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	10/31/2024

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 - Immediate jeopardy to resident health or safety 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** 49572 Based on interviews and record review, the facility failed to ensure two residents (R2 and R7) were free from abuse from a resident (R3) with a known violent behavior by failing to perform R3's background checks and ensure fingerprint order was obtained for a new resident (R3) within the required time frames; failed to identify R3's known behaviors placing other residents at risk for abuse; failed to ensure a care plan was developed for R3's known violent behavior. These failures resulted in R3 physically assaulting 2 residents (R2 & R7) and causing multiple facial fractures to one resident (R7). This was identified as an immediate jeopardy began on 9/26/24. On 10/21/24 at 1:06 PM, the administrator was notified of the immediate jeopardy. The facility presented an abatement plan to remove the immediacy on 10/22/24 at 2:12pm. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 10/24/24 at 3:11pm. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented another revised abatement plan on 10/28/24 at 1:34pm, and the survey team accepted the abatement plan on 10/28/24. The immediate jeopardy was removed on 10/28/24 at 1:34 PM. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Findings Include: R3's clinical record indicated in part the following: (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/21/24, R3 was admitted with medical diagnosis that includes but not limited to aphasia following cerebral infarction; major depressive disorder, recurrent, unspecified; essential (primary) hypertension; unspecified psychosis not due to a substance or known physiological condition; other specified diabetes mellitus without complications; polyosteoarthritis, unspecified; arthropathy, unspecified; gastro-esophageal reflux disease without esophagitis; long term (current) use of aspirin; insomnia, unspecified; hyperlipidemia, unspecified; vascular dementia, unspecified severity, with other behavioral disturbance; bipolar disorder, current episode mixed, unspecified; cerebral infarction, unspecified; dysphagia, oropharyngeal phase; cognitive communication deficit; other Alzheimer's disease. R3's Referral records, the facility received prior to R3's admission, fax date of 8/16/24, documents, in part, (R3) with a history of dementia, depression, and anxiety was transferred from a local nursing home for direct admission. He (R3) was involved in a physical altercation with a fell ow resident . He (R3) remains anxious, irritated, confused, and bizarre, with no recollection of why he (R3) is being treated. Due to his (R3) dysregulated mood, aggression, and confusion, he (R3) poses a danger to himself and others . Verbal aggression during pt (patient) care . On 10/16/24 at 11:50am, when asked if the facility was aware of R3's history of aggression and prior physical altercation at the preceding facility R3 was residing at, V9 (Nurse Consultant) replied, In R3's referral it did state R3 had an altercation with another resident, but it did not state who hit who. R3's CHIRP (Criminal History Information Response Process), dated 8/27/24, documents, in part, HIT . (R3) . FELONY CONVICTION(S) . Date of Arrest: 03/10/1997 THEFT/CONTROL/FIREARM/2ND . V9's (Nurse Consultant) e-mail, dated 10/16/24 at 11:04am), documents, in part, Spoke with the social service director (R3) was not fingerprinted. On 10/17/24 at 2:51pm, V17 (Social Work Consultant) and this surveyor reviewed R3's criminal background check as follows: V17 confirmed R3 was admitted on [DATE] and the Resident Background Check form was initiated for a CHIRP (Criminal History Information Response Process) on 8/27/24 which is greater than 24 hours from R3's admission. V17 confirmed there were no fingerprints completed for R3 even though R3 had multiple arrests including theft with a firearm. V17 said, The CHIRP is run within 24 hours of admission of a new resident. Once we (facility) get the CHIRP back we (facility) have 72 hours to schedule fingerprints, 72 hours to put it in portal, and then a forensic investigator comes out. The investigator interviews and gives a criminal analysis within 45 days showing what their (residents) risk level is. They (criminal investigators) make recommendations for plan of care implementations. I (V17) do just believe it was a lapse in timing with transitioning employees coming in for the reason R3's CHIRP was not done, and the fingerprints were not ordered. There was a new person coming in and there was a lot going on. R3's progress note, dated 9/7/2024 at 1:41pm, transposed by V3 (Licensed Practical Nurse/LPN), documents, in part, Resident (R3) combative with all staff when asked to remain in his wheelchair for safety; refused blood glucose check and midday medicine pass; attempted to open secured doors on the unit. Resident (R3) used vulgar language with Writer. Family notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's progress note, dated 9/26/2024 at 7:20am, transposed by V5 (Licensed Practical Nurse/LPN) documents, in part, Informed by CNA (certified nursing assistant) upon rounds resident (R3) had a cane in his hand and blood was coming from roommates head. All staff proceeded to room . When asked what happened, resident (R3) stated, I (R3) thought someone was in my house. I (R3) didn't know he (R2) was supposed to be here. No concerns at this time. On 10/15/24 at 12:46pm, with translator V6 (Certified Nursing Assistant/CNA) present to translate for R2, this surveyor inquired about the altercation with R2 and R3 on 9/26/24. R2 replied, R3 hit me on the head with my cane. I (R2) was in the bathroom and R3 came up behind me and told me to get out of his apartment, grabbed my cane, and hit me in the head with it. I (R2) turned and seen R3. I (R2) am positive it was my roommate. I (R2) was bleeding from my head. R3 hit me good. The nurses took me to a different a room and I (R2) no longer stayed with R3. I (R2) wasn't happy R3 was still here. I (R2) would see him walking around even though the nurses tried to keep him in the wheelchair. Didn't know if he (R3) would try to attack me (R2) again. When asked if R2 feels safe here at the facility, R2 replied, I (R2) don't want to answer cause we don't know. R2's Face Sheet, documents, in part, medical diagnosis including but not limited to peripheral vascular disease, unspecified; other specified soft tissue disorder; and constipation, unspecified. R2's Minimum Data Set (MDS), dated [DATE], documents, in part, R2's Brief Interview for Mental Status (BIMS) score is 13 which indicates R2 is cognitively intact. V10's (CNA/certified nursing assistant) Facility Reported Incident of 9/26/24 Witness Statement, dated 9/26/2024, documents, in part, I (V10) walked into (R2's) room he (R2) was walking out saying (R3) hit him with his cane. (R3) came out of the room yelling, get him out of my apartment. R2's Facility Reported Incident of 9/26/24 Witness Statement, dated 9/26/2024, documents, in part, (R3) hit him (R2) head. On 10/16/24 at 1:10pm, V10 (Certified Nursing Assistant/CNA) said, I know R2. That morning (9/26/24) I (V10) just came in. I (V10) came in and did my rounds. I (V10) was coming back down the other hall and saw R2 staggering out of the room with a bleeding wound on his head. R2 said he (R3) was hitting him. R3 was cursing and yelling. R3's baseline is if you tell him (R3) what to do he'd get agitated. R3 was regularly agitated, every other day. We try to talk to him (R3) and calm him down. Just a lot of foul language. Yeah, I (V10) felt like he (R3) could do something like again cause he (R3) didn't listen. On 10/17/24 at 2:15pm, V5 (Licensed Practical Nurse/LPN) said, Yes, I (V5) am familiar with R3. I (V5) was there 9/26/24 with the R2 and R3 altercation. (R3) has moments of anxiousness and combativeness. CNA came and got me and showed me the opening on R2's head with blood. R2 said R2 was hit with a cane by R3. R3 is aggressive 50/50 percent of time. R3 had some bad days and some chill days. At times I (V5) was worried R3 would hurt other residents. Not sure what R3 was capable of. There are other residents are more helpless than me and can be harmed by R3. Upon review of R3's EMR (Electronic Medical Record), this surveyor observed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Record review of R3's Minimum Data Set (MDS) dated [DATE] documents in part a brief interview of mental status summary score of 10 indicating R3 has cognitive impairment, documents R3 has behavioral symptoms and wandering. 2. Record review of R3's CAA (Care Area Assessment) Worksheet (dated 8/28/24) documents in part R3 had behavioral symptoms and wandering. V8 signed the CAA worksheet stated R3's behaviors would be addressed within R3's Care Plan. 3. Record review of state final reportable of the physical abuse investigation occurred between R2 and R3 on 9/26/24, documents in part the R2 and R3's care plans were updated after the incident. 4. Record review of R3's care plan documents in part R3's aggressive behaviors were addressed on 10/10/24 after the incident between R3 and R7. R3's care plan was not updated with the MDS dated [DATE] in response to the CAA worksheet completed by V8 or after the final report and investigation of the incident occurred between R2 and R3. 5. Inaccuracy of R3's Screening Assessment for Trauma Factors Including Abuse/Neglect, dated 10/10/24 with a lock date (changes were made) of 10/16/24. R3's Screening Assessment for Trauma Factors Including Abuse/Neglect documents, in part, Question 1. History of Abuse/Neglect including physical, sexual, verbal, emotional, financial, domestic violence, involuntary seclusion and/or unexplained injuries prior to admission. Answer NO. This answer is not accurate as evidenced by prior to admission R3 was in a physical altercation at the previous facility he (R3) resided at with another resident. Documented in hospital records prior to R3's admission is a history of aggression both verbal and physical. Question 2. History of presences of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Answer Unable to be determine. This answer is not accurate as evidenced by R3's criminal history and R3 invading R2's space when R3 hit R2 ion the head with a cane on 9/26/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Inaccuracy of R3's Screening assessment for indicators of aggressive and/or harmful behaviors. R3's Screening assessment for indicators of aggressive and/or harmful behaviors,' documents, in part, Question A. 1. General awareness, insight, judgement, reasoning, memory, concentration and orientation, including diagnosed dementing illness (i.e. Alzheimer's Disease, Vascular Dementia NOS, Pick's Disease, OBS, Substance Induced Dementia). Answer 0. This answer is not accurate as evidenced by R3's diagnosis of Alzheimer's disease and vascular dementia. Question D 1. History of Abuse/Neglect including physical, sexual, verbal, emotional, financial, domestic violence, involuntary seclusion and/or unexplained injuries prior to admission. Answer NO. This answer is not accurate as evidenced by prior to admission R3 was in a physical altercation at the previous facility he (R3) resided at with another resident. Documented in hospital records prior to R3's admission is a history of aggression both verbal and physical. Question D 2. Factors increase resident's vulnerability (e.g. dementia, confusion, disorientation, poor insight/poor judgement, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of exploitation, heavy care needs, unable to make needs known, on psychotropic meds)? Answer Unable to be determine. This answer is inaccurate as evidenced by R3's diagnosis of vascular dementia. Question D 3. Psychiatric history and/or mental health diagnosis, including psychotic symptoms (e.g. delusional thoughts, hallucinations) and possible misinterpretation of events and the intentions of peers? Answer Unable to be determine. This answer is inaccurate as evidenced by R3's mental health diagnosis including but not limited to bipolar disorder, current episode mixed, unspecified; Alzheimer's disease; dementia; major depressive disorder. Question D 6. History of presences of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Answer Unable to be determine. This answer is not accurate as evidenced by R3's criminal history and R3 invading R2's space when R3 hit R2 ion the head with a cane on 9/26/24. On 10/22/24 at 9:53 AM, V8 (Social Services Director) stated the social services department is responsible for creating a plan of care for residents with behaviors. Inappropriate behaviors, aggression, or refusal/combativeness to care would all be care planned by the social services department. V8 reviewed R3's plan of care and affirmed R3's behaviors were not care planned until after both incidents (9/26 and 10/10). V8 stated R3's aggressive behaviors should have been addressed in R3's care plan upon admission when the history of aggression/abuse was identified. V8 did not know why the R3's behaviors were not addressed in R3's care plan. On 10/22/24 at 9:57 AM, V8 (Social Services Director) stated the screening for aggressive behavior is to be completed with every MDS (quarterly, annually significant change) and if aggressive behavior occurs. V8 did not know why the aggression screening assessment was not completed after R3's incidents of violent behavior on 9/26 and 10/10. V8 stated these assessments are important because they help to trigger staff to develop a plan of care to address the aggression. On 10/15/2024 at 11:50 AM, V9 (Registered Nurse Consultant stated, If documentation cannot be produced, then it didn't happen. On 10/15/24 at 3:18 PM, R7 recalled a few days ago, R7 was sitting by R7's bed and R7's back was turned away towards the door. R7 stated R7 began getting punched in the head from behind with a closed fist, many times. R7 stated R7 tried to grab the person punching R7 to prevent getting punched further but R7 stated R7 was in a daze from the punches and I almost got knocked out. R7 remembered having face pain at the time of the incident and staff came in and broke up the fight. R7 stated R7 was sent to the hospital to see if R7 was injured. R7 stated, I don't know if I feel safe here anymore. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In R7's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 at 1:07pm, documents, in part, (R7) is the receiver in a physical altercation with peer. (R7) was knocked down to the floor by peer. In R3's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 at 2:42pm, documents, in part, Writer and staff heard yelling in the hall from a resident's room. All staff reported to another resident's room where (R3) was observed punching the resident out of his wheelchair to the floor. When removing (R3) from the room he became combative with his CNA (certified nursing assistant) striking her. Writer intervened and the resident became combative with writer using verbal aggression and vulgar language to staff. Resident petitioned out to (Hospital) via 911. POA (power of attorney) Family. In R3's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 3:04pm, documents, in part, Resident sent to (Hospital). Family notified. In R3's EMR (electronic medical record), V4's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 3:59pm, documents, in part, (R3) discharged to: 10/10/2024 3:08 PM. Reason for transfer: Physical aggression . The following people were notified of transfer: Physician Family Yes - Current reconciled medication list provided to the subsequent provider. In R7's EMR (electronic medical record), V5's (Licensed Practical Nurse/LPN) progress note, dated 10/11/2024 at 1:44am, documents, in part, (R7) returned from hospital with two fractures to cheek and fracture to nose. R7's Face Sheet, documents, in part, medical diagnosis including but not limited to fracture of unspecified part of neck of right femur, sequela; other cervical disc degeneration, unspecified cervical region; fusion of spine, cervical region; and seizures. R7's Minimum Data Set (MDS), dated [DATE], documents, in part, R7's Brief Interview for Mental Status (BIMS) score is 07 which indicates R7 has severe cognitive impairment. R7's hospital records, dated 10/10/24, documents, in part, Sent from (Facility) after assaulted by another resident there. Apparently, this resident was punching multiple other residents and punched this patient in the head, knocking him out of his wheelchair. On 10/10/24 at 9:30 PM, R7's hospital records document a CT (computed tomography scan was completed) and documents the following findings: fracture of the nasal bones, small fracture of the lateral wall of the right orbit, small fracture of the right arm of the zygomatic arch, dehiscence of the floor of the right orbit. These fractures are of indeterminate age; clinical correlation is recommended. At 9:46 PM, R2's physician documented, Likely mix of new and old injuries. V3's (Licensed Practical Nurse/LPN) Facility Reported Incident of 10/10/24 Witness Statement, dated 10/11/2024, documents, in part, Writer and staff heard yelling in the hall from a resident's room (R7's room). All staff reported to room where the yelling was heard; Upon arrival (R3) had punched (R7) out of his wheelchair to the floor. When staff attempted to remove (R3) he became combative with his CNA (certified nursing assistant) taking a swing striking her. Writer intervened and the residents became combative with writer using verbal aggression and vulgar language with threats. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V15's (CNA/certified nursing assistant) Facility Reported Incident of 10/10/24 Witness Statement, dated 10/11/2024, documents, in part, (R3) was very aggressive he (R3) was about to hit me (V15) so I (V15) step out of the room. Using abusive language toward everybody. R7's Facility Reported Incident of 10/10/24 Witness Statement, dated 10/10/2024, documents, in part, (R3) went to (R7's) room and hit him (R7) on the side of the face. On 10/16/24 at 11:50am, V1 (Administrator) said, I (V1) got abuse training on hire and multiple times after. Training began with HR (Human Resource), then I (V1) reviewed companies' policies on physical, emotional, negligence, misappropriation of funds, sexual, verbal, and mental abuse. Abuse is causing any king of harm falls under those categories. Abuse is harm with intent. When someone willfully is doing any of those actions. Making a choice to cause harm. We (facility) did not substantiate abuse for either incident because dementia residents do not have the mental capacity to make a choice to harm. On 10/16/24 at 11:50am, V9 (Nurse Consultant), In R3's referral it did state R3 had in an altercation with another resident, but it did not stay who hit who. We've (facility) been cited every month for abuse. I (V9) started being in the building every day. When asked what was put into place after R3 hit R2 with a cane, V9 replied, behavior monitoring, offer activities, sister visiting more to assist with behaviors. When asked for the documentation of R3's behavior monitoring, V9 replied, I (V9) need to see if V8 (Social Service Director) has the behavior monitoring sheets upstairs. When asked if R3 has ever seen a therapist, V9 replied, I'm not sure. I'll have to check with social service team. Assessments are done on admission, updated when changes. The assessment should indicate if there were changes and if aggressive to staff or residents. No behavior monitoring for R3 could be produced by the facility by the end of the survey. On 10/17/24 at 11:33am, V15 (Certified Nursing Assistant) said, Yes sir, I (V15) am familiar with R3. R3 had his moments when we (staff) couldn't tell R3 anything cause R3 would get upset/agitated and call us (staff) names like, 'You bitch'. Even if you (staff) tried to calm R3 down R3 wouldn't calm down. Yes, R3 would be physical. R3 would get aggressive with me (V15). R3 would grab my hand and try punching me. I (V15) was working day (10/10/24). I (V15) heard a little commotion and went towards R7's room. I (V15) tried to help him (R3) calm down. R3 was very aggressive. R3 grabbed my hand. R3 kept coming at me. R3 walks. R3 stands up from his wheelchair. R3 won't sit down. I (V15) just heard R3 screaming. R7 was complaining of pain in face. We (staff) didn't know when R3 would get upset. When R3 just got the urge R3 would just get aggressive. I (V15) was worried R3 would hurt me. R3 was a strong guy. Yes, I (V15) was definitely worried R3 would hurt the other residents. I (V15) believe, everyone (all employees) knew R3 would get upset. There was no training for R3. You (staff) can have a conversation with R7. He (R7) remembers almost everything. Just can be a little forgetful but R7 would not forget anything like this. Since happened R7 always brings it up. I (V15) would say R7 remembers things, sometimes forget things, but he remembers most things. I (V15) don't think R7 would make up a story of what happened to him (R7). R3 is not appropriate to have a roommate. R3 was aggressive toward staff since the beginning. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/17/24 at 12:03pm, V3 (Licensed Practical Nurse/LPN) said, Yes, I (V3) am familiar with R3. He'd (R3) get up from the chair and curse you out. Gets very vulgar and then more vulgar. We (staff) try to redirect R3. R3 has swung at me (V3) before but never actually made contact. I (V3) was sitting at the nurse's station, heard someone yelling, CNAs (certified nursing assistants) and I (V3) got up and went to see what was happening. R3 was up over, standing over R7. I (V3) assessed R7, helped him up, and removed R3 from the room. R3 got aggressive with the CNA and me. R3 was full of aggressiveness, vulgarity, and more aggression. R3 struck the CNA. R3 walked up on me with his fist and swung, but I (V3) backed up. R3 continued being vulgar. My documentation, I (V3) admit, sucked. I (V3) asked if a resident's daughter visiting witnessed it and the family member said yes. When I (V3) asked the family member if she (family member) seen R3 strike R7, she (family member) said yes. The family member was in tears. Staff was with R3 in the dining room but R3 will roll out of the dining room, we'll watch him role out, but R3 has right. R3 has the freedom to roll back and forth. Residents have the freedom to roll around. I (V3) have been worried R3 would hurt me. I (V3) have been concerned R3 would hurt other residents. I (V3) never notified anyone; I (V3) just diffused the situation. R3 was 50/50 percent aggressive all of the time. R3 could be decent and then would just snap. On 10/17/24 at 12:19pm, V16 (CNA), said, I (V16) was working 10/10/24. I (V16) heard yelling, ran, and the other nurse followed. R7's wheelchair was flipped over and R3 was standing over R7. R7 said R3 punched him (R7) and knocked him (R7) over. R7 is pretty much oriented, forgets here and there, but for the most part R3 remembers even like missing a shoe. No, R7 wouldn't make up a story. Half of the time R3 is aggressive. On 10/22/2024 at 10:48am, V18 (Medical Director) said, I (V18) was the attending physician for R3. R3 had Bipolar, dementia, anxiety depression, Psych issues. Medically ok. Main reason was psych issues as far as I (V18) remember. I (V18) did his (R3) admission, and he (R3) had some altercation at other facility and's why other facility transferred him out to our facility. Based on R3's history of aggression towards other residents, I (V18) don't know if he (R3) had a roommate. When asked if it was appropriate for R3 to have a roommate, V18 replied, Difficult to answer. There are a lot of psych, and they can have behaviors and stabilize. When I'm (V18) admitting a patient I (V18) assume they are stabilized. With identified behaviors prior to admission, the facility should have increased R3's supervision and observation. Yeah, when we see there R3 required increased monitoring. Nursing homes don't have a lot of staff, so if we (facility) can't care for them appropriately, we (facility) send them to the hospital. I (V18) was aware of 10/10/24 altercation with R2 and R3. We sent R3 out. No, I (V18) don't remember a change of condition. When I (V18) went in the room R3 was using vulgar language. Being hit in the head and falling out of a wheelchair cause facial fractures definitely caused harm to (R7). The severity of harm happens after a resident is hit in the head can vary depending on the velocity of the hit, the size of the resident. Facial fractures can be caused by a punch to the head or falling out of a wheelchair. R3's plan of care should have been developed to address those behaviors. Dementia and psych are very challenging. We try to control the behaviors but if it's out of control we (facility) send them out. If the Plan of care isn't done, the resident's aggressive behaviors can continue. We (facility) need to address it because other residents are at risk. If a resident is assessed incorrectly, can harm be caused? is a hard question. Behaviors change. If behaviors changed the assessments should be redone. On 10/28/24 at 1:10pm, V9 (Nurse Consultant) said, We (facility) do not have an assessment policy or a policy specifically for completing the aggression screening and trauma assessment. We (facility) follow the RAI (Resident Assessment Instrument) guidelines for Assessments. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R3's medication administration record (October 2024) documents in part R3 has an order for Seroquel (Quetiapine Fumarate) give 1 tablet by mouth every 8 hours as needed for agitation for 14 days began on 10/1/2024. The medication administration record indicates this medication was not given in on 10/10/24 when R3 displayed agitation. Record review of CMS's RAI (Resident Assessment Instrument) 3.0 Manual Chapter 3 MDS Items [B] (dated October 2024) documents in part the following: 9. Behavioral Symptoms In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a symptom and not a disease. The MDS only identifies certain behaviors but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention. Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms . The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, reduce the frequency of truly problematic behaviors, and minimize any resultant harm. Facility policy titled Behavior Management for Agitated Behavior (undated), documents in part, Targeted Behavior: Agitated Behavior, which represents a danger to self and others, due to Alzheimer's disease with anxiety, dementia, mental illness or other illnesses. Preventative Measures: .2. When resident's voice is loud, offer drink, food, toileting, take for a walk, or redirect to activity of interest .3. Observe resident for behavior escalation of anxiety, aggression such as loud voice tone, hand ringing, swearing, yelling, and/or other irritability. Interventions if Behaviors Escalates and/or Reoccurs: 1. Remove from problem area, separate from other, when necessary, APPROACH from the front . 4. If uncontrolled anger, aggression or anxiety cannot be redirected, i.e. the resident is in danger of harming self or others after attempting the above interventions, administer physician ordered medication for anxiety for the symptoms being exhibited. **** .6. Document all interventions attempted and administered and the resident's response to medical interventions . 8. Monitor the response to drug therapy 1:1 until dangerous symptoms are reduced. If the resident responds to the medication by becoming quiet and anxiety free and aggressive acts have minimized, i.e. no longer harm to self and others 1:1 monitoring will be discontinued . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility policy titled Abuse Prevention Facility Policy and Procedure dated 1/4/2018, 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. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services needed to attain or maintain physical, mental or psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse or mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm . II. Pre-Admission Screening of Potential Residents: this facility shall check and review the criminal history background for any resident seeking admission to the facility in order to identify previous criminal convictions. This facility will: - request a Criminal History Background Check within 24 hours after admission of a new resident, - check for the residents and sex offender registration website. www.isp.state.il.us - Check for the resident's name on the Illinois department of Corrections sex registrant search page. www.idoc.state.il.us - While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take steps necessary to ensure safety . IV. Establishing a Resident Sensitive Environment This facility desires to prevent abuse, neglect exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50728 Based on interview and record review, the facility failed to conduct QAPI (Quality Assurance and Performance Improvement) meetings quarterly and ensure abuse data collection was implemented/coordinated within the QAPI meeting. These failures have the potential to affect all 200 residents residing in the facility. Findings include: Review of facility census dated 10/15/24 documents that there are 200 residents residing in the facility. Record review of facility-provided documentation titled, QPAI Meeting Minutes dated 3/7/2024, does not indicate any reporting, tracking or data regarding abuse or that abuse outcomes was discussed. The template used for the QAPI meeting minutes does not indicate any area for reporting, tracking or data regarding abuse/allegations of abuse. No further QAPI meeting minutes were provided during the survey from 3/7/2024 until 10/21/24. Record review of facility state reportable documents for incidents occurring on 9/26/24 and 10/10/24 documents in part, Once complete, forward a copy and send the original to the QAPI committee . On 10/15/2024 at 11:50 AM, V9 (Nurse Consultant) affirmed V9 participates as a member of the QAPI committee's governing body. V9 stated the facility completes QAPI meetings at least quarterly, and that abuse is discussed. V9 stated the facility had a QAPI meeting in August and abuse was discussed, but the documentation cannot be produced. V9 stated no QAPI meetings occurred between April 2024 and August 2024. V9 stated, if documentation cannot be produced, then it didn't happen. On 10/15/2024 at 11:55 AM, V1 (Administrator) stated the facility had not reviewed the physical abuse incidences with the QAPI committee that occurred on 9/26/24 and 10/10/2024. V1 affirmed there are no other QAPI meeting documentation that can be provided after 3/7/2024. On 10/22/24 at 10:48 AM, V18 (Medical Director) stated the incidents that occurred on 9/26/24 and 10/10/24 have not been reviewed in a QAPI meeting. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled Quality Assurance Committee dated 11/22, documents in part, Purpose: To ensure the organization has an organized quality assessment and improvement process program that includes performance measurement, performance assessment and performance improvement . On a regular basis the Committee will collect data and analyze, using appropriate statistical techniques, the following important components about its processes or outcomes: a. Accidents b. Prevalence of falls c. Prevalence of Behavioral/Emotional Patterns d. Prevalence of Symptoms of Depression e. Prevalence of Depression without Treatment f. Use of 9 or more different medications g. Incidence of cognitive impairment h. Prevalence of Bladder or Bowel Incontinence i. Prevalence of Occasional or frequent Bladder or Bowel Incontinence without toileting plan j. Prevalence of Fecal Impaction* k. Prevalence of Urinary Tract Infection l. prevalence of weight loss m. Prevalence of Tube Feeding n. Prevalence of Dehydration* o. Presence of Bedfast Residents p. Prevalence of Decline in Late Loss ADL's q. Incidence of decline in ROM r. Prevalence of Antipsychotic use in the Absence of Psychotic Related Conditions s. Prevalence of any Anti-anxiety/Hypnotic Use t. Prevalence of Hypnotic use more than two times in last week. U. Prevalence of Daily Restraints v. Prevalence of Little or No Activity w. Prevalence of Stage I-V Pressure Ulcers for low-risk resident* *Sentinel Events . Abuse is not mentioned within this policy. Facility policy titled Abuse Prevention Program Facility Policy and Procedure dated 1/4/2018 documents in part, . Pattern Assessment: At least quarterly, the Quality Management committee will review concern identification reports, accident reports, incident reports, missing items reports and safety committee reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, or other unusual occurrences that may constitute abuse, neglect, mistreatment or misappropriation of resident property. Based on an assessment of the reports, the Quality Management committee will further investigate and/or determine whether a change in facility practices is warranted.

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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. 50728 Based on interview and record review, the facility failed to submit a final investigation report regarding physical abuse to the state survey agency within 5 business days. This failure affects 2 residents (R2, R3) reviewed for reporting. Findings include: Record review of initial report to the state survey agency (Illinois Department of Public Health) dated 9/26/24, documents in part that a physical altercation occurred between R2 and R3. No final report to the state survey agency was noted within the investigative documents. Facility presented e-mail from V1 (Administrator) that documents, in part, Subject: Facility Reported Incident (R2) and (R3) Final 9.26.24. Date: Wednesday, October 16, 2024, at 11:42 AM Central Daylight Time. From: (V1, Administrator). To: (Illinois Department of Public Health), indicating that the final investigative report was sent to the state survey agency on 10/16/2024 (20 days after the incident occurred and 20 days after the initial report was sent). On 10/16/24 at 11:50am, V1 (Administrator) affirmed that V1 is the abuse prevention coordinator for the facility and that V1 conducted the investigation for the alleged abuse that occurred on 9/26/24 between R2 and R3. V1 stated that V1 could not find evidence that the final investigation report was submitted to the state survey agency, so V1 submitted it (the final report) again today. V1 stated that all allegations of abuse require an initial report to be sent to the state survey agency within 2 hours of the allegation and a final report is to be sent in within 5 business days. Facility policy titled Abuse Prevention Program Facility Policy and Procedure (dated 1/4/2018), documents in part, . External Reporting . 2. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a completed written report of the conclusion of the investigation, including the steps the facility has taken in response to the allegation, will be sent to the Department of Public Health .

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F 0641 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to accurately complete assessments that identify R3's aggressive behaviors and blindness. These failures resulted in R3 physically assaulting 2 residents (R2 & R7) and causing multiple facial fractures to one resident (R7). These failures caused harm and affected 3 residents (R2, R3, and R7) reviewed for assessment accuracy. Findings include: R3's admission record documents in part that R3 was admitted on [DATE] and had the following active diagnosis: cerebral infarction, cognitive communication deficit, bipolar disorder, other Alzheimer's disease, vascular dementia with other behavioral disturbance, major depressive disorder, unspecified psychosis not due to a substance or a known physiological condition, and legal blindness. R3's background check dated 8/27/24 documents in part that R3 has a convicted criminal history of forgery, theft, and violating probation. R3's Minimum Data Set (MDS) dated [DATE] documents in part a brief interview of mental status summary score of 10 indicating that R3 has cognitive impairment. R3 has behavioral symptoms that occurred 1 to 3 days and has adequate vision. The coding of B1000: Vision indicating that R3 has adequate vision is inaccurate as R3 is legally blind. R3's progress notes completed on 8/28/24 by V18 (Physician, Medical Director) identified that R3 had . behavioral issues (and) was transferred from the nursing home to the hospital after a physical altercation with a fell ow resident. Patient (R3) was admitted in the hospital seen by psych adjusted medication and discharged to this facility to continue skilled nursing medical supervision. R3's Screening Assessment for Trauma Factors Including Abuse/Neglect, dated 10/10/24 with a lock date (changes were made) of 10/16/24. R3's Screening Assessment for Trauma Factors Including Abuse/Neglect documents, in part, Question 1. History of Abuse/Neglect including physical, sexual, verbal, emotional, financial, domestic violence, involuntary seclusion and/or unexplained injuries prior to admission. Answer NO. This answer is not accurate as evidenced by prior to admission R3 was in a physical altercation at the previous facility he (R3) resided at with another resident. Documented in hospital records prior to R3's admission is a history of aggression both verbal and physical. Question 2. History of presences of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Answer Unable to be determine. This answer is not accurate as evidenced by R3's criminal history and R3 invading R2's space when R3 hit R2 ion the head with a cane on 9/26/24. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	R3's Screening assessment for indicators of aggressive and/or harmful behaviors. R3's Screening assessment for indicators of aggressive and/or harmful behaviors,' documents, in part, Question A. 1. General awareness, insight, judgement, reasoning, memory, concentration and orientation, including diagnosed dementing illness (ie. Alzheimer's Disease, Vascular Dementia NOS, Pick's Disease, OBS, Substance Induced Dementia). Answer 0. This answer is not accurate as evidenced by R3's diagnosis of Alzheimer's disease and vascular dementia. Question D 1. History of Abuse/Neglect including physical, sexual, verbal, emotional, financial, domestic violence, involuntary seclusion and/or unexplained injuries prior to admission. Answer NO. This answer is not accurate as evidenced by prior to admission R3 was in a physical altercation at the previous facility he (R3) resided at with another resident. Documented in hospital records prior to R3's admission is a history of aggression both verbal and physical. Question D 2. Factors that increase resident's vulnerability (e.g. dementia, confusion, disorientation, poor insight/poor judgement, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of exploitation, heavy care needs, unable to make needs known, on psychotropic meds)? Answer Unable to be determine. This answer is inaccurate as evidenced by R3's diagnosis of vascular dementia. Question D 3. Psychiatric history and/or mental health diagnosis, including psychotic symptoms (e.g. delusional thoughts, hallucinations) and possible misinterpretation of events and the intentions of peers? Answer Unable to be determine. This answer is inaccurate as evidenced by R3's mental health diagnosis including but not limited to bipolar disorder, current episode mixed, unspecified; Alzheimer's disease; dementia; major depressive disorder. Question D 6. History of presences of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Answer Unable to be determine. This answer is not accurate as evidenced by R3's criminal history and R3 invading R2's space when R3 hit R2 in the head with a cane on 9/26/24. R3's progress notes dated 9/7/2024 documents in part that R3 was combative with staff, refusing medications (including insulin) and blood glucose testing. On 9/26/24 at 7:20 AM, R3 was observed with a cane in R3's hand and blood was noted from R3's roommate's (R2) head. On 9/26/24, R3 had another altercation with another peer in the dining room and was verbally aggressive and combative with staff. Subsequently, R3 was sent to the hospital for a psychiatric evaluation and returned on 9/28/24. On 10/10/2024, R3 was observed punching another resident (R7) out of the wheelchair and on to the floor. R3 additionally struck the CNA and was verbally aggressive to the nurse. R3 was sent to the hospital for psychiatric admission on 10/10/24. R2's progress notes indicate staff observed R2 bleeding from an open area to R2's head and that R2's roommate (R7) was holding a cane. R2 stated, I was in the bathroom and the man just came in there and hit me in the head with my cane and said I wasn't supposed to be in his apartment. R2's open area on R2's was cleaned, dressing applied, and neurological checks were initiated. R7's progress notes documents in part on 10/10/2024 that R7 is the receiver of physical aggression by a peer (R3) and R7 was knocked down to the floor by a peer (R3) and was transferred to the hospital for evaluation. R7 returned on 10/11/2024 with fractures to the cheek and nose. R7's hospital records dated 10/10/2024 document in part that computed tomography (CT) scans were completed and fractures were identified to the nasal bones, lateral wall of right orbit, right zygomatic arch and dehiscence of the floor of the right orbit. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 9:56 AM, V8 (Social Services Director) affirmed V8 supervises the social services department and is familiar with R3. V8 stated the incident that occurred between R2 and R3 on 9/26 was partially because R3 was blind and couldn't realize who R2 was. V8 stated the screening assessment for indicators of aggressive and/or harmful behaviors should be completed on admission, quarterly and as needed if aggressive/harmful behaviors happen. V8 reviewed R3's electronic health record, including R3's diagnosis list, progress notes, care plan, and assessments, including the screening assessment or aggressive behaviors dated 9/11/24. V8 affirmed the assessment is incorrect and stated the assessment does not identify R3's criminal background, history of abuse (physical altercation from prior facility), R3's dementia diagnosis, R3's psychiatric history, dysfunctional behavior, wandering. V8 stated the screening assessment for indicators of aggressive and/or harmful behaviors assessment is important to be completed and completed accurately because the screening drives the plan of care for the resident and identifies needs. V8 affirmed the assessment being completed inaccurately can cause the resident's aggressive behavior to be unidentified and unaddressed. On 10/22/24 at 10:48 AM, V18 (Medical Director) stated, If residents are assessed incorrectly what harm could be caused is a hard question because behaviors change. V18 stated if behaviors change, behavioral assessments should be redone. On 10/22/24 at 11:08 AM, V20 (MDS Coordinator, Licensed Practical Nurse) stated that one of focuses/purposes of the MDS is to identify resident needs and drive the care plan. V20 confirmed R3 was legally blind and was visually impaired. V20 reviewed R3's 8/28/24 MDS and stated that R3's vision in B1000 should have been coded as impaired. V20 stated that if assessments are not completed accurately, care needs may not be developed in the care plan. V20 reviewed R3's care plan and affirmed that R3's blindness was not addressed on the care plan and affirmed that if B1000 was coded correctly, a Care Area Assessment (CAA) would have triggered for visual function. On 10/28/24 at 1:10pm, V9 (Nurse Consultant) said, We (facility) do not have an assessment policy or a policy specifically for completing the aggression screening and trauma assessment. We (facility) follow the RAI (Resident Assessment Instrument) guidelines for Assessments. Record review of CMS's RAI (Resident Assessment Instrument) 3.0 Manual Chapter 3 MDS Items [B] (dated October 2024) documents in part the following: .B1000: Vision .Coding Instructions Code 0, adequate: if the resident sees fine detail, including regular print in newspapers/books. Code 1, impaired: if the resident sees large print, but not regular print in newspapers/books. Code 2, moderately impaired: if the resident has limited vision and is not able to see newspaper headlines but can identify objects nearby in their environment. Code 3, highly impaired: if the resident's ability to identify objects nearby in their environment is in question, but the resident's eye movements appear to be following objects (especially people walking by). Code 4, severely impaired: if the resident has no vision, sees only light, colors or shapes, or does not appear to follow objects with eyes.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to develop a plan of care to address R3's known aggressive behaviors and history of aggressive behaviors. These failures resulted in R3 physically assaulting 2 residents (R2 & R7) and causing multiple facial fractures to one resident (R7). These failures caused harm and affected 3 residents (R2, R3, and R7) reviewed for care planning. Findings include: R3's Referral records, that the facility received prior to R3's admission, fax date of 8/16/24, documents, in part, (R3) with a history of dementia, depression, and anxiety was transferred from a local nursing home for direct admission. (R3) was involved in a physical altercation with a fell ow resident . (R3) remains anxious, irritated, confused, and bizarre, with no recollection of why (R3) is being treated. Due to (R3's) dysregulated mood, aggression, and confusion, (R3) poses a danger to (R3) and others . Verbal aggression during pt (patient) care . On 8/21/24, R3 was admitted with medical diagnosis include but not limited to aphasia following cerebral infarction; major depressive disorder, recurrent, unspecified; essential (primary) hypertension; unspecified psychosis not due to a substance or known physiological condition; other specified diabetes mellitus without complications; polyosteoarthritis, unspecified; arthropathy, unspecified; gastro-esophageal reflux disease without esophagitis; long term (current) use of aspirin; insomnia, unspecified; hyperlipidemia, unspecified; vascular dementia, unspecified severity, with other behavioral disturbance; bipolar disorder, current episode mixed, unspecified; cerebral infarction, unspecified; dysphagia, oropharyngeal phase; cognitive communication deficit; other Alzheimer's disease. Record review of R3's Minimum Data Set (MDS) dated [DATE] documents in part a brief interview of mental status summary score of 10 indicating that R3 has cognitive impairment, documents that R3 has behavioral symptoms and wandering. Record review of R3's CAA (Care Area Assessment) Worksheet (dated 8/28/24) documents in part that R3 had behavioral symptoms and wandering. V8 (Social Services Director) signed the CAA worksheet stated that R3's behaviors would be addressed within R3's Care Plan. R3's progress note, dated 9/26/2024 at 7:20am, transposed by V5 (Licensed Practical Nurse/LPN) documents, in part, Informed by CNA (certified nursing assistant) upon rounds that resident (R3) had a cane in his hand and blood was coming from roommates head. All staff proceeded to room . When asked what happened, resident (R3) stated I (R3) thought someone was in my house, I (R3) didn't know (R2) was supposed to be here . No concerns at this time. (continued on next page)

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	145995	A. Building B. Wing	10/31/2024

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 0656 Level of Harm - Actual harm Residents Affected - Few	On 10/15/24 at 12:46pm, with translator V6 (Certified Nursing Assistant/CNA) present to translate for R2, this surveyor inquired about the altercation with R2 and R3 on 9/26/24. R2 replied, (R3) hit me on the head with my cane. I (R2) was in the bathroom and (R3) came up behind me and told me to get out of (R3's) apartment, grabbed my cane, and hit me (R2) in the head with it. I (R2) turned and seen R3. I (R2) am positive it was my roommate. I (R2) was bleeding from my head. R3 hit me good. The nurses took me to a different a room and I (R2) no longer stayed with R3. I (R2) wasn't happy that R3 was still here. I (R2) would see (R3) walking around even though the nurses tried to keep (R3) in the wheelchair. Didn't know if (R3) would try to attack me (R2) again. When asked if R2 feels safe here at the facility, R2 replied, I (R2) don't want to answer cause we don't know. On 10/16/24 at 1:10pm, V10 (Certified Nursing Assistant/CNA) said, I know R2. That morning (9/26/24) I (V10) just came in. I (V10) came in and did my rounds. I (V10) was coming back down the other hall and saw R2 staggering out of the room with a bleeding wound on (R2's) head. R2 said (R3) was hitting (R2). (R3) was cursing and yelling. (R3's) baseline is if you tell (R3) what to do (R3) get agitated. (R3) was regularly agitated, every other day. We try to talk to (R3) and calm (R3) down. Just a lot of foul language. Yeah, I (V10) felt like (R3) could do something like that again cause (R3) didn't listen. On 10/17/24 at 2:15pm, V5 (Licensed Practical Nurse/LPN) said, Yes, I (V5) am familiar with R3. I (V5) was there 9/26/24 with the R2 and R3 altercation. (R3) Has moments of anxiousness and combativeness. CNA came and got me and showed me the opening on R2's head with blood. R2 said R2 was hit with a cane by R3. R3 is aggressive 50/50 percent of time. R3 had some bad days and some chill days. At times I (V5) was worried R3 would hurt other residents. Not sure what R3 was capable of. There are other residents that are more helpless than me and can be harmed by R3. On 10/15/24 at 3:18 PM, R7 recalled a few days ago, R7 was sitting by R7's bed and R7's back was turned away towards the door. R7 stated that R7 began getting punched in the head from behind with a closed fist, many times. R7 stated that R7 tried to grab the person punching R7 to prevent getting punched further but R7 stated that R7 was in a daze from the punches and I almost got knocked out. R7 remembered having face pain at the time of the incident and that staff came in and broke up the fight. R7 stated that R7 was sent to the hospital to see if R7 was injured. R7 stated, I don't know if I feel safe here anymore. In R7's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 at 1:07pm, documents, in part, (R7) is the receiver in a physical altercation with peer. (R7) was knocked down to the floor by peer. In R3's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 at 2:42pm, documents, in part, Writer and staff heard yelling in the hall from a resident's room. All staff reported to another resident's room where (R3) was observed punching the resident out of his wheelchair to the floor. When removing (R3) from the room he became combative with his CNA (certified nursing assistant) striking her. Writer intervened and the resident became combative with writer using verbal aggression and vulgar language to staff. Resident petitioned out to (Hospital) via 911. POA (power of attorney) Family. In R7's EMR (electronic medical record), V5's (Licensed Practical Nurse/LPN) progress note, dated 10/11/2024 at 1:44am, documents, in part, (R7) returned from hospital with two fractures to cheek and fracture to nose. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of R3's care plan documents in part that R3's aggressive behaviors were addressed on 10/10/24 after the incident between R3 and R7. R3's care plan was not updated with the MDS dated [DATE] in response to the CAA worksheet completed by V8 or after the final report and investigation of the incident that occurred between R2 and R3. Record review of state final reportable of the physical abuse investigation that occurred between R2 and R3 on 9/26/24, documents in part the R2 and R3's care plans were updated after the incident. This is inaccurate as the care plan was not updated until 10/10/2024 to address R3's behaviors. On 10/22/24 at 9:53 AM, V8 (Social Services Director) stated that the social services department is responsible for creating a plan of care for residents with behaviors. Inappropriate behaviors, aggression, or refusal/combativeness to care would all be care planned by the social services department. V8 reviewed R3's plan of care and affirmed that R3's behaviors were not care planned until after both incidents (9/26 and 10/10). V8 stated that R3's aggressive behaviors should have been addressed in R3's care plan upon admission when the history of aggression/abuse was identified. V8 did not know why the R3's behaviors were not addressed in R3's care plan. On 10/22/2024 at 10:48am, V18 (Medical Director) stated,R3's plan of care should have been developed to address those behaviors (aggression). Dementia and psych are very challenging. We try to control the behaviors but if it's out of control we (facility) send them out. If the Plan of care isn't done, the resident's aggressive behaviors can continue. We (facility) need to address it cause other residents are at risk. On 10/22/2024 at 11:08 AM, V20 (MDS Coordinator, LPN) stated the facility does not have a care plan coordinator, all departments are responsible for developing their plan of care according to the MDS triggered CAAs. V20 reviewed R3's MDS dated [DATE] and affirmed that R3 had a behavioral symptoms CAA trigger and that V8 signed affirming V8 would develop the plan of care. V20 reviewed R3's plan of care and confirmed that R3's violent behavior was not addressed until after the incident on 10/10/2024 by V8. V20 stated that R3 should have had a care plan to address R3's violent behavior. Facility policy titled, CHANGE IN RESIDENT'S CONDITION (reviewed 11/2023), documents in part, . RESPONSIBLE PARTY: RN, LPN, Social Services . 5. The Care Plan for the residents will be updated as indicated. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled, CARE PLAN (undated) documents in part, A. POLICY: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status . 1. The residents comprehensive care plan initiated upon admission within 24 hours. 2. A comprehensive care plan is developed within 7 days of the completion of the comprehensive assessments and trigger legend (which is completed within 14 days of admission . a. Concerns, needs and/or strengths have a corresponding goal. The format for a goal is who, what, how, and when. Goals are resident oriented, specific problem- oriented goals relative to medical and nursing diagnosis, realistic, measurable, and directed towards increased functional levels . b. When a change occurs in a resident's condition the Care Plan Coordinator is notified by a member of the interdisciplinary team. The care plan is then reviewed and updated . 9. The Care Plan Coordinator has responsibility for each resident's care plan. A. the care plan coordinator is responsible for coordinating each resident's care plan and for ensuring that the appropriate information is available to all staff . b. The Interdisciplinary Team is responsible for the implementation of resident care management. 10. All interdisciplinary team departments are responsible for charting that reflects the care plan concerns, problems, needs and/or strengths, approaches, progress, or lack of progress with possible reasons for new problems . Record review of CMS's RAI (Resident Assessment Instrument) 3.0 Manual Chapter 3 MDS Items [B] (dated October 2024) documents in part the following: .9. Behavioral Symptoms In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a symptom and not a disease. The MDS only identifies certain behaviors but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention. Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms . The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, reduce the frequency of truly problematic behaviors, and minimize any resultant harm .

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F 0689 Level of Harm - Actual harm 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** 49572 Based on interview and record review, the facility failed to provide and ensure adequate supervision to a resident (R3) with a known violent behavior. These failures resulted to R3 physically assaulting 2 (R2 & R7) residents and causing multiple facial fractures to one resident (R7). Findings include: On 10/15/24 at 12:46pm, with translator V6 (Certified Nursing Assistant/CNA) present to translate for R2, this surveyor inquired about the altercation with R2 and R3 on 9/26/24. R2 replied, R3 hit me on the head with my cane. I (R2) was in the bathroom and R3 came up behind me and told me to get out of his apartment, grabbed my cane, and hit me in the head with it. I (R2) turned and seen R3. I (R2) am positive it was my roommate. I (R2) was bleeding from my head. R3 hit me good. The nurses took me to a different a room and I (R2) no longer stayed with R3. I (R2) wasn't happy that R3 was still here. I (R2) would see him walking around even though the nurses tried to keep him in the wheelchair. Didn't know if he (R3) would try to attack me (R2) again. When asked if R2 feels safe here at the facility, R2 replied, I (R2) don't want to answer cause we don't know. R2's Face Sheet, documents, in part, medical diagnosis including but not limited to peripheral vascular disease, unspecified; other specified soft tissue disorder; and constipation, unspecified. R2's Minimum Data Set (MDS), dated [DATE], documents, in part, that R2's Brief Interview for Mental Status (BIMS) score is 13 which indicates R2 is cognitively intact. R7's hospital records, dated 10/10/24, documents, in part, Sent from (Facility) after assaulted by another resident there. Apparently, this resident was punching multiple other residents and punched this patient in the head, knocking him out of his wheelchair. On 10/10/24 at 9:30 PM, R2's hospital records document that a CT (computed tomography scan was completed) and documents the following findings: fracture of the nasal bones, small fracture of the lateral wall of the right orbit, small fracture of the right arm of the zygomatic arch, dehiscence of the floor of the right orbit. These fractures are of indeterminate age, clinical correlation is recommended. At 9:46 PM, R2's physician documented, Likely mix of new and old injuries. R7's Face Sheet, documents, in part, medical diagnosis including but not limited to fracture of unspecified part of neck of right femur, sequela; other cervical disc degeneration, unspecified cervical region; fusion of spine, cervical region; and seizures. R7's Minimum Data Set (MDS), dated [DATE], documents, in part, that R7's Brief Interview for Mental Status (BIMS) score is 07 which indicates R7 has severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Referral records, that the facility received prior to R3's admission, fax date of 8/16/24, documents, in part, (R3) with a history of dementia, depression, and anxiety was transferred from a local nursing home for direct admission. He (R3) was involved in a physical altercation with a fell ow resident . He (R3) remains anxious, irritated, confused, and bizarre, with no recollection of why he (R3) is being treated. Due to his (R3) dysregulated mood, aggression, and confusion, he (R3) poses a danger to himself and others . Verbal aggression during pt (patient) care . On 10/16/24 at 11:50am, when asked if the facility was aware of R3's history of aggression and prior physical altercation at the preceding facility R3 was residing at, V9 (Nurse Consultant) replied, In R3's referral it did state that R3 had an altercation with another resident, but it did not state who hit who. R3's progress note, dated 9/7/2024 at 1:41pm, transposed by V3 (Licensed Practical Nurse/LPN), documents, in part, Resident (R3) combative with all staff when asked to remain in his wheelchair for safety; refused blood glucose check and midday medicine pass; attempted to open secured doors on the unit. Resident (R3) used vulgar language with Writer. Family notified. On 8/21/24, R3 was admitted with medical diagnosis include but not limited to aphasia following cerebral infarction; major depressive disorder, recurrent, unspecified; essential (primary) hypertension; unspecified psychosis not due to a substance or known physiological condition; other specified diabetes mellitus without complications; polyosteoarthritis, unspecified; arthropathy, unspecified; gastro-esophageal reflux disease without esophagitis; long term (current) use of aspirin; insomnia, unspecified; hyperlipidemia, unspecified; vascular dementia, unspecified severity, with other behavioral disturbance; bipolar disorder, current episode mixed, unspecified; cerebral infarction, unspecified; dysphagia, oropharyngeal phase; cognitive communication deficit; other Alzheimer's disease. R3's progress note, dated 9/26/2024 at 7:20am, transposed by V5 (Licensed Practical Nurse/LPN) documents, in part, Informed by CNA (certified nursing assistant) upon rounds that resident (R3) had a cane in his hand and blood was coming from roommates head. All staff proceeded to room . When asked what happened, resident (R3) stated I (R3) thought someone was in my house, I (R3) didn't know he (R2) was supposed to be here . No concerns at this time. On 10/15/24 at 12:46pm, with translator V6 (Certified Nursing Assistant/CNA) present to translate for R2, this surveyor inquired about the altercation with R2 and R3 on 9/26/24. R2 replied, R3 hit me on the head with my cane. I (R2) was in the bathroom and R3 came up behind me and told me to get out of his apartment, grabbed my cane, and hit me in the head with it. I (R2) turned and seen R3. I (R2) am positive it was my roommate. I (R2) was bleeding from my head. R3 hit me good. The nurses took me to a different a room and I (R2) no longer stayed with R3. I (R2) wasn't happy that R3 was still here. I (R2) would see him walking around even though the nurses tried to keep him in the wheelchair. Didn't know if he (R3) would try to attack me (R2) again. When asked if R2 feels safe here at the facility, R2 replied, I (R2) don't want to answer cause we don't know. V10's (CNA/certified nursing assistant) Facility Reported Incident of 9/26/24 Witness Statement, dated 9/26/2024, documents, in part, I (V10) walked into (R2's) room he (R2) was walking out saying (R3) hit him with his cane. (R3) came out of the room yelling, get him out of my apartment. R2's Facility Reported Incident of 9/26/24 Witness Statement, dated 9/26/2024, documents, in part, (R3) hit him (R2) head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/16/24 at 1:10pm, V10 (Certified Nursing Assistant/CNA) said, I know R2. That morning (9/26/24) I (V10) just came in. I (V10) came in and did my rounds. I (V10) was coming back down the other hall and saw R2 staggering out of the room with a bleeding wound on his head. R2 said he (R3) was hitting him. R3 was cursing and yelling. R3's baseline is if you tell him (R3) what to do he'd get agitated. R3 was regularly agitated, every other day. We try to talk to him (R3) and calm him down. Just a lot of foul language. Yeah, I (V10) felt like he (R3) could do something like that again cause he (R3) didn't listen. On 10/17/24 at 2:15pm, V5 (Licensed Practical Nurse/LPN) said, Yes, I (V5) am familiar with R3. I (V5) was there 9/26/24 with the R2 and R3 altercation. (R3) Has moments of anxiousness and combativeness. CNA came and got me and showed me the opening on R2's head with blood. R2 said R2 was hit with a cane by R3. R3 is aggressive 50/50 percent of time. R3 had some bad days and some chill days. At times I (V5) was worried R3 would hurt other residents. Not sure what R3 was capable of. There are other residents that are more helpless than me and can be harmed by R3. Supervision, usually in bed, during the day they do dining room time. We did some in-services about the behaviors . R3 specifically no, but just about behaviors in general. We just would keep an extra eye on him (R3). There was no special written down supervision for (R3). Upon review of R3's EMR (Electronic Medical Record), this surveyor observed the following: 1. Record review of R3's Minimum Data Set (MDS) dated [DATE] documents in part a brief interview of mental status summary score of 10 indicating that R3 has cognitive impairment, documents that R3 has behavioral symptoms and wandering. 2. Record review of R3's CAA (Care Area Assessment) Worksheet (dated 8/28/24) documents in part that R3 had behavioral symptoms and wandering. V8 signed the CAA worksheet stated that R3's behaviors would be addressed within R3's Care Plan. 3. Record review of state final reportable of the physical abuse investigation that occurred between R2 and R3 on 9/26/24, documents in part the R2 and R3's care plans were updated after the incident. 4. Record review of R3's care plan documents in part that R3's aggressive behaviors were addressed on 10/10/24 after the incident between R3 and R7. R3's care plan was not updated with the MDS dated [DATE] in response to the CAA worksheet completed by V8 or after the final report and investigation of the incident that occurred between R2 and R3. On 10/22/24 at 9:53 AM, V8 (Social Services Director) stated that the social services department is responsible for creating a plan of care for residents with behaviors. Inappropriate behaviors, aggression, or refusal/combativeness to care would all be care planned by the social services department. V8 reviewed R3's plan of care and affirmed that R3's behaviors were not care planned until after both incidents (9/26 and 10/10). V8 stated that R3's aggressive behaviors should have been addressed in R3's care plan upon admission when the history of aggression/abuse was identified. V8 did not know why the R3's behaviors were not addressed in R3's care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 9:57 AM, V8 (Social Services Director) stated that the screening for aggressive behavior is to be completed with every MDS (quarterly, annually significant change) and if aggressive behavior occurs. V8 did not know why the aggression screening assessment was not completed after R3's incidents of violent behavior on 9/26 and 10/10. V8 stated these assessments are important because they help to trigger staff to develop a plan of care to address the aggression. On 10/15/2024 at 11:50 AM, V9 (Registered Nurse Consultant stated, If documentation cannot be produced, then it didn't happen. the survey. On 10/17/24 at 11:33am, V15 (Certified Nursing Assistant) said, Yes sir, I (V15) am familiar with R3. R3 had his moments when we (staff) couldn't tell R3 anything cause R3 would get upset/agitated and call us (staff) names. You bitch. Even if you (staff) tried to calm R3 down R3 wouldn't calm down. Yes! R3 would physical. R3 would get aggressive with me (V15). R3 would grab my hand and try punching me. I (V15) was working that day (10/10/24). I (V15) heard a little commotion and went towards R7's room. I (V15) tried to help him (R3) calm down. R3 was very aggressive. R3 grabbed my hand. R3 kept coming at me. R3 walks. R3 stands up from his wheelchair. R3 won't sit down. I (V15) just heard R3 screaming. R7 was complaining of pain in face. We (staff) didn't know when R3 would get upset. When R3 just got the urge R3 would just get aggressive. I (V15) was worried that R3 would hurt me. R3 was a strong guy. Yes, I (V15) was definitely worried that R3 would hurt the other residents. I (V15) believe, everyone (all employees) new R3 would get upset. There was no training for R3. You (staff) can have a conversation with R7. He remembers almost everything. Just can be a little forgetful but R7 would not forget anything like this. Since that happened R7 always brings it up. I (V15) would say R7 remembers things, sometimes forget things, but he remembers most things. I (V15) don't think R7 would make up a story of what happened to him (R7). R3 is not appropriate to have a roommate. R3 was aggressive toward staff since the beginning. On 10/17/24 at 12:03pm, V3 (Licensed Practical Nurse/LPN) said, Yes, I (V3) am familiar with R3. He'd (R3) get up from the chair and curse you out. Gets very vulgar and then more vulgar. We (staff) try to redirect R3. R3 has swung at me (V3) before but never actually made contact. I (V3) was sitting at the nurse's station, heard someone yelling, CNAs (certified nursing assistants) and I (V3) got up and went to see what was happening. R3 was full of aggressiveness, vulgarity, and more aggression. R3 struck the CNA. R3 walked up on me with his fist and swung, but I (V3) backed up. R3 continued being vulgar. My documentation, I (V3) admit, sucked. Staff was with R3 in the dining room but R3 will roll out of the dining room, we'll watch him role out, but R3 has that right. R3 has the freedom to roll back and forth. Residents have the freedom to roll around. I (V3) have been worried that R3 would hurt me. I (V3) have been concerned that R3 would hurt other residents. I (V3) never notified anyone; I (V3) just diffused the situation. R3 was 50/50 percent aggressive all of the time. R3 could be decent and then would just snap. On 10/17/24 at 12:19pm, V16 (CNA), said, I (V16) was working 10/10/24. I (V16) heard yelling, ran, and the other nurse followed. R7's wheelchair was flipped over and R3 was standing over R7. R7 said R3 punched him (R7) and knocked him (R7) over. Half of the time R3 is aggressive. (continued on next page)

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	10/31/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/2024 at 10:48am, V18 (Medical Director) said, I (V18) was the attending physician for R3. R3 had Bipolar, dementia, anxiety depression, Psych issues. Medically ok. Main reason was psych issues as far as I (V18) remember. I (V18) did his (R3) admission, and he (R3) had some altercation at other facility and that's why other facility transferred him out to our facility. Based on R3's history of aggression towards other residents, I (V18) don't know if he (R3) had a roommate. When asked if it was appropriate for R3 to have a roommate, V18 replied, Difficult to answer. There are a lot of psych, and they can have behaviors and stabilize. When I'm (V18) admitting a patient I (V18) assume they are stabilized. With identified behaviors prior to admission, the facility should had increased R3's supervision and observation. Yeah, when we see there R3 required increased monitoring. Nursing homes don't have a lot of staff, so if we (facility) can't care for them appropriately, we (facility) send them to the hospital. I (V18) was aware of 10/10/24 altercation with R2 and R3. We sent R3 out. No, I (V18) don't remember a change of condition. When I (V18) went in the room R3 was using vulgar language. Being hit in the head and falling out of a wheelchair cause facial fractures definitely caused harm to (R7). The severity of harm that happens after a resident is hit in the head can vary depending on the velocity of the hit, the size of the resident. Facial fractures can be caused by a punch to the head or falling out of a wheelchair. R3's plan of care should have been developed to address those behaviors. Dementia and psych are very challenging. We try to control the behaviors but if it's out of control we (facility) send them out. If the Plan of care isn't done, the resident's aggressive behaviors can continue. We (facility) need to address it cause other residents are at risk. If a resident is assessed incorrectly, can harm be caused? is a hard question. Behaviors change. If behaviors changed the assessments should be redone. Facility policy titles, Policy and Procedure Supervision Policy, dated 1/2024, documents, in part, Additional supervision may be required in order to meet the specialized needs of residents. Additional supervision may be but not limited to 1: 1 supervision, 15-minute checks, 30- minute and so forth. Purpose To ensure resident safety. Additional supervision is followed per the plan of care in accordance with an individualized resident focused approach.