in part: To ensure that a complete, accurate and legal record of the resident's care that's maintained contains justification of diagnoses, treatment results. It is the policy of this facility that an organized, accurate and complete written record will be maintained for each resident in accordance with applicable State and Federal guidelines and laws. Diagnoses may be authenticated by one of the following methods; Admission - History & Physical, Physician Orders, Progress Notes or Hospital/Nursing Home Transfer Records or Hospital Discharge Summary.