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	09/13/2024

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

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interviews and record reviews, the facility failed to intervene and protect 4 residents (R2, R3, R4, R5) from verbal and physical abuse out of 4 residents reviewed for abuse. These failures resulted in; 1.) R2 attempting to run out the facility after an incident with another resident (R3). R2 then struck a window, resulting in a laceration to the right arm, R2 was sent to the local hospital and received sutures; 2.) R4 and R5 became verbally aggressive and then physically aggressive to one another. Findings Include: 1.) R2's clinical records show an admitted [DATE] with diagnoses that included but not limited to schizoaffective disorder and bipolar disorder. R2's minimum data set (MDS) dated [DATE] shows R2 had moderately impaired cognition and required supervision with walking. R2's progress notes dated 8/16/24 at 5:48 PM written by V3 (Licensed Practical Nurse/LPN) reads in part: [R2] noted receiving verbal and sexual inappropriate remarks from peer. Peer stated to [R2], Come here, and push me my b**ch. Staff and [R2] requested multiple times for peer to stop and was redirected to the dining room. Peer returned to the nursing station and began to provoke [R2]. Staff attempted to redirect [R2]; however, [R2] was non-compliant and unable to be redirected. [R2] began to swing [R2's] belt and hit peer in the head. Staff separated the residents for safety precautions. [R2] was assessed, and no injury was noted. The residents were placed on a 1 on 1 monitoring. [R2] then ran down the hall away from staff and broke the window resulting in an injury to right arm. R2's hospital AFTER VISIT SUMMARY dated 8/17/24 to 8/19/24 revealed R2 received sutures for R2's right arm laceration. R3's clinical records show an admitted [DATE] with diagnoses that included but not limited to paraplegia and schizoaffective disorder, bipolar type. R3's MDS dated [DATE] shows R3 was cognitively intact, not ambulatory, and used a wheelchair as primary mode of locomotion. R3 was discharged from the facility on 8/22/24. (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 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's final abuse report on R2 and R3 with incident date of 8/16/24 timed 6:00 PM reads in part: On 8/16/24, R3 propelled himself towards R2 and asked R2 to push R3 while in the wheelchair. R2 declined and R3 started to make homosexual comments towards R2 saying, Push me now, my b****, push me now. R2 grew upset and pulled off R2's belt and started to swing it in R3's direction. R3 would continue to taunt R2 as R2 would swing the belt. Facility staff was attempting to de-escalate R2 while attempting to move R3 from the direction of R2 as R2 swung R2's belt. As staff attempted to separate the two, R2's belt made contact with R3 and hit R3 on R3's forehead. R2 was taken to the social service office and allowed to vent R2's frustrations. R2 became worked up and ran out of the social service office in fear the police would come and arrest R2. Facility staff immediately followed R2 while maintaining distance to so R2 would not feel threatened. The facility staff attempted to verbally de-escalate R2 when R2 punched the window causing an injury to R2's right arm. First aid was rendered, and emergency ambulance was called and transported R2 to the local hospital. On 9/10/24 at 11:06 AM, interviewed V3 (Licensed Practical Nurse) about the incident between R2 and R3 on 8/16/24. V3 stated R3 was being antagonistic the entire day and was making comments towards R2. R2 became upset. R3 called R2 the B word. R2 tried to hit R3 with the belt. V3 stated R2 was extremely anxious after the incident, was pacing the hallway and said, Oh my God what did I do. When I'm like this I can't calm down. V3 stated R2 was kicking the door. R2 would not calm down. V3 stated R2 banged the window on the 3rd floor and that's when R2's right arm had a laceration. V3 stated R2 was bleeding a lot and emergency paramedics, and the police were called. V3 stated R3 has done things to multiple residents before like swearing at the residents. On 9/10/24 at 11:29 AM, interviewed R2 and stated R2's been in the facility for couple of years. V2 stated there was a resident that bothered R2 before and it was the same resident that bothered R2 during the incident on 8/16/24. R2 stated R3 kept going at the nurses' station bothering V3. R2 stated, R3 was told by multiple nurses to stop bothering them. [R3] was going to the nurses' station and none of us are allowed by the nurses' stations. I told [R3] to get the f*** away from the nurses' station. I wheeled [R3] in the day room. [R3] was calling me his B****. I went to go get my belt I wrapped my belt around my hand with the metal part hanging and I started attacking and swinging at [R3] with the belt. I hit [R3] on the head. I don't think [R3] bled but I did hit [R3] with the belt. It was [V3] and [V5 Behavioral Technician] and other people were trying to stop me. After that V5 tried to bring me to the nurses' station. I was very upset, so I swung at [V5]. [V5] tried to stop me then I was on the ground. I was in the Social Service office. I tried to grab the coffee maker. I felt very scared and very angry. The other nurse gave me a shot to calm me down and then after that I got up and ran in the dining room started throwing chairs in there. I don't think I hurt anyone in the dining room. After that I went to the elevator, I was planning to run out the door, but they stopped me, so I ran down the hall and I hit the window with my right elbow. I busted the window. I fell to the ground I was crying because it hurt really bad. I tried to climb out the window, but they stopped me. I had blood all over. They called the ambulance, and they took me to [local hospital] and they did the MRI [Magnetic Resonance Imaging] and surgery. I had an open wound and they stitched it. I had to stay in the hospital for a couple of days. They told me they closed the wound in surgery. On 9/10/24 at 12:05 PM, interviewed V5 (Behavioral Technician) and stated R2 was very upset about the incident that happened with R3. V5 stated R2 was pacing so V5 called R2 to V5's office. V5 stated R2 ran out of V5's office and went to the dining room and started throwing chairs then R2 ran down the hall and broke the window. V5 stated R2 was bleeding and was crying. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/11/24 at 11:20 AM, interviewed V2 (Acting Director of Nursing/Regional Nurse Consultant) about R2 and R3's incident on 8/16/24. V2 stated from the investigation R3 came to the nurses' station and antagonizing R2. R3 called R2 You're my B****, Come push me my B****. V8 (Certified Nursing Assistant) re-directed R2 into the dining room area. R3 left after that to smoke. When R3 came back up R3 started antagonizing R2 again. V2 stated, From my understanding there were at the nurses' station. [R2] was hitting [R3] with the belt. The staff separated them. [R3] went down again. The nurse ran down to get [V5]. They were able to get [R2] to calm down. [R2] was scared and was panicking thinking that [R2] was going to jail. [R2] ran down the hall and [R2] tried to run out the door. When [R2] could not get the door opened, [R2] started hitting the window. [R2] injured his right arm. They both went to the hospital. [Local hospital] sutured [R2's] wound. V2 stated verbal abuse is not just through language but also through body language if the resident presents with negative disposition, if the resident is talking down to another resident and intimidating, cursing, yelling, using profanity. V2 stated physical abuse is hitting, pushing, smacking with intent to the person. On 9/11/23 at 12:54 PM, interviewed V8 (Certified Nursing Assistant) about R2 and R3's incident on 8/16/24. V8 stated, R3 was antagonizing R2 saying gay comments like I want to make you my B****. I want you to be my boyfriend. V8 stated it happened for 2-3 hours. V8 stated R3 was also inappropriately touching R2. R3 was grabbing R2's hands trying to grab R2's behind. V8 stated, I saw [R3] doing that, and I kept redirecting them. But [R3] would come back and would do it again. Finally, [R2] got upset and took a belt and was hitting [R3] and told [R3] to stop touching [R2]. We separated them and then [R3] went to the first floor. [R3] came back up and at this point [R2] was still upset. We tried to calm [R2] down. [R2] felt like he let us down. [R2] said he didn't want to go to jail. I was called again by the time I made it out [R2] was trying to go out the door, but [R2] could not open the door, so [R2] hit the window with his right arm. [R2] was bleeding really bad. [R2] was laying on floor. I called the code through the receptionist. Police and paramedics came. On 9/12/24 at 10:34 AM, V1 (Administrator) stated V1 is the abuse coordinator and any kind of form or suspected or hint of abuse it must be reported to V1 as soon as possible. V1 stated V1 has two hours to report and to begin initial investigation. V1 stated abuse in-service in done with all staff at least annually. V1 stated the types of abuse are physical, neglect, misappropriation of funds, verbal, sexual, and secluding resident. V1 stated an example of physical abuse between resident to resident is if there is a determination that there is willful act to harm the other resident in any kind of physical attack. V1 stated an example of verbal abuse is any kind of verbal attack. A willful intent to cause harm such as cursing and using profanities directed towards the resident. V1 stated first if there is resident to resident altercations, the staff need to separate the resident. They cannot see each other. V2 stated residents have the right to be free of abuse while residing in the facility. 2.) R5's clinical records show an admitted d of 2/11/16 with included diagnoses but not limited to chronic obstructive pulmonary disease, heart failure, and cerebral infarction. R5's MDS dated [DATE] shows R5 is cognitively intact, does not walk, and uses a wheelchair. R4's clinical records show an admitted [DATE] with included diagnoses but not limited to paraplegia, bipolar disorder, and attention-deficit hyperactivity disorder. R4's MDS dated [DATE] shows R4 was cognitively intact, did not walk, and used a wheelchair. R4 was discharged from the facility on 8/2/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R4's progress notes dated 8/2/24 at 1:30 PM written by V15 (Social Service Consultant) reads in part: R4 was noted leaving the patio from the smoke break when R4 stopped in the dining room to converse with a R5. R4 stated they were conversing about floor-to-floor movement and R5 alleged that visitation is cancelled on all units due to R4 being alleged to have violated the substance use policy. R4 stated the conversation then led to an argument due the disagreement. R4 then stated that argument became physical when R5 pushed R4. The facility's final abuse report on R4 and R5 with incident date of 8/2/24 at 9:20 AM reads in part: While leaving from smoke break, R4 observed R5 entering the smoking area and started to call R5 a snitch. R5 asked R4 to leave R5 alone. As R5 continued to propel himself toward the patio to smoke, R4 grabbed R5's wheelchair and continued to taunt R5. R5 grew angry and stood quickly from R5's wheelchair and started to fall. R5 grabbed R4's wheelchair causing them both to fall onto the floor. On 9/10/24 at 12:05 PM, interviewed V5 (Behavioral Technician) regarding R4 and R5's incident on 8/2/24. V5 stated V5 did not witness the incident but heard that R4 started the situation. R4 antagonized R5. V5 stated R4 was verbally abusive to R5. V5 stated R5 does not bother anybody. V5 stated R5 could not take what was said by R4 and R5 pushed R4. V5 stated that R4 has always been verbally abusive towards staff and residents. On 9/10/24 at 3:08 PM, a phone interview conducted with V15 regarding R4 and R5's incident on 8/2/24. V15 stated V15 did not witness what happened and was reported back to V15 that something happened with R4 and R5. V15 stated, I believe the activity aide [V24] was there during smoke break. I believe it was the end of smoke break. From my conversation with [R4], [R4] said that [R4] was having friendly conservation with [R5]. [R5] was saying that somebody put [R4] on observation. [R5] was telling [R4] that [R4] is not on observation. You're off the floor now how can you be on observation. [R4] went behind [R5's] wheelchair kinda yanking it. [R4] alleges [R4] was playing around. [R5] stood up from [R5's] wheelchair. [R5] said [R5] swung [R5's] hands backwards and made [R4] fall. [R4] said [R5] made physical contact. On 9/11/24 at 9:51 AM, interviewed R5. R5 was alert and able to verbalize needs. R5 stated R4 was coming in from the patio and R5 was at the dining room waiting to go out to smoke. R4 was yelling at R5. R4 was cursing at R5. R5 stated R4 pushed R5 from the front, so R5 pushed R4 back and R4's wheelchair tipped over. R4 fell on the ground. R5 stated V24 was there passing out cigarettes. 9/11/24 at 11:20 AM, interviewed V2 (Acting Director of Nursing/Regional Nurse Consultant) and stated when there's abuse, they call the code, staff come, they try to separate the resident, all staff come and help, notify family, physician, and if it escalates notify the police. If it becomes aggressive, call 911. Called V24 (Activity Aide) multiple times from 9/11/24 to 9/13/24 but V24 did not answer calls from surveyor. Surveyor left messages to no avail. The facility's policy titled; Abuse Prevention Program Facility Policy and Procedure dated 1/4/18 reads in part: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Orientation and training of employees include staff obligations to prevent and report abuse, neglect, exploitation, mistreatment and misappropriation or resident property. How to assess, prevent and manage aggressive, violent and/or catastrophic reactions or residents in a way that protects both residents and staff. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The facility's policy on residents' rights with no date reads in part: The residents have the rights to safety and must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally or sexually.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview and record review the facility failed to ensure that necessary treatment and services consistent with professional standards of practice were adhered to for 1 resident (R7). The facility: 1.) Failed to assess, monitor, and document on R7 post fall. 2.) Failed to inform physician of R7's fall incident in a timely manner. 3.) Failed to send R7 who sustained head, injury while on anticoagulant, to the hospital in a timely manner. R7 fell on [DATE] and was subsequently sent to the hospital on 8/5/24 sustaining a subdural hematoma. Findings include: R7's face sheet documents in part medical diagnoses including but not limited to traumatic subdural hemorrhage with loss of consciousness, atrial fibrillation, long term current use of anticoagulants, and spondylolisthesis lumbar region. R7's Minimum Data Set (MDS) dated [DATE] shows R7 is cognitively intact. On 9/10/24 at 11:04 AM, R7 stated R7 fell from R7's bed. R7 stated R13 (R7's roommate) called the nurse, but the nurse did not respond until after an hour. R7 stated that was a wrong thing for the nurse to do. R7 could have gotten sicker, and R7 felt bad. On 9/10/24 at 11:24 AM, R13 stated that R7 fell few weeks ago. R13 stated R13 observed R7 falling from R7's bed. R13 helped to get R7 off the floor. R13 walked to the nurses' station to inform the nurse that R7 had fallen and that R13 asked for some ice to apply to R7's right forehead but the nurse and the Certified Nursing Assistant/CNA did not give R13 any ice. R13 came back to R13's room to pull the call light, the nurse came to attend to R7 after an hour. R13 stated the facility sent R7 to the hospital few days later. On 9/11/24 at 10:11 AM, V17 (Licensed Practical Nurse/LPN) stated V17 worked on 7/28/24, 7AM-7PM. V17 did not witness a fall, but a CNA told V17 that R7 may have fallen. V17 did not remember the CNA. Surveyor asked if V17 observed any bruise on the forehead of R7. V17 stated that V17 did not observe any bruise on R7 on 7/28/24. V17 stated R7 complained of headache and pain on 8/5/24. V17 stated later R7 reported that R7 had fallen some days ago. V17 called V46 (R7's Nurse Practitioner/NP) with the order to send R7 to the nearest hospital for evaluation. V17 stated a resident with a head injury post fall should be sent to the hospital immediately for evaluation. V17 stated the fall happened prior to 8/5/24, but it was not reported to V17. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/11/24 at 11:30 AM, V8 (CNA) stated V8 recalled someone telling V8 that R7 had fallen. V8 stated that V8 cannot remember the staff and the date of the incident, but V8 noticed a knot size swelling on the right side of R7's head and it was covered with something like a bandage. On 9/11/24 at 11:40 AM, V3 (LPN) stated when a resident reports a head injury post fall, V3 will be calling the doctor immediately. On 9/11/24 at 12:50 PM, during the second interview, surveyor asked if V17(LPN) observed any skin abrasion on R7's forehead. V17 stated V17 did not observed any bruise or abrasion on R7's head. Surveyor and V17 reviewed the nurse's note of 7/28/24 at 6:41 PM which shows that V17 documented observing bruise on R7's forehead. V17 was shocked and V17 stated, yes, that is my documentation. On 9/11/24 at 1:27 PM, V39 (Restorative Director) stated that when V39 came to the facility on Monday 7/29/24, V17 (LPN) told V39 that R7 fell on Sunday 7/28/24. V39 informed V38 on Monday 7/29/24 during the morning meeting. V39 stated that V39 observed small dry blood on R7's right forehead. V39 stated that the doctor should be notified immediately post fall with head injury. On 9/11/24 at 1:39 PM, via telephone interview V22 (CNA) stated that before lunch time on 7/28/24, R13 told V22 that R7 had a fall. V22 told V17 (LPN) that R7 could have fallen. On 9/11/24 at 3:03 PM, via telephone interview with V38 (Former Director of Nursing) stated that R7 had a fall on 7/28/24. V38 stated that V17 told V38 that R7 had a fall. V38 stated R7 had a raised knot on R7's forehead. V38 stated it is V38's expectation that 72 hours follow up charting will be done every shift, and neuro check should be done to monitor any changes in condition. V38 stated R7 is at risk for fall, so R7 should be monitored more frequently to prevent another fall. V38 stated that R7 was sent to the hospital on 8/5/24 due to complaint of headache. On 9/12/24 at 10:16 AM, R14 stated R14 has no concerns with quality of care. On 9/12/24 at 10:50 AM, V2 (Acting Director of Nursing/Regional Nurse Consultant) stated that R7 fell on [DATE] and R7 was not sent to the hospital because there was no order from V46 (R7's Nurse Practitioner/NP) to send R7 out to the hospital. V2 stated it is V2's expectation that the nurse will assess R7, start a neuro check per protocol and do 72 hours follow up charting after a fall incident with abrasion on the forehead. V2 stated the facility has no policy on head injury. On 9/12/24 at 11:19 AM, via a telephone interview, surveyor asked V46 (R7's NP) what could happen if a resident has a bruise on the head after a fall. V46 stated that it could lead to a hematoma, the resident can lose consciousness, and could have a lifelong impact on the resident's mobility. V46 stated a resident on a blood thinner with head abrasion or bruise should be sent to the hospital immediately because this could cause subdural hematoma. V46 stated V46 was not notified on 7/28/24 that R7 had a fall incident. V46 stated R7 was on a blood thinner Apixaban 5 mg tablet daily so V46 would have sent R7 to the hospital immediately for evaluation to conduct a CT-Scan to rule out any internal bleeding, if V46 was notified of a fall on 7/28/24. V46 stated V17 called V46 on 8/5/24 to report a bump and abrasion on R7's head and that R7 had a fall few days ago. V46 gave order to send R7 out to the hospital on 8/5/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/12/24 at 12:30 PM, V17 (LPN) stated that V17 notified V46 of the abrasion on R7's head on 7/28/24. When surveyor asked V17 if V17 was notified of R7's fall incident on 7/28/24 V17 stated that V17 was not comfortable to answer the surveyor and V17 walked away. Medical Administration record (MAR) from 7/1/24 to 8/4/24 shows R7 received Apixaban 5 mg tablet by mouth every evening for paroxysmal atrial fibrillation. R7's electronic health record (EHR) was reviewed, 72 hours follow up charting and neuro checks were not completed. Reviewed Facility Reported Incident witness statement dated 7/28/24. Reviewed Hospital Record dated 8/7/24, documents in part, OSH CT head showed (Right Subdural Hematoma) R SDH. Reviewed Neurological Assessment policy dated 3/23, documents in part; Residents will have a neurological assessment completed when they experience a head injury. Reviewed Change in Resident's Condition policy dated 2/1/22 documents in part; 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.