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	05/07/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to ensure that personal hygiene including nail care is provided for one (R1) out of three residents in the sample who are dependent on staff for Activities of Daily Living (ADLs) personal hygiene. This failure affected R1 who did not receive appropriate personal hygiene care in a timely manner. Findings include: On 03/31/25 at 11:12am, R1 noted in the room in a wheelchair dosing off wearing hospital gown with front of body exposed. R1 noted in wheelchair without incontinent brief and wet. R1 was observed with long nails and blackish particles underneath the nails. A plate of food was noted on R1's lap with whitish yellowish food fallen in between legs and on the floor. R1 was observed using dirty hands to eat without any cutlery. R1's room had a fowl urine odor. R1 stated no one (referring to facility staff) came to help him since yesterday. His hair was unkempt and matted. R1 did not move both lower extremities, these were noted with dry whitish skin peeling off and swollen. At 11:20am, when this observation was shown to V4 LPN (Licensed Practical Nurse) in charge of R1's care. V4 identified V5 CNA (Certified Nurses Aide) as the CNA that is assigned to R1. V4 stated that rounds are to be made at least every two hours. V4 could not clarify the last time she saw R1. V4 stated that AM (Morning) ADL care should have been done with V5 assistance. V4 stated none of the CNAs (staff) had reported that (R1) had refused the AM (Morning) care. On 03/31/25 at 11:25am, V6 CNA (Certified Nurses Aide) stated (V5 CNA) was just sitting at the nurse's station before the surveyor went into R1 room, so V4 paged V5 to come to the floor. The surveyor showed V6 the condition in which R1 left in the room. the surveyor then asked V6 whether it is appropriate for R1 to be left without any ADL care at 11:20am. V6 stated in part that this is not right. R1 needs a bigger gown than what he was wearing. V6 stated that I (V6) see what you (referring to the surveyor) mean, (R1) need to be cleaned up and the room should not be looking like that. At 11:33am, V5 came back to the floor and stated I (V5) was busy with another resident. On 03/31/25 at 11:41am, V5 acknowledged that she was the assigned CNA for R1, when asked about the last time she checked on R1 and how often do you (V5) check on your resident. V5 stated that she checked at around 7:30am when I (V5) first get here (Facility) and before I (V5) go home. The surveyor asked whether R1 has been assisted with ADL's personal hygiene, incontinent care this morning on V5 shift. V5 stated not yet, I (V5) was with other residents. When asked whether R1 refused ADL care this morning, V5 stated (R1) did not refuse care today. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's plan of care for potential /actual impairment to skin integrity r/t (related to) comorbidities/medical initiated 09/06/2024 with goal target of 07/12/2025 and listed interventions includes to avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. R1's care plan documented focus showed that R1 has a self care deficit (ADL's/Mobility) with revised date of 03/06/2025. Interventions listed includes but not limited to perform dressing/grooming tasks without physical assist, cues and /or (supervise)as needed with revised date 02/13/2025. R1's MDS (Minimum Data Set) BIMS score summary dated 1/7/2025 scored R1 at 15 indicating that R1 is not cognitively impaired. The facility policy on ADLS (Activities of Daily Living presented and dated 9/2020 documented that the purpose is to preserve ADL function, promote independence, and increase self-esteem and dignity. The facility Job Description of Certified Nurse's Assistant documented under job summary that the purpose of this position is to assist the nurses in the providing of resident care primarily in daily living routine. Listed main duties includes but not limited to bathing, grooming, shaving, feeding, wash, clean, dry all incontinent residents and be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow to reconcile the hospital recommendation with the facility physician for BIPAP/CPAP treatment for one resident (R1) who has chronic hypercapnia and was supposed to wear BIPAP machine at night. This affected R1 who was not set up for BIPAP treatment as ordered. Findings include: R1 is a [AGE] year-old male, with diagnosis that includes but not limited to Chronic embolism and thrombosis of unspecified deep veins of lower extremity, difficulty in walking, chronic obstructive pulmonary disease with acute exacerbation, respiratory syncytial virus as the cause of diseases classified elsewhere, primary insomnia, acute bronchitis, and another pulmonary embolism with acute Cor-pulmonale. R1 was re-admitted to the facility on [DATE] and as at 03/31/25 before surveyor prompting the facility, R1 has not receive any respiratory BIPAP treatment. On 3/31/25 at 11:30am, R1 stated that the only time BIPAP treatment was administered was whenever I (R1) was at the hospital, R1 stated no C-PAP/BIPAP treatment was given (administered) at the facility. R1 stated that since he got back no treatment had been given to him. R1's facility MAR (Medication Administration Record) from March 25, 2025 to March 31, 2025, did not show any documentation that R1 received any C-PAP/BIPAP treatment, neither did the TAR (Treatment Administration Record) documentation provided for this period March 25, 2025 to March 2025 show any treatment for it despite the hospital instructions. R1's hospital record documented that the facility was contacted to arrange nocturnal BIPAP setting of inspiratory pressure 15CM/H2O. On 03/31/25 at 11:30am, R1 stated that the only time BIPAP treatment was administered was whenever (R1) was in the hospital. R1 stated that no C-PAP/BIPAP treatment was administered at the facility. R1 stated he did not refuse any C-PAP/ BIPAP treatment at the facility, the only time he refused to use the (respiratory device) was when he was in the hospital and at the time he (R1) was not sleeping because he was to use it only when sleeping at night or taking a nap. R1 stated that the facility did not have the machine he needed. As at 03/31/25 at 2:00pm, R1's care plan did not include any plan of care for CPAP/BIPAP therapy. R1's hospital discharge report of 03/25/25 showed instructions for R1 to have a BIPAP therapy every night which was not followed and there was no physician order or documentation seeking clarification of order for CPAP or BIPAP therapy thereby putting R1 at risk for serious respiratory failure with potential for death. On 03/31/25 at 4:00pm, R1's medical record show that R1 was re-admitted to the facility on [DATE] with instructions to use BIPAP at night time. R1 had not received any respiratory BIPAP treatment and the facility did not have any order documenting that either BIPAP was implemented. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/31/25 R1's medical record physician order summary showed that R1 was to receive C-PAP machine treatment from 9:00pm to 6:00am. reviewed the order on 04/02/25 the order read BIPAP setting at 10/5 at bedtime for SOB, on 9:00pm, off 6:00am order status discontinued with order date 03/31/25 and date started 03/31/25 and order status read discontinued. On 04/17/25 R1's medical record physician order reviewed showing that on BIPAP setting at 10/5 at bedtime for SOB on 9:00pm off 6:00am with order status discontinued. On 04/03/25 at 2:22pm V8 LPN (Licensed Practical Nurse) stated that I did admit R1 back to the (facility) on 03/25/25 but I cannot recall what the hospital put in R1's discharge instruction. V8 stated, Don't you (referring to the surveyor) think the DON (referring to V2) should have gone through what R1 needs before bringing R1 back to the here (Facility). When the surveyor asked about the facility admission or the re-admission policy regarding medication clarification, V8 stated that the night shift nurses are responsible for the CPAP/BIPAP machine, they should have noted that this must be done. On 04/15/25 at 11:48am, V22 NP (Nurse Practitioner) stated that she is familiar with R1, I (V22) remember V30 (Physician) talking to me about (R1) regarding the C-PAP machine. V30 said that R1 needs the C-PAP machine at night time. Somehow, R1 is not getting it. I (V22) came specifically to see R1 about that. V30 went to see the resident when R1 was at the hospital, I (V22) think V30 was part of the treatment physicians. They (facility) wanted me to come and assess R1. On 04/17/25 at 9:31am, the surveyor asked about the facility policy on admission orders. V2 stated the admitting nurse is expected to clarify the orders from the hospital with physician (referring to primary physician) and carry them out by putting the medications and treatment orders in the computer. At 9:42am, V23 (Nurse Practitioner) stated that if you are looking for the BIPAP order for R1 it was not sent to the facility, but it was just in the instructions sent. The surveyor then asked who is responsible for making sure the admitted resident get the necessary and appropriate care and services as needed. On 04/17/25 at 2:08pm, V28 (LPN) stated that her first day of working with R1 was 3/21/25 and the first and last time she administered the C-PAP machine was on 3/31/25 when she came to work. V2 (DON) told me to make sure R1 had it on. During this investigation V2 stated calls were placed to V36 and V37 RN (Registered Nurse) identified by V2 as staff on night shift and they did not return the calls. R1 medical record did not show that nursing staff sought clarification on discrepancy of respiratory treatment orders putting R1 at risk for respiratory distress, apnea, heart attack and possible death. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's medical record TAR (Treatment Administration Record) from March 25, 2025 to April 2025 showed no documentation that respiratory care regarding C-PAP/ BIPAP order was initiated or done it read no order data found for Treatment Administration Record. V23 (Nurse Consultant) stated that there is no documentation in both the MAR and TAR but that does not mean it was not done. The surveyor then asked V23 and V2 who was present at the time about the professional standard in nursing and the facility policy on medication administration policy in documentation. V23 stated if it is not documented then it is not done. The facility Job Description for Charge Nurse presented documented that job summary includes but not limited to caring for the clinical nursing needs of the residents on his/her wing. Listed main duties includes but not limited to administering or supervising all treatments prescribed by the physician, be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty and ensure that all medication and treatments are charted by the person administering the medication or completing the treatment on his/her assigned shift (EMR system) The facility policy on BIPAP/CPAP dated 4/23 documented that the BIPAP/CPAP therapy will be administered by respiratory therapist or nurse upon order of a physician. Listed procedure includes but not limited the respiratory therapist or nurse will fit the patient for the proper headgear and mask, if the nursing staff has been previously trained and is knowledgeable on the equipment, they will be responsible to set IPAP, EPAP and mode setting per the physician's orders and the RN or LPN is responsible for placing the resident on the BIPAP/CPAP unit daily per physician order.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow physician order in administering correct oxygen liter to one of three residents (R1) reviewed for oxygen administration. This failure affected R1 who was supposed to get three liters of oxygen per nasal cannula and was administered five liters per nasal cannula. Two liters over the ordered dosage. Findings include: R1 is a [AGE] year-old male, with diagnosis that includes but not limited to Chronic embolism and thrombosis of unspecified deep veins of lower extremity, difficulty in walking, chronic obstructive pulmonary disease with acute exacerbation, respiratory syncytial virus as the cause of diseases classified elsewhere, primary insomnia, acute bronchitis, and another pulmonary embolism with acute Cor-pulmonale. On 04/02/25 at 11:32am, R1 observed in bed in the room with oxygen per cannula in use. Oxygen concentrator set at 5liter per nasal cannula. When V4 LPN (Licensed Practical Nurse) was made aware of this observation and the surveyors inquire from V4 (LPN) what the oxygen setting should be. V4 stated it should be set at 3 liters per nasal cannula. When the surveyor V4 was shown the setting on the oxygen concentrator. V4 stated oh no it should be at 3 liters. Both the surveyor and V4 review R1 order in the computer and it read 3liters per nasal cannula. V4 stated any medication must have a doctor's (physician) order and it must be followed and administered as ordered. V4 (LPN) stated that R1 has diagnosis of COPD, 5liter is not a recommended dose unless ordered by the physician. The surveyor asked when the last time V4 checked the oxygen concentrator setting, how often rounds are made and whether checking equipment used by the resident was part of what should be monitored or checked. V4 stated rounds are made at least every 2hours but she had not checked on the oxygen concentrator today, so she did not know it was that high. V4 acknowledge that oxygen is considered a medication, and it should be monitored and given as ordered. On 04/02/25 at 11:41am, V2 DON (Director of Nurses) was made aware of R1 oxygen settings and was asked about the facility policy on medication orders and administration. V2 stated that medications are ordered by the physician and the nurses are supposed to follow physician order. V2 stated that for COPD, oxygen setting should be at 2Liter or 3Liter range unless ordered to be more by physician. At 11:45am, both V4 and V2 were asked what can happen to R1 if R1 continued to receive a high dose of the oxygen considering the list of diagnosis that include COPD, V4 and V2 stated it can cause R1 to have signs and symptoms of oxygen toxicity. The surveyor and V4 reviewed R1's electronic physician order and it read oxygen @3L via nasal cannula for shortness of breath with order date of 03/31/25 active order status. On 04/15/25 at 11:48am, V22 NP (Nurse Practitioner) stated that the oxygen order was 3liters per nasal cannula and that order should be followed. And that by administering 5liters, R1 can have too much oxygen that can complicate the diagnosis COPD. When the surveyor asked whether Oxygen can be considered as a medication. V22 stated that yes definitely oxygen is considered a medication, and it should be administered as ordered. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration with effective date 10/25/2014 documented that medication is administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Listed procedure includes but not limited to medications are administered in accordance with written orders of prescriber.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure that medication was locked up safely when not in visual proximity of the nurses and not in use to prevent tampering and accidental hazard. This failure affected R13, R15, R16, and R17 whose medications were left at the bedside having the potential to affect residents on the 3rd floor. Findings include: On 04/02 /25 at 11:13am, V15 (family) came out of R13's room stating I don't want my brother (R13) to overdose of pills. This (one pink capsule and a white tablet was on R13's bed just lying there). V17 CNA (Certified Nurses Aide) took the medications and was about to put it in the trash can. The surveyor stopped V17 from doing so. V16 LPN (Licensed Practical Nurse) who was sitting at the nurse's station was shown the medication. V16 stated that I (V16) am not the nurse for R13, but no medication should not be stored at the bed side. The surveyor asked V16 what the facility policy on medication administration was. V16 stated that the nurse giving the medicine should make sure the resident swallows the medication before leaving the resident's room unless they are on self medication administration program. V18 (LPN) the assigned medication nurse for R13 check the medication and stated R13 was not on any of the medication that looks like the two pills. On 04/02/25 at 11:15am, R13 stated that the medications were given to me (R13) by the night nurse, the nurse left it on my table and left when I was about to take them these two fell and I was not able to pick it up. R13 stated I (R13) take those pills at night every day. The surveyor asked whether the nurse was aware that they fell, R13 stated that they (referring to nursing staff) don't come around anymore at night after they give you the medicine, even if you call them. On 04/02/25 at 11:29AM V2 DON (Director of Nurses) and V19 (HR / Assistant Administrator) came to the 2nd floor and was shown the medications. Both came to R13 asking about the medication. R13 repeated the same statement as told to the surveyor. V2 then stated this cannot be made up. V2 clarify with V18 checking R13's EMAR (Electronic Medication Record). V18 then stated that the white pill is melatonin, and the pink capsule is Benadryl. V2 stated that I don't know why the two pills are given together because the melatonin is schedule for 5pm. V18 then stated yes, the white pill is melatonin for sure. R13's medical record electronic physician order showed that R13 has order for Melatonin tablet with instruction to give 6mg by mouth one time a day related to insomnia. No order for Benadryl noted. 0n 04/02/25 at 1:06pm, V2 stated that I checked the orders and there is no order for Benadryl. I (V2) don't know why R13 has that medicine. ___ (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/25 at 12:48pm, R15 observed in the room sitting at the edge of the bed with an inhaler Trelegy fluticasone furate 100MCG/62.5MCG/25MCG noted on top of the oxygen concentrator. R15 stated that the nurse left the medication so that I (R15) can use it when I need it. R15 could not identify who the nurse was. On 04/03/25 at 12:50am, when this observation was brought to V10 LPN (Licensed Practical Nurse)'s attention, V10 stated she was not the nurse that the medication was left on the oxygen concentrator or knows how it got there. The surveyor asked V10 about the facility policy on medication administration and medication storage. V10 stated that no medicine should be left at the bedside without physician order and the resident has been examined (Assessed) and educated on how to self-administer the medicines. V10 stated that R15 is not on any self-administration program. On 04/03/25 at 12:51pm, V2 DON (Director of Nurses) was made of the observation and stated I know you cannot make this up, they (Facility Nursing Staff) are all trying to set me up to fail. They (Nursing staff) know there should be no medication at the bedside unless ordered by the physician. V2 stated R15 is not on any self-administration program. R15 medical record showed that R15 has an order Trelegy Ellipta inhalation (Fluticasone umeclidinium-vilanterol) aerosol powder breath activated 100-62.25-25 MCG/ACT with instruction 1 puff inhale orally one time a day with no order to keep at bed side. On 04/14/25 at 11:10am, surveyor observed that the 3rd floor medication cart was left in the hallway unlocked and unattended to in front of the nurse's station with no one present. At 11:15pm, V8 stated I am the only nurse on the floor, and I had to run downstairs to get some paperwork that I need for a patient (resident). The surveyor asked V8 about the facility policy on medication cart storage. V8 stated that the cart should be locked when the nurse is not by the cart. On 04/14/25 at 12:04pm, V2 stated that the medication cart, treatment carts are supposed to be locked when not being used by the nurses and not in few feet of the nurses. On 04/14/25 at 12:19pm, Treatment cart noted in the hallway unlocked and unattended to. V31 (Infection Prevention Nurse) who was the treatment nurse for the day stated that she was the one using the treatment cart and just forgot. On 04/14/25 at 12:20pm, R16 noted in the room sitting at the edge of the bed with two insulin Kwik pens one was insulin glargine (Lantus Solostar Pen 100units/ML subcutaneous solution), and the second one was insulin Lispro (Insulin Lispro Kwik pen 100 units/ML. The surveyor made V8 who was present at the time of observation aware and was asked about facility policy on medication storage and insulin storage. V8 stated that the two insulin kiwk pens are for (R17) and (R17) was supposed to give them to the son whenever he comes to visit. V8 stated we (referring to facility Licensed Nurses) are not to keep medicine at the bedside but (R16) was going to keep it for the son. V8 then walked away not removing the insulin Kwik pens. On 04/14/25 at 12:38pm, the same medication cart assigned to V8 was noted unlock and unattended to. When this was shown to V2. V2 stated I do not believe (V8) will leave this cart unlocked again. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/14/25 at 4:11pm, R17 observed in the room and on the bedside table was a plastic medication cup with eight (8) pills. R17 stated that the pills were not from today pills that was given to (R2). V9 LPN (Licensed Practical Nurse) who was in the hallway was called to R2's room and was shown the pills. V9 (LPN) stated that she did not give the pills to R17. V9 stated that she will not leave any resident medication with any resident, V9 stated that the facility policy on medication storage and medication administration is to make sure the resident swallows the medication. V9 stated medication is locked in the medication carts. On 04/15/25 at 11:46am, V22 NP (Nurse Practitioner) stated that R2 should not have any medication at the bedside. The facility policy on Storage of Medications presented with revision date 05/01/2018 documented that medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff member lawfully authorized to administer medications.