STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50728 Based on observation, interview and record review, the facility failed to honor the resident's right to a sanitary, clean environment throughout the facility. This has the potential to affect all 208 residents residing within the facility. Findings include: Record review of facility provided census documents in part that 208 residents reside within the facility. On 3/10/2025 at 11:30 AM, R8 was observed eating lunch (tuna salad, green beans, mashed potatoes) in the dining room along with other residents that reside within the 4th floor. Underneath the table was unidentified orange food (similar to crumbs of cheese puffs/chips), and splatters of brown dirt. Splatters of brown dirt and dirty footprints were observed throughout the dining room. On 3/10/2024 at 11:34 AM, V7 (Certified Nursing Assistant) affirmed that V7 was assigned to care for R8 and other residents on the floor. V7 affirmed that the dining room is where the residents that reside on the floor eat. V7 observed the orange food and dirt underneath the table and was unable to identify what the food was. V2 (Director of Nursing) walked to the surveyor and V7. V2 observed the dining room floors and affirmed that they were in need of cleaning. Surveyor walked over to R8's right side and the surveyor's shoes began to stick and squeak when walking near R8. V2 affirmed that the floor was sticky, not wet, not caused by food currently being eaten and V2 left to get housekeeping to clean the floors. V2 returned and stated that the housekeepers would come to clean the floors after the residents had finished eating. On 3/10/2025 at 11:38 AM, V33 (Housekeeper) was observed mopping the floor of a resident's room. V33 stated that floor techs are assigned to clean the floors in the common areas of the facility. V33 was unsure if the dining room floor had been cleaned prior to lunch. On 3/10/2025 at 11:43 AM, surveyor observed dining room and hallways on the 3rd floor. The floors appeared dirty with splattered brown dirt and splattered orange substance. Additionally, empty sugar packets and used tissues were noted on the floor of the hallway. When V2 observed the orange substances, V2 was unsure what the substance was, stating, maybe it's paint?. V2 left to find a housekeeper to clean the floors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Archer Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/2025 at 11:46 AM, R3 stated that the facility is not clean at all and makes me (R3) feel really bad. Sometimes the facility is so filthy I (R3) have to get mops and other cleaning supplies and clean it up myself. They (facility staff) should be doing it, not me (R3). On 03/10/25 at 12:00 PM, observed dark black stains/discoloration throughout R1's room floors. The second floor hallway was observed with dark, discolored streaks throughout (dirt). On 03/10/25 at 12:04pm R1 stated, I have to get on my knees to clean the floor because they don't come in here and clean. On 03/10/25 at 12:43pm V4 (Restorative Technician) stated I have had resident complain about housekeeping issues and their rooms not being clean. They have been short on housekeepers. Sometimes we get on the carts ourselves, we sweep and mop ourselves. Typically, if we page for housekeeping they come and help us out. We have been short with housekeeping for over a month. On 3/11/2025 at 10:35 AM, tour of the first floor was completed. The floors appeared dirty with excessive dirt covering the floor in the shape of footprints, wheelchair tracks, and splatters. V10 (Licensed Practical Nurse) observed the floors and affirmed that the floors were dirty and need to be cleaned. V10 was unaware the last time the floors were cleaned on the floor but stated that housekeeping usually completes them daily. On 3/11/2025 at 12:43 PM, V1 (Administrator) explained that the facility recently had issues with housekeeping and that a new housekeeping manager started on 3/10/2025. V1 stated that residents have the right to a clean environment. On 3/12/2025 at 10:44 AM, V14 (Certified Nursing Assistant) affirmed that residents regularly complain about the cleanliness of the facility. V14 recalled that V14 has had to clean the facility floors at times so the residents have a clean environment. On 3/13/2025 at 2:31 PM, V19 (Social Services Director) stated that V19 has had residents complain about the facility not being clean. V19 stated that V19 would tell the housekeeping manager when V19 received complaints. Record review of facility provided document titled, RESIDENTS' RIGHTS for People in Long-Term Care Facilities documents in part, .Your rights to safety . Your facility must be safe, clean, comfortable and homelike.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
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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 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** 50728 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse and verbal abuse. This failure affects 2 residents (R8, R15) reviewed for abuse. This failure caused harm to R8, evidenced by R8 sustaining a laceration to the back of R8's head that required closure with staples and hospitalization . Findings include: 1. R8's progress notes (dated 2/18/2025) documents in part, Patient fell in dinner are hit the back of head. Small laceration with mild blood drainage noted. Patient vitals with in normal limits BP 122/70 HR 70 Sp02 98.5 Resp 18. Patient is being sent to (Hospital) for Head CT.Neuro Checks normal . On 2/19/2025, V9 (Nurse Practitioner) documented, Per (Hospital) nurse, Admitting Dx: anemia (9.8 hemoglobin at ER, f/u hemoglobin on 2/19/25 is 12.7). CT head result is unremarkable. She needed staples on her head. Planned for endoscopy. Not sure about discharge plan yet. Will f/u. R8's hospital records (admitted [DATE]) document in part, .At the nursing home, patient fell down. According to the nurse practitioner at the nursing home, the patient was trying to take a meal tray from another resident and he pushed her. And she fell down. Patient was sent to the emergency room for further evaluation. Patient was found to have a laceration of the scalp and she was also anemic she was admitted for further evaluation . Record review of investigation to the state survey agency (SSA) and supplementary investigative documents for R8's fall with injury documents in part, .Analysis and Conclusion . On 2/18/2025, (R8) was ambulating around the unit. (R8) ambulated into the dining room where (R8) lost (R8's) balance and fell to the floor. Staff nursing (were) made aware and immediately went to assess the (R8). While on the floor the (R8) was observed with an open area to the back of (R8's) head. The nurse cleansed the area and applied a pressure dressing to the site. (R8's) guardian and physician were made aware, and an order was received to transport the (R8) to the local hospital where (R8) was later admitted with a diagnosis of anemia. (R8) returned to the facility on [DATE] 21:45 and was noted to have a staple to the back of (R8's) head . This report was completed by V2 (Director of Nursing). Written witness statements gathered from V26 (Licensed Practical Nurse) and V27 (Licensed Practical Nurse) affirms that V26 and V27 did not witness the incident. V26 documents that V14 (Certified Nursing Assistant) told V26 what happened but did not describe what happened. On 3/11/2025 at 11:34 PM, V9 (Nurse Practitioner) affirmed that V9 is a provider for R8 and was made aware of the incident by V27. V9 affirmed that V9 was not in the building at the time of the incident. V9 explained that V27 told V9 that R8 was pushed to the ground by another resident and sustained a laceration to the back of R8's head. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/11/2025 at 12:24 PM, V27 (Licensed Practical Nurse) affirmed that V27 was assigned to care for R8 on the day of the incident. V27 recalled that V27 had come back from break and there was a lot of commotion but that R8 had already fallen. V27 did not see R8 fall. Other staff were claiming that R12 had pushed R8 but V27 could not recall who the staff members were that stated that. V27 stated that V27 did report that R8 was pushed to V9 because that is what I (V27) thought happened at the time. (V2) completed an investigation and that's not what happened according to the investigation. I don't know what happened because I (V27) wasn't there. On 3/11/2025 at 12:40 PM, V2 (Director of Nursing) affirmed that V2 completed the investigation into the incident. V2 said it was reported to V2 by V26 that R8 had fallen in the dining room. V2 stated that V2 did see the laceration near the crown of R8's head but that R8 was in the process of being sent out. V2 stated the root cause of the fall was R8's anemia. V2 denied knowledge of R8 being pushed to the ground. Surveyor reviewed the hospital records and investigative documents with V2 and V1 (Administrator). V2 affirmed that the hospital records indicated that R8 was pushed to the ground. V2 stated, I did not look at those (hospital records). On 3/12/2025 at 10:44 AM, V14 (Certified Nursing Assistant) affirmed that V14 was in the dining room for the dementia unit (4th floor) during the time of the incident. V14 explained that V14 was feeding another resident when V14 observed R8 go up to R12 across the dining room. R8 was attempting to take food off of R12's plate. V14 tried to get up and intervene but V14 was across the room and could not intervene before R12 pushed R8 to the ground. V14 affirmed that R8 did hit R8's head against the ground. On 3/13/2025 at 12:55 PM, V26 (Licensed Practical Nurse) explained that V26 was on duty the day of the incident and heard a commotion in the dining room. V27 was not on the floor so V26 responded to the dining room and saw R8 lying on the ground bleeding from R8's head. V26 provided first aide and took R8 to R8's room. Surveyor inquired if V14 told V26 that R8 was pushed. V26 responded, No, I do not know anything about (R12) pushing (R8). Surveyor noted to V26 that R12's name was not brought up within the interview, and inquired why V26 would bring up R12's name in response. V26 did not initially respond. Surveyor asked again for an accurate answer if V14 had told V26 that R12 pushed R8 to the floor and V26 affirmed that V14 and other staff had mentioned that they thought R8 was pushed to the ground by R12. V26 stated that V26 told V2 that V14 and other staff said R8 was pushed to the ground by R12. Record review of R8's admission record documents in part the following diagnosis: unspecified dementia with behavioral disturbance, pseudobulbar affect, generalized anxiety disorder, peripheral vascular disease, unspecified lack of coordination, repeated falls. Record review of R8's minimum data set (dated 3/6/2025) documents a brief interview of mental status summary score of of 0, indicating that R7 has severe cognitive impairment and is unable to understand others. Record review of R12's admission record documents in part the following diagnosis: chronic obstructive pulmonary disease, unspecified dementia without behavioral disturbance, emphysema, anemia, other speech disturbances, and restlessness and agitation. Record review of R12's minimum data set (dated 2/5/2025) documents in part a brief interview of mental status summary score of 9, indicating that R12 is cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of R12's care plan identifies that R12 has a history of physical and verbal aggression. 2. On 3/11/2025 at 11:35 AM, R9 stated that R3 was, crazy and always up to something. R9 explained that the other day (3/9/2025), R9 witnessed R3 yelling at R15, accusing R15 of taking R3's clothes. R3 began to yell louder and threaten R15, saying he was going to beat his a**. R3 came to R15 who was sitting by the nurse's station in the hallway and slapped the s*** out of him across the face . (R3) hit him so hard. After the hit, V17 (Licensed Practical Nurse) came over and separated R3 and R15. R3 was unsure if V17 actually saw the hit but remembered V17 was in the area. On 3/11/2025 at 12:40 PM, V1 (Administrator) stated that R3 and R15 had a verbal disagreement a few days prior and that R3 was sent via petition as a result from the verbal disagreement. V1 affirmed that verbal disagreements do not warrant psychiatric admission. V1 stated that V1 was aware that R3 was yelling at R15. V1 denied knowledge of any other aspect of the incident outside of the yelling (ie. R3 striking R15). V1 stated that yelling at another resident is not abuse. V13 (Nurse Consultant) stated that yelling could be abuse, it depends. On 3/12/2024 at 12:43 AM, V22 (Licensed Practical Nurse) stated that V22 was familiar with both R3 and R15. V22 stated that V22 heard that R3 had hit R15 in the past few days but couldn't recall where V22 heard it from. V22 stated that R3 has a lot of behaviors, like physical aggression and verbal aggression. On 3/12/2025 at 1:37 PM, R15 stated that R15 was hit by R3 in the past couple of days. R15 stated, It was later in the day a couple days ago. (R3) thought I was wearing (R3's) jacket. I told him [NAME] man, it's my jacket. (R3) was yelling at me, threatening me to take the jacket off or (R3) was gonna hit me. I told (R3) if you hit me, you will go to jail. Then next thing I know, (R3) smacked me across the face really hard. It hurt bad, man. I don't know if any staff were around when it happened, but I remember (V17) coming up to me after, I told her to call the police. The police came and filled out an incident report. On 3/13/2025 at 2:31 PM, V19 (Social Services Director) stated that R3 and R15 had an incident and that R3 was in the process of being transferred to the hospital because of the incident. V19 affirmed that V19 was aware that R3 had hit R15 in the head because R15 told V19. V19 explained that V19 told V1 that R15 was hit in the head and that V1 was doing (V1's) due diligence and following up. V19 was unaware if V1's investigation was able to substantiate the incident. On 3/13/2025 at 3:02 PM, V17 (Licensed Practical Nurse) recalled the incident that occurred between R3 and R15. V17 explained that V17 was in the dining room with another patient and V17 heard yelling in front of the nurse's station. V17 could hear R3 and R15 yelling and V17 could hear R3 yell, I (R3) am gonna whoop yo a** if you (R15) don't give me that shirt!. V17 went over to R3 and R15 and separated them. V17 stated that V17 was not aware of R3 hitting R15. V17 recalled that once the residents were separated, V17 reported the incident to V2 (Director of Nursing) and V1 (Administrator). V17 affirmed that threatening could be verbal abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of R3's progress notes documents in part that on 3/9/2025, R3 was noted to be having a verbal disagreement with peer. R3's provider ordered R3 to be evaluated for psychiatric admission. R3 was sent to the hospital and returned later on 3/9/2025 in stable condition. R3 was sent to the hospital again for behaviors on 3/10/2025. No care interventions were noted to be added within R3's progress notes after 3/9/2025. Record review of R3's care plan documents in part that on 2/23/25 and 2/25/25 R3 displayed verbal and physical aggressive behaviors. An intervention of petition out for psychiatric admission was added to the care plan on 2/23/25. No other appropriate, person-centered care plan interventions were added to address R3's aggressive behaviors. Record review of R3's face sheet documents in part a diagnosis of epilepsy, chronic obstructive pulmonary disease, paranoid schizophrenia, delusional disorder, and drug induced akathisia. Record review of R3's minimum data set (dated 1/2/2025) documents in part a brief interview of mental status summary score of 13, indicating R3 is cognitively intact. Record review of R15's face sheet documents in part a diagnosis of degenerative disk disease of the lumbar region, chronic obstructive pulmonary disease, and osteoarthritis. Record review of R15's minimum data set (dated 2/5/2025) documents in part a brief interview of mental status summary score of 15, indicating that R15 is cognitively intact. Record review of facility abuse policy titled, Policy and Procedure Abuse Prevention Program (1/2024) documents in part, .Definition Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Record review of facility provided document titled, RESIDENTS' RIGHTS for People in Long-Term Care Facilities documents in part, .Your rights to safety You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally or sexually .

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50728

Based on interview and record review, the facility staff failed to notify the state survey agency within time reporting requirements of abuse; failed to report witnessed abuse to the abuse prevention coordinator. This failure affects 4 residents (R8, R12, R3 and R15) sampled for abuse reporting.

Findings include:

1. Record review of investigation to the state survey agency (SSA) and supplementary investigative documents for R8's fall with injury documents in part, .Analysis and Conclusion . On 2/18/2025, (R8) was ambulating around the unit. (R8) ambulated into the dining room where (R8) lost (R8's) balance and fell to the floor. Staff nursing (were) made aware and immediately went to assess the (R8). While on the floor the (R8) was observed with an open area to the back of (R8's) head. The nurse cleansed the area and applied a pressure dressing to the site. (R8's) guardian and physician were made aware, and an order was received to transport the (R8) to the local hospital where (R8) was later admitted with a diagnosis of anemia. (R8) returned to the facility on [DATE] 21:45 and was noted to have a staple to the back of (R8's) head . This report was completed by V2 (Director of Nursing). Written witness statements gathered from V26 (Licensed Practical Nurse) and V27 (Licensed Practical Nurse) affirms that V26 and V27 did not witness the incident. V26 documents that V14 (Certified Nursing Assistant) told V26 what happened but did not describe what happened. The initial report was sent to the state survey agency on 2/24/2025 (6 days after incident), with a final report completed on 2/26/2025. No mention of R12 pushing R8 is noted within this investigation or the documents.

On 3/10/2024 at 2:43 PM, V1 (Administrator) affirmed that V1 is the abuse prevention coordinator for the facility. V1 stated that V1 was unaware that the hospital had documented that R8 was pushed by another resident. V1 denied that any staff member had reported potential physical abuse to R8. V1 stated that allegations of abuse are to be reported to the state survey agency immidiately but no later than 2 hours.

On 3/12/2025 at 10:44 AM, V14 (Certified Nursing Assistant) affirmed that V14 was in the dining room for the dementia unit (4th floor) during the time of the incident (2/18/2025). V14 explained that V14 was feeding another resident when V14 observed R8 go up to R12 across the dining room. R8 was attempting to take food off of R12's plate. V14 tried to get up and intervene but V14 was across the room and could not intervene before R12 pushed R8 to the ground. V14 affirmed that R8 did hit R8's head against the ground. V14 affirmed that when staff witness abuse, staff are supposed to report it to the administrator (abuse prevention coordinator). V14 stated that V14, should have reported it to V1, but I (V14) reported it to (V26).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/2025 at 12:55 PM, V26 (Licensed Practical Nurse) explained that V26 was on duty the day of the incident and heard a commotion in the dining room. V27 was not on the floor so V26 responded to the dining room and saw R8 lying on the ground bleeding from R8's head. V26 provided first aide and took R8 to R8's room. Surveyor inquired if V14 told V26 that R8 was pushed. V26 responded, No, I do not know anything about (R12) pushing (R8). Surveyor noted to V26 that R12's name was not brought up within the interview, and inquired why V26 would bring up R12's name in response. V26 did not initially respond. Surveyor asked again for an accurate answer if V14 had told V26 that R12 pushed R8 to the floor and V26 affirmed that V14 and other staff had mentioned that they thought R8 was pushed to the ground by R12. V26 stated that V26 told V2 that V14 and other staff said R8 was pushed to the ground by R12. V26 explained that V1 is the abuse prevention coordinator and that pushing residents could be a form a physical abuse. V26 did not report the allegation the administrator because (V2) was aware of the incident and we (facility staff) had too much to do that day. 2. On 3/11/2025 at 12:40 PM, V1 (Administrator) stated that R3 and R15 had a verbal disagreement a few days prior and that R3 was sent via petition as a result from the verbal disagreement. V1 affirmed that verbal disagreements do not warrant psychiatric admission. V1 stated that V1 was aware that R3 was yelling at R15. V1 denied knowledge of any other aspect of the incident outside of the yelling (ie. R3 striking R15). V1 stated that yelling at another resident is not abuse. V13 (Nurse Consultant) stated that yelling could be abuse, it depends. V1 said, okay, I see what you mean and affirmed this allegation was not reported. On 3/13/2025 at 2:31 PM, V19 (Social Services Director) stated that R3 and R15 had an incident and that R3 was in the process of being transferred to the hospital because of the incident. V19 affirmed that V19 was aware that R3 had hit R15 in the head because R15 told V19. V19 explained that V19 told V1 that R15 was hit in the head and that V1 was doing (V1's) due diligence and following up. V19 was unaware if V1's investigation was able to substantiate the incident. On 3/13/2025 at 3:02 PM, V17 (Licensed Practical Nurse) recalled the incident that occurred between R3 and R15. V17 explained that V17 was in the dining room with another patient and V17 heard yelling in front of the nurse's station. V17 could hear R3 and R15 yelling and V17 could hear R3 yell, I (R3) am gonna whoop yo a** if you (R15) don't give me that shirt!. V17 went over to R3 and R15 and separated them. V17 stated that V17 was not aware of R3 hitting R15. V17 recalled that once the residents were separated, V17 reported the incident to V2 (Director of Nursing) and V1 (Administrator). V17 affirmed that threatening someone could be verbal abuse. Record review of R3's progress notes documents in part that on 3/9/2025, R3 was noted to be having a verbal disagreement with peer. R3's provider ordered R3 to be evaluated for psychiatric admission. R3 was sent to the hospital and returned later on 3/9/2025 in stable condition. R3 was sent to the hospital again for behaviors on 3/10/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility abuse policy titled, Policy and Procedure Abuse Prevention Program (1/2024) documents in part, .Definition Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Employees are required to report any incident allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator . The nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises, lacerations or other abnormalities as they occur . Incidents will be reviewed, investigated and documented whether or not abuse, neglect exploitation, mistreatment or misappropriation of resident property occurred, was alleged, or suspected . Incidents or allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be reviewed by the administration and shall be investigated, as indicated and appropriate. Record review of facility policy titled Incident/Accident Reports (1/2024) documents in part, .4. Abuse incidents must be reported to the Illinois Department of Public health within two (2) hours of occurrance or immidiately .

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50728

Based on interview and record review, the facility failed to complete a thorough investigation after a fall with injury to substantiate if abuse occurred; failed to complete an abuse allegation after an allegation of verbal abuse was reported. This failure affects 4 residents (R8, R12, R3 and R15) sampled for abuse reporting.

Findings include:

1. R8's progress notes (dated 2/18/2025) documents in part, Patient fell in dinner are hit the back of head. Small laceration with mild blood drainage noted. Patient vitals with in normal limits BP 122/70 HR 70 Sp02 98.5 Resp 18. Patient is being sent to (Hospital) for Head CT.[NAME] Checks normal . On 2/19/2025, V9 (Nurse Practitioner) documented, Per (Hospital) nurse, Admitting Dx: anemia(9.8 hemoglobin at ER, f/u hemoglobin on 2/19/25 is 12.7). CT head result is unremarkable. She needed staples on her head. Planned for endoscopy. Not sure about discharge plan yet. Will f/u.

R8's hospital records (admitted [DATE]) document in part, .At the nursing home, patient fell down. According to the nurse practitioner at the nursing home, the patient was trying to take a meal tray from another resident and he pushed her. And she fell down. Patient was sent to the emergency room for further evaluation. Patient was found to have a laceration of the scalp and she was also anemic she was admitted for further evaluation .

Record review of investigation to the state survey agency (SSA) and supplementary investigative documents for R8's fall with injury documents in part, .Analysis and Conclusion . On 2/18/2025, (R8) was ambulating around the unit. (R8) ambulated into the dining room where (R8) lost (R8's) balance and fell to the floor. Staff nursing (were) made aware and immediately went to assess the (R8). While on the floor the (R8) was observed with an open area to the back of (R8's) head. The nurse cleansed the area and applied a pressure dressing to the site. (R8's) guardian and physician were made aware, and an order was received to transport the (R8) to the local hospital where (R8) was later admitted with a diagnosis of anemia. (R8) returned to the facility on [DATE] 21:45 and was noted to have a staple to the back of (R8's) head . This report was completed by V2 (Director of Nursing). Written witness statements gathered from V26 (Licensed Practical Nurse) and V27 (Licensed Practical Nurse) affirms that V26 and V27 did not witness the incident. V26 documents that V14 (Certified Nursing Assistant) told V26 what happened but did not describe what happened. No witness statement was provided from V14 from the facility's investigation.

On 3/11/2025 at 11:34 PM, V9 (Nurse Practitioner) affirmed that V9 is a provider for R8 and was made aware of the incident by V27. V9 affirmed that V9 was not in the building at the time of the incident. V9 explained that V27 told V9 that R8 was pushed to the ground by another resident and sustained a laceration to the back of R8's head.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER: Archer Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/2025 at 12:24 PM, V27 (Licensed Practical Nurse) affirmed that V27 was assigned to care for R8 on the day of the incident. V27 recalled that V27 had come back from break and there was a lot of commotion but that R8 had already fallen. V27 did not see R8 fall. Other staff were claiming that R12 had pushed R8 but V27 could not recall who the staff members were that stated that. V27 stated that V27 did report that R8 was pushed to V9 because that is what I (V27) thought happened at the time. (V2) completed an investigation and that's not what happened according to the investigation. I don't know what happened because I (V27) wasn't there. On 3/11/2025 at 12:40 PM, V2 (Director of Nursing) affirmed that V2 completed the investigation into the incident. V2 said it was reported to V2 by V26 that V26 had fallen in the dining room. V2 stated that V2 did see the laceration near the crown of R8's head but that R8 was in the process of being sent out. V2 stated the root cause of the fall was R8's anemia. V2 denied knowledge of R8 being pushed to the ground. Surveyor reviewed the hospital records and investigative documents with V2 and V1 (Administrator). V2 affirmed that the hospital records indicated that R8 was pushed to the ground. V2 stated, I did not look at those (hospital records). V1 and V2 affirmed that the hospital records should have been reviewed as part of the investigation. Witness statements were requested from V14 (Certified Nursing Assistant that observed the incident per V26's interview) and this was not provided prior to the end of the survey. V1 and V2 affirmed that V14 was not interviewed during the investigation and should have been interviewed. On 3/12/2025 at 10:44 AM, V14 (Certified Nursing Assistant) affirmed that V14 was in the dining room for the dementia unit (4th floor) during the time of the incident. V14 explained that V14 was feeding another resident when V14 observed R8 go up to R12 across the dining room. R8 was attempting to take food off of R12's plate. V14 tried to get up and intervene but V14 was across the room and could not intervene before R12 pushed R8 to the ground. V14 affirmed that R8 did hit R8's head against the ground. On 3/13/2025 at 12:55 PM, V26 (Licensed Practical Nurse) explained that V26 was on duty the day of the incident and heard a commotion in the dining room. V27 was not on the floor so V26 responded to the dining room and saw R8 lying on the ground bleeding from R8's head. V26 provided first aide and took R8 to R8's room. Surveyor inquired if V14 told V26 that R8 was pushed. V26 responded, No, I do not know anything about (R12) pushing (R8). Surveyor noted to V26 that R12's name was not brought up within the interview, and inquired why V26 would bring up R12's name in response. V26 did not initially respond. Surveyor asked again for an accurate answer if V14 had told V26 that R12 pushed R8 to the floor and V26 affirmed that V14 and other staff had mentioned that they thought R8 was pushed to the ground by R12. V26 stated that V26 told V2 that V14 and other staff said R8 was pushed to the ground by R12. Record review of R8's admission record documents in part the following diagnosis: unspecified dementia with behavioral disturbance, psuedobulbar affect, generalized anxiety disorder, peripheral vascular disease, unspecified lack of coordination, repeated falls. Record review of R8's minimum data set (dated 3/6/2025) documents a brief interview of mental status summary score of of 0, indicating that R7 has severe cognitive impairment and is unable to understand others. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of R12's admission record documents in part the following diagnosis: chronic obstructive pulmonary disease, unspecified dementia without behavioral disturbance, emphysema, anemia, other speech disturbances, and restlessness and agitation. Record review of R12's minimum data set (dated 2/5/2025) documents in part a brief interview of mental status summary score of 9, indicating that R12 is cognitively impaired. Record review of R12's care plan identifies that R12 has a history of physical and verbal aggression. 2. On 3/11/2025 at 11:35 AM, R9 stated that R3 was, crazy and always up to something. R9 explained that the other day (3/9/2025), R9 witnessed R3 yelling at R15, accusing R15 of taking R3's clothes. R3 began to yell louder and threaten R15, saying he was going to beat his a**. R3 came to R15 who was sitting by the nurse's station in the hallway and slapped the s*** out of him across the face . (R3) hit him so hard. After the hit, V17 (Licensed Practical Nurse) came over and separated R3 and R15. R3 was unsure if V17 actually saw the hit but remembered V17 was in the area. On 3/11/2025 at 12:40 PM, V1 (Administrator) stated that R3 and R15 had a verbal disagreement a few days prior and that R3 was sent via petition as a result from the verbal disagreement. V1 affirmed that verbal disagreements do not warrant psychiatric admission. V1 stated that V1 was aware that R3 was yelling at R15. V1 denied knowledge of any other aspect of the incident outside of the yelling (ie. R3 striking R15). V1 stated that yelling at another resident is not abuse. V13 (Nurse Consultant) stated that yelling could be abuse, it depends. V1 affirmed this allegation was not investigated and should have been investigated. On 3/12/2024 at 12:43 AM, V22 (Licensed Practical Nurse) stated that V22 was familiar with both R3 and R15. V22 stated that V22 heard that R3 had hit R15 in the past few days but couldn't recall where V22 heard it from. V22 stated that R3 has a lot of behaviors, like physical aggression and verbal aggression. On 3/12/2025 at 1:37 PM, R15 stated that R15 was hit by R3 in the past couple of days. R15 stated, It was later in the day a couple days ago. (R3) thought I was wearing (R3's) jacket. I told him [NAME] man, it's my jacket. (R3) was yelling at me, threatening me to take the jacket off or (R3) was gonna hit me. I told (R3) if you hit me, you will go to jail. Then next thing I know, (R3) smacked me across the face really hard. It hurt bad, man. I don't know if any staff were around when it happened, but I remember (V17) coming up to me after, I told (V17) to call the police. The police came and filled out an incident report. On 3/13/2025 at 2:31 PM, V19 (Social Services Director) stated that R3 and R15 had an incident and that R3 was in the process of being transferred to the hospital because of the incident. V19 affirmed that V19 was aware that R3 had hit R15 in the head because R15 told V19. V19 explained that V19 told V1 that R15 was hit in the head and that V1 was doing (V1's) due diligence and following up. V19 was unaware if V1's investigation was able to substantiate the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/2025 at 3:02 PM, V17 (Licensed Practical Nurse) recalled the incident that occurred between R3 and R15. V17 explained that V17 was in the dining room with another patient and V17 heard yelling in front of the nurse's station. V17 could hear R3 and R15 yelling and V17 could hear R3 yell, I (R3) am gonna whoop yo a** if you (R15) don't give me that shirt!. V17 went over to R3 and R15 and separated them. V17 stated that V17 was not aware of R3 hitting R15. V17 recalled that once the residents were separated, V17 reported the incident to V2 (Director of Nursing) and V1 (Administrator). V17 affirmed that threatening could be verbal abuse. Record review of R3's progress notes documents in part that on 3/9/2025, R3 was noted to be having a verbal disagreement with peer. R3's provider ordered R3 to be evaluated for psychiatric admission. R3 was sent to the hospital and returned later on 3/9/2025 in stable condition. R3 was sent to the hospital again for behaviors on 3/10/2025. No care interventions were noted to be added within R3's progress notes after 3/9/2025. Record review of R3's care plan documents in part that on 2/23/25 and 2/25/25 R3 displayed verbal and physical aggressive behaviors. An intervention of petition out for psychiatric admission was added to the care plan on 2/23/25. No other appropriate, person-centered care plan interventions were added to address R3's aggressive behaviors. Record review of R3's face sheet documents in part a diagnosis of epilepsy, chronic obstructive pulmonary disease, paranoid schizophrenia, delusional disorder, and drug induced akathisia. Record review of R3's minumum data set (dated 1/2/2025) documents in part a brief interview of mental status summary score of 13, indicating R3 is cognitively intact. Record review of R15's face sheet documents in part a diagnosis of degenerative disk disease of the lumbar region, chronic obstructive pulmonary disease, and osteoarthritis osteoarthritis. Record review of R15's minimum data set (dated 2/5/2025) documents in part a brief interview of mental status summary score of 15, indicating that R15 is cognitively intact. Record review of facility abuse policy titled, Policy and Procedure Abuse Prevention Program (1/2024) documents in part, .Definition Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Employees are required to report any incident allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator . The nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises, lacerations or other abnormalities as they occur . Incidents will be reviewed, investigated and documented whether or not abuse, neglect exploitation, mistreatment or misappropriation of resident property occurred, was alleged, or suspected . Incidents or allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be reviewed by the administration and shall be investigated, as indicated and appropriate. Record review of facility policy titled Incident/Accident Reports (1/2024) documents in part, .5. Incidents of unknown origin are to be investigated thoroughly in an effort to rule out abuse .

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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** 50662 Based on observation, interview, and record review the facility failed to assure that one resident (R1) with a surgical wound was provided the necessary treatment and services to promote wound healing and pain control. This failure resulted in R1's wound worsening and having avoidable pain. Findings include: R1's diagnoses include but are not limited to surgical amputation, chronic obstructive pulmonary disease, asthma, paranoid schizophrenia, complete traumatic amputation of left foot, superficial frostbite of left toes, hallucinations, major depressive disorder, kidney failure, essential hypertension, bacterial pneumonia. R1's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15, which indicates R1's cognition is intact. On 03/10/25 at 12:00pm R1 observed sitting on bed with dressing to left foot. R1's left foot dressing observed to be secured in place with band-aides, unraveling and with what appeared to be dark dirt-like substance in multiple areas of the bandage. R1's bandage observed to have no date. On 03/10/25 at 12:04pm, R1 stated on 03/03/25 she asked V18 (Licensed Practical Nurse/LPN) for pain medication and V18 did not give her pain medication V18's entire 12-hour shift. R1 stated that she was in pain for the entire shift. R1 stated that the wound dressing on her left foot has not been changed since Friday 03/07/25 and should be changed every day. R1 stated that the facility does not have enough staff to change her wound dressing on the weekend. R1's active physician order documents in part, Oxycodone Capsule 5mg (milligram) give 1 capsule by mouth every 6 hours as needed for analgesics related to partial traumatic amputation of left foot, level unspecified. R1's active physician order documents in part, Site: left foot: Cleanse with NSS (normal saline solution) pat dry, apply xeroform, ABD (abdominal gauze), wrap with kerlix and secure with tape daily or as need (prn). R1's Controlled Drug Receipt form shows multiple dates and times from 03/03/25 through 03/10/25 that nurses removed oxycodone from locked medication storage. Record review of R1's Medication Administration Record (MAR) showed no documentation that the medication was administered to R1. R1's Treatment Administration Record (TAR) for left foot wound dressing show no documentation for 03/02/25, 03/06/25, 03/08/25, 03/09/25 and 03/10/25. On 03/10/25 at 12:56pm V6 (LPN) stated that she was R1's nurse over the weekend and did not change R1's wound bandage. V6 stated that she gave R1 supplies to change her own dressing. V6 stated that she does not know if R1 has been assessed to change her own bandage. V6 stated that R1 had never refused care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/11/25 at 1pm V2 (Director of Nursing/DON) stated that when medications are administered, the medications should be documented on the Medication Administration Record (MAR) and if medications are not documented on the MAR they should be assumed as not given. V2 stated that daily wound dressings are expected to be changed daily. V2 stated that not doing wound care as ordered by the physician can lead to deterioration of the wound. V2 stated that R1 is not capable of changing her own wound dressing and if the wound care nurse is not available then the nurses should be doing the wound care. On 03/11/25 at 2:26pm R1 stated that she informed the doctor at her clinic appointment that the facility was not changing her left foot wound as ordered. R1 stated that the clinic gave her a bag full of wound supplies so that she can have supplies for her dressing change. R1 stated she was informed her wound was not doing well and may need further amputation. R1 stated that she is afraid of losing her whole foot. R1's after visit document dated 03/11/25 at 11:29am documents in part, Patient is not improving and may need further amputation. On 03/12/25 at 12:28pm V12 (Wound Care Nurse) stated that resident's wound dressings should have a date on them. V12 stated that placing dates on the dressing lets the staff know when the last time the wound dressing was changed. V12 stated that she has been requesting to have a wound care nurse to do dressing changes on the weekend, but the facility has not hired anyone yet. V12 stated that when a wound is changed, there should be documentation in the resident's treatment administration record (TAR). V12 stated that when wound dressings are not changed as ordered that it could lead to infection and deterioration of the wound. V12 stated that R1 has not refused a dressing change. On 03/12/25 at 11:52am V18 (LPN) stated that R1 always wants pain medication. V18 stated that R1 is always moving around, so V18 is unsure if R1 was really in pain when R1 asked for pain medication. V18 stated that medication should be documented on the MAR when given. V18 stated that she is not sure why R1's pain medication is not documented on the MAR. R1's care plan dated 02/25/25 documents in part, R1 has potential/actual impairment to skin integrity related to surgical wound, left foot amputation .R1 will have no complications to left foot surgical site through next review .wound care per MD (medical doctor) orders. Facility's Policy titled IIA2 Medication Administration dated 10/25/2014 documents in part, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a mediation distribution system to ensure safe administration of medications without unnecessary interruptions .B. Administration .2. Medications are administered in accordance with written orders of the prescriber .D. Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR (medication administration record) directly after the medication is given .5. When PRN (as needed) medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site. b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. D. Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Facility's policy titled Pressure Ulcer and Skin Condition Assessment Policy dated 10/2020 documents in part, Policy: It is the policy of this facility that pressure and other ulcers, will be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved wound assessment form . Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure, and other ulcers and assuring interventions are implemented .Standards .7. A notation will be made in the nurse notes, treatment administration record .8. Dressings which are applied to pressure ulcers, skin tears, wounds, lesions or incisions shall include the date of the procedure. Dressing will be checked daily for placement, cleanliness, and signs and symptoms of infection. Facility's policy titled Residents' Rights dated 11/18 documents in part, Your right to safety .Your facility must provide services to keep your physical and mental health at their highest practical levels.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 45346 Based on observation, interview, and record review, the facility failed to ensure the community survival skills assessment was completed in a timely manner to determine if a resident could safely be out in the community independently, and failed to have a system in place to ensure staff were able to identify right the way when a resident do not return to facility from the appointments. This affected one resident (R13)out of the three residents reviewed for timely completion of community survival skills assessments. As a result, on 3/11/2025 R13 left the facility without supervision for an appointment, did not return to the facility until 3/15/25 approximately at 8:30 pm. Facility and R13 ' s family were unaware of R13 ' s whereabouts and R13 ' s family were concerned for his safety. Findings include: R13's diagnosis includes but are not limited to encounter for other orthopedic aftercare, muscle wasting and atrophy, not elsewhere classified, multiple sites, difficulty in walking, not elsewhere classified, unspecified lack of coordination, cocaine abuse with intoxication, unspecified, unspecified open wound, right thigh, subsequent encounter, and unspecified open wound, left thigh, subsequent encounter. R13's Brief Interview for Mental Status (BIMS) dated 02/07/2025 documents R13 has a BIMS score of 15, which indicates R13's cognition is intact. Per R13's admission record, R13 was admitted to the facility on [DATE]. On 3/11/2025 R13 had an eye doctor appointment scheduled. R13 left the faciity on [DATE] at approximately 11:13am by scheduled transportation. R13 did not return to the facility on [DATE] from the scheduled appointment. On 3/12/2025 at 12:58pm V22(LPN/Licensed Practical Nurse) stated I was assigned to rooms 301 to 316 on 3/11/2025, I worked the 7am to 7pm shift. V22 stated I was assigned to R13. V22 stated I do not know if R13 has outside pass privileges. On 3/12/2025 at 1:17pm R14, R13's roommate, stated the last time I saw my roommate was early afternoon on yesterday. R14 stated R13 has been out on pass before and R13 usually tells me where he is going. On 3/12/2025 at 1:33pm V23(CNA/Certified Nursing Assistant) stated I saw R13 yesterday (3/11/2025) around 11am at the nurse's station talking to some other residents. V23 stated it is not communicated by staff if a resident goes out on pass. V23 stated if we don't ask where a resident is at then we do not know. V23 stated if a resident is going out on pass, the resident goes to the social worker for a pass, the nurse reviews and signs the pass, and the resident takes the pass to the front desk. V23 stated I have never heard of R13 going out on pass before. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/12/2025 at 2:20pm observed the V29(front desk receptionist) look through a white binder located on the receptionist's desk. The white binder contained the facility's community pass program sheets for each resident (the sheets were in the binder alphabetically by the resident's last name) who is allowed to leave the building and go out into the community on pass. V29 stated R13 does not have a community pass program sheet in the binder at this time. V29 stated if the resident can go out on pass, the resident would have a sheet in this binder. On 3/12/2025 at 2:40pm V19(Social Service Director) stated R13 came to this facility on 1/31/2025. V19 stated R13 was admitted with a gunshot wound to the foot. V19 stated R13 is cognitively intact. V19 stated R13 has a community pass. V19 stated a community survival skills assessment is completed for each resident to determine if the resident can go out of the facility on pass. V19 stated V30(Psychosocial Rehabilitation Services Coordinator) completed the community survival skills assessment for R13. V19 stated the community survival skills assessment is placed into the resident's electronic health record. V19 stated R13's community survival skills assessment was not completed upon R13's admission. V19 stated I would need to speak with V30 about why R13's community survival skills assessment was not completed at admission. V19 stated the purpose of the community survival skills assessment is to determine if the resident can enter the community on their own. On 3/13/2025 at 12:32pm V13(Nurse Consultant) stated I was informed that R13's Community Survival Skills assessment was completed on 3/10/2025. V13 stated the lock date on the assessment in the date the social worker closed the assessment out. On 3/13/2025 at 2:53pm V30(PRSC/Psychosocial Rehabilitation Services Coordinator)) stated I am responsible for residents on the first and third floors. V30 stated R13 is a resident on my caseload. V30 stated I am aware R13 is currently missing from the facility. V30 stated no staff currently knows where R13 is at in the community. V30 stated R13 apparently had an eye doctor appointment on 3/11/2025 and went to the appointment but did not return to the facility after the appointment on 3/11/2025. V30 stated I started the Community Skills Assessment for R13 on Sunday 3/9/2025. V30 stated I don't know how often the community skills assessments are to be completed. V30 stated I did not complete the Community Skills Assessment for R13 on 3/9/2025, completing the assessment slipped my mind and I left the facility for the day. V30 stated I opened the Community Skills Assessment for R13 again on 3/12/2025, this is when I completed the assessment, this is the lock date. V30 stated I backed dated R13's Community Survival Skills assessment to 3/10/2025. V30 stated the Community Skills Assessment is completed after the community test. V30 stated the community test is to see if the resident can function well in the community. V30 stated on 3/9/2025, I took R13 to the facility parking lot and allowed R13 to roll around the parking lot to see if R13 could maneuver his wheelchair around the parking lot. V30 stated R13's cognitive status is also used to factor in his ability to be in the community. V30 stated I educated R13 that his outside pass privileges where between 10am-3pm. V30 stated R13 was also educated to call the facility to let the facility staff if he would be late returning from an outside pass. V30 stated as of today R13 is currently not in the facility. On 3/17/2025 at 11:38am R13 observed lying in the bed watching television and looking at his cellphone. R13 alert and oriented times three. R13 stated on Sunday (3/9/2025), I was assessed by V30(PRSC) to see if I could safely be in the community. R13 stated V30 took me to the facility parking lot to see if I could maneuver around safely in my wheelchair, and I did. R13 stated I was able to leave the facility on Monday (3/10/2025) to go cash a check and go to the doctor, I got back to the facility at about 8pm that day. R13 stated I know I must be back in the facility by 8pm, when I leave out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Archer Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Note: The nursing home is disputing this citation.	On 3/12/2025 reviewed R13's Community Survival Skills Assessment (SS) V2 in R13's electronic health record. The Community Survival Skills Assessment documents a date of 3/10/2025 at 13:53 and a lock date of 3/12/2025 at 13:53. Recommendations: 1. The resident appears to be capable of outside pass privileges at this time. On 3/18/2025 reviewed R13's current POS (Physician Order Statement) as of 3/18/2025 which documents in part, Verbal order obtained 3/17/2025, may have supervised community access. On 3/12/2025 reviewed the facility's policy titled Policy and Procedure Community Pass Policy with an issue date of 10/2014. Policy documents in part, 1. A Community Survival Skills Assessment will be completed by Social Services upon resident admission, quarterly, and when there is a significant change in condition. 2. Decisions regarding pass privileges, including independent privileges or being accompanied by a responsible individual, are determined by physician's orders and social services assessments. 50728