

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  05/16/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>40061</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide a home-like environment by not having enough chairs in the first and second floor day/dining room, thoroughly cleaning and maintaining residents' rooms and common areas. This has the potential to affect 148 residents that reside in the first, second, and fourth floors.</p> <p>Findings include:</p> <p>On 5/14/2025, at 10:44 AM, there were eight chairs in the first-floor day/dining room and one chair just outside of it near the nurses' station.</p> <p>On 5/14/2025, at 10:58 AM, R1 stated there is not enough chairs in the first-floor day room. R1 stated that at best there's maybe ten chairs in the day room and other residents would already be sitting in them. R1 stated it's hard to find anywhere to sit. R1 stated I have to sit on my rollator and that's the best I can do. R1 stated the rollator is not comfortable to sit in for prolonged times.</p> <p>On 5/14/2025, at 11:05 AM, R16 stated [R16] goes into the first-floor day room occasionally but doesn't eat there. R16 stated if there's a chair open, then I'll sit, but sometimes I have to stand and wait a bit for someone to get up. Then I'll be able to sit.</p> <p>On 5/14/2025, at 11:15 AM, there were 11 chairs in the second-floor day/dining room.</p> <p>On 5/14/2025, at 11:29 AM, R19 stated there's not enough chairs in the second-floor dining room. R19 stated whoever moves first grabs the chair. We just try to lean on the windowsill or sit on the heater or something. There's not much we can do if all the chairs are taken.</p> <p>On 5/15/2025, at 9:51 AM, V29 (Minimum Data Set Nurse) stated most of the first-floor residents are ambulatory and can sit and socialize in the day room. During a follow-up interview at 12:02 PM, V29 reported that 26 out of 33 residents on the first floor and 24 out of 59 residents on the second floor were ambulatory and can sit in the day room.</p> <p>-----</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/14/2025, at 10:58 AM, R1 stated it takes a long time for the facility to fix things. R1 stated the bathroom light turns off and on at random times. R1 informed the staff but it still hasn't been fixed. Further observations in R1's room included black spots on the ceiling panel in the left corner above the window. The corner wall underneath it had bubbling to the paint that went from the ceiling to the heater on the floor. During an interview with V24 (Maintenance Director) on 5/14/2025, at 2:40 PM, V24 stated the black stuff from the ceiling could be dirt. When asked about the bubbling on the wall, V24 recalled that R1's water heater was one of the heaters that did not have a coil. V24 stated the bedroom directly above R1's room also had a missing coil in the heater. V24 had to call the plumbers to assist with the problem. V24 stated the bubbling in the wall can be from a water leak but V24 was not sure how long it's been there. V24 stated it could have been from before V24 started at the facility (November 2024). V24 stated if there's suspicion of mold, then the facility must take the dry wall out completely and try to fix it immediately.</p> <p>On 5/14/2025, at 11:15 AM, the second-floor hallway window by the north stairwell had a hole in the wall underneath the window. The drywall was pushed in.</p> <p>On 5/14/2025, at 11:54 AM, R11's bedroom had chipped paint to the bathroom wall near R11's bed. There was also a tan/orange stain on the ceiling panel near the foot of the bed.</p> <p>On 5/15/2025, at 9:30 AM, the fourth-floor dining room floor was sticky and had multiple smudges by the television.</p> <p>On 5/15/2025, at 10:51 AM, floor in front of the freight elevator on the first floor had brown stains and sticky spots. The door that leads out to the lobby had chips to the side panels. The wall near the beauty room had long, black smudges.</p> <p>On 5/15/2025, at 11:18 AM, V33 (Floor Tech) stated operating the floor machines such as the auto-scrubber, side-by-side, and buffer. V33 stated the auto-scrub brushes and mops the floor; the side-by-side strips the heavy dirt on the floor; and the buffer buffs the floor afterwards. V33 stated the floor techs are supposed to do the hallways and dining rooms daily. V33 stated the residents' rooms are done on a schedule but did not elaborate on how the schedule was set up or how often the bedroom floor's were cleaned using the machines.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/15/2025, at 11:26 AM, R19 was sitting in the second-floor day room. R19 stated the walls, tables, and bathroom are disgusting. They clean but they don't clean good like they don't do a deep clean. [V32 - Housekeeping] was just in here, but the walls got stains. R19 stated the housekeeping staff do not wipe down the walls and the stains on the walls have been there for weeks. R19 also stated that the staff do not regularly wipe down the dining tables after the meals. R19 stated the tables are still sticky. R19 stated they should be cleaning the dining room before the next meal but most of the time they don't or do the bare minimum. There's still stuff on the floors right now and [V32] just left here. R19 pointed to the debris under the heaters and tables nearby. R19 stated there were issues in the bedroom as well and wanted to show the surveyor. When the surveyor lifted the paperwork from the table R19 was sitting at, the bottom paper stuck to the table. R19 stated see I told you it's still sticky. At 11:29 AM, R19 pointed out bedroom's bathroom. The shower had cracked tiles in the bottom corners. The bottom tiles had brown and orange stains. R19 stated it was mildew. The floors inside and outside of the bathroom had black and brown marks and smudges. R19 stated housekeeping sweep and mop the floors daily but it doesn't get the marks off. R19 stated the facility has to strip the floors to really get the heavy smudges and marks out. R19 stated being at the facility for four months, the facility hasn't stripped the bedroom floors yet. R19 stated the floor techs buff the floors weekly but have not seen them strip it. R19 stated if they did, it'd clean all this off. Further observations of R19's room included paint chips on the windowsill and a large grey/black web in the ceiling above the heater.</p> <p>On 5/15/2025, at 11:46 AM, the fourth-floor dining room floor remains sticky by the television. Surveyor was wearing slip-on flats, and the shoes were sticking and pulling off.</p> <p>Resident Council Minutes from 2/28/2025 and 3/31/2025 document in part concerns from residents regarding room cleaning.</p> <p>On 5/15/2025, at 12:25 PM, V2 (Director of Nursing) stated expecting maintenance to keep everything fixed and in working condition. V2 also expects housekeeping to keep everything clean and tidy.</p> <p>When survey team asked for facility's residents' rights policy, the facility provided the Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities document (Rev. 11/18). It documents in part: Your facility must be safe, clean, and comfortable and homelike.</p> <p>Facility's Preventative Maintenance Program policy (11/14; review date of 11/2023), documents in part that it is the Maintenance Director and/or Housekeeping Director's responsibility to conduct regular environmental tours/safety audits to identify areas of concern within the facility. They are to do random rounds to review all facility areas are kept clean and in safe condition; floor tiles are assessed for cracking and wear; paint is free from watermarks and peeling; and ceiling tiles are free from watermarks or spots.</p> <p>Facility's Housekeeping Guidelines (review date of 11/2022) documents in part: The Administrator and Environmental Services Director will routinely make visual quality control observations to ensure that a high level of sanitation is maintained.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44314</p> <p>Based on interview and record review, facility failed to protect residents from physical abuse. This failure affected three residents (R2, R3, R5) of ten residents reviewed for abuse. This failure resulted in R1 slapping R2 on the smoking patio, R4 punching R3 in the face causing R3 to bleed from her mouth, R6 punching R5 in the face, and R6 pulling R5's hair resulting in R5 being pulled down to the ground by her hair.</p> <p>Findings include:</p> <p>Facility's Final Investigation Report (dated 04/14/2025) states in part: On April 08,2025, staff observed an interaction between residents R1 and R2 that involved a brief verbal and physical exchange. R1 allegedly made contact with R2's wheelchair when he was trying to maneuver his walker on the smoking patio. R2 allegedly responded by making a remark to R1. R1 then allegedly made soft physical contact with R2. A head-to-toe assessment was completed, and no injuries were noted. Staff responded promptly, calmly separated the residents, and ensured the safety and well-being of both individuals. No further incidents have occurred. The physician ordered for R1 to be sent for psychiatric evaluation at the hospital.</p> <p>R1's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Muscle wasting and atrophy, dysphagia, oropharyngeal phase, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, type 2 diabetes mellitus without complications, asthma.</p> <p>Minimum Data Set Section (MDS) section C (dated April 22, 2025) documents that R1 has an Interview for Mental Status (BIMS) score of 15, indicating that R1's cognition is intact.</p> <p>Care plan (dated 01/15/2025) documents that R1 presents with moderate to intense anger related to verbal expressions of distress, persistent worry and frequent complaints.</p> <p>R2's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Limitation of activities due to disability, difficulty in walking, lack of coordination, pain in right lower leg, pain in left lower leg, muscle wasting and atrophy.</p> <p>Minimum Data Set Section (MDS) section C (dated [DATE]) documents that R2 has an Interview for Mental Status (BIMS) score of 11, indicating that R2 has a mild cognitive impairment.</p> <p>Care plan (dated 04/01/2025) documents that R2 has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior.</p> <p>On 05/13/2025, at 1:40 PM, surveyor observed R2 sitting in his bed. Surveyor conducted an interview with R2 pertaining to the physical altercation with R1 that took on 04/08/2025, on the outside smoking patio. R2 stated, R1 hit me in the face outside while I was smoking. I did not know R1 prior to the incident. We did not have an argument, R1 just hit me in the face out of the blue. R1 said that I was sitting in his spot. We have not had any more incidents after that.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/13/2025, at 2:00 PM, V3 (social worker) stated, On 04/08/2025, I was passing out the cigarettes to the residents on the 1st floor dining hall during the smoke break. A resident walked up to me and told me that R1 hit R2. I went outside to the patio. I asked R2 what happened and R2 said nothing happened. I asked everybody else on the patio what happened, and they all said nothing. I went to speak to the residents on the left side of the patio and the residents said that R1 hit R2. I went back inside to resume passing out cigarettes and then R2 came inside and told me that R1 hit him. R2 explained to me what happened. I told him to stay by my side until the smoke break is over. I asked R2 if he was okay, and R2 said that he was fine. After the smoke break, I reported this to the social service director, V4, and administrator. V4 (social service director) and I went to the administrator's office to watch the footage of what occurred between R1 and R2. After watching the footage, it was true that R1 hit R2. V4 and I went to speak to R1 and to hear his side. R1 said that R2 hit R1, and that R1 hit R2 in self-defense, which was not true. R2 did not have any injuries. R2 was stable and not in distress. R1 did display aggressive behavior towards staff but not residents. R1 and R2 did not have any prior encounters or any prior issues. R2 is known to use foul language towards other residents and staff, however, there was no prior encounters between R1 and R2.</p> <p>On 05/14/2025, at 9:46AM, V1 (administrator) stated, On 04/08/2025, during a smoke break on the smoking patio, R2 was sitting in his wheelchair blocking the walkway. R1 was trying to walk past R2 with his walker. While R1 was passing R2, R1 bumped R2's wheelchair. R2 had words with R1 about R1 bumping R2's wheelchair. R1 and R2 were at each other's face. While arguing, R1 slapped R2. The smoke attendant immediately intervened. At first, the smoking attendant did not witness R1 slapping R2, but R2 reported being slapped to the smoking attendant. The two residents were immediately separated. R1 was checked to see if he was injured. The smoking attendant notified the nurse. There were no prior incidents between R1 and R2. R1 and R2 have not had any other incidents after the altercation.</p> <p>On 05/14/2025, at 10:42 AM, surveyor observed R1 lying in his bed. Surveyor conducted an interview with R1 pertaining to the physical altercation with R2 that took on 04/08/2025, on the outside smoking patio. R1 stated, I'm on oxygen and I normally sit by the door on the smoking patio. All the residents know that I sit there because that's my usual spot. I noticed several times that R2 would be sitting there in his wheelchair. I offered R2 a cigarette a few times so that R2 can move out of my spot, but he would continue to sit there. I confronted R2 about why he keeps on sitting in my spot. When I confronted R2, R2 told me, F*** Y**. I stood up and went to sit on the opposite side of R2, but R2 continued to argue with me. I said to R2 that R2 wasn't having a problem with me when I kept giving him cigarettes so that he can move out of my spot. R2 called me a B****, and I told R2 that he's a B****. That's when R2 said, What are you going to do about it, and R2 tried to swing on me. Luckily, I moved out of the way so R2 did not punch me. That's when I punched R2 in self-defense. R2 and I never had any issues or arguments prior to the physical altercation. R2 and I are fine now, and we don't hold any grudges. We are both men and we both don't hold grudges.</p> <p>On 05/14/2025, at 12:02 PM, V4 (social service director) stated, I did not witness the incident that occurred on 04/08/2025, between R1 and R2. I reviewed the video footage. From the footage it appeared like R1 and R2 were arguing. R2 had his hands up in self-defense. R1 punched R2. I did not see in the footage that R2 was trying to hit R1 at all. I am not aware of R1 and R2 having any conflicts prior to this incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Progress Note (dated 04/08/2025) documents, Resident allegedly displayed violent/aggressive behavior towards peers. Resident was placed on 1:1 with a staff member. Doctor was notified and gave an order to send resident to the community hospital for a psychiatric evaluation. Ambulance was called estimated time of arrival is 60 minutes.</p> <p>R1's Progress Note (dated 04/08/2025) documents, Resident sent to community hospital for psychiatric evaluation. Resident transported by ambulance.</p> <p>R2's Progress Note (dated 04/08/2025) documents, R2 was involved in a peer-to-peer disagreement in the smoke break area. Body assessment completed. No injuries noted. Police notified. Physician notified. R2 is own responsible party. Social services notified. Director of nursing and administrator notified.</p> <p>Facility Final Incident Investigation Report (dated 05/01/2025) documents in part: On April 25, 2025, it was reported that R3 and R4 were involved in a peer-to-peer altercation in their room. R3 and R4 both agreed that R3 [NAME] water on R4 and then R4 made contact with R3 as she was trying to not get the water thrown on her. Staff immediately intervened and separated the two residents. A body assessment was performed. R3 was noted to be free from any injury and was in good spirits. R4 was very upset and wanted to go against medical advice (A.M.A.) because she didn't mean to make contact. R4 was sent out to the hospital for the incident as she was crying hysterically and was unable to control her emotions.</p> <p>R3's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Dysphagia, oropharyngeal phase, dementia in other diseases classified elsewhere, unspecified severity, with anxiety, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, essential (primary) hypertension, weakness, metabolic encephalopathy.</p> <p>Minimum Data Set Section (MDS) section C (dated [DATE]) documents that R3 has an Interview for Mental Status (BIMS) score of 12, indicating that R3's cognition is intact.</p> <p>Care plan (dated 03/03/2025) documents that R3 is at risk for seizure activity related to seizure disorder and receives medication for management.</p> <p>R4's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Muscle wasting and atrophy, paranoid schizophrenia, hallucinations, major depressive disorder, psychoactive substance abuse, uncomplicated.</p> <p>Minimum Data Set Section (MDS) section C (dated [DATE]) documents that R4 has an Interview for Mental Status (BIMS) score of 12, indicating that R4's cognition is intact.</p> <p>Care plan (dated 02/25/2025) documents that R4 uses psychotropic medications and has potential for falls and or drug related movement disorder 2/2 adverse effects of medication.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/13/2025, at 2:36 PM, surveyor observed R3 lying in bed. Surveyor interviewed R3 pertaining to the physical altercation that took place on 04/25/2025, between R3 and her roommate, R4. R3 stated, On 04/25/2025, R4 punched me really hard. We were roommates. R4 came to my side of the bed while I was lying down. She punched me really hard causing me to bleed from my mouth. Prior to the physical altercation, R4 and I always argued. R4 was always starting with me. R4 threatened me with a knife before and we had many arguments. On 04/25/2025, that's when R4 came to my side of the bed, and she punched me. I was bleeding. The staff knew that we had arguments before the physical altercation, and they interviewed on many occasions. I feel safe in the facility now that R4 is gone.</p> <p>On 05/13/2025, at 2:41 PM, V3 (social worker) stated, On 04/25/2025, the nurse on duty requested for social services to come to R3 and R4's room. R3 and R4 were roommates at the time. As I walked in, there was two certified nursing assistants and a nurse in R3 and R4's room. The nurse informed me that R4 hit R3. I called V4 (social service director) immediately to come to the room as well. V4 and I spoke to R3 to see what happened. R3 said that R4 came to R3's side of the bed and hit R3 in her mouth. It was obvious that R3 got hit by R4 because there was blood on R3's mouth. R3 is alert and oriented and R3 was able to tell me what happened. R3 and R4 were separated by staff. Prior to the physical altercation on 04/25/2025, R3 and R4 had verbal arguments because they were not getting along. There was conflict between R3 and R4 before R4 got physical with R3. Prior to the physical altercation, R3 and R4 had to be separated during verbal arguments a few times, but it was not physical, it was verbal. R3 and R4 would argue and then they would act as if it never happened. When it comes to moving rooms, the admission director is in charge of moving residents. I asked R3 and R4 if they wanted to change rooms and they both refused to change rooms. R3 came from the 4th floor and R3 was refusing to move back to the 4th floor. There was no other female room that was available for R4 to move to at the time they argued. R3 and R4 had about 3 verbal arguments that had to be separated by staff. After the physical altercation, R4 was sent to the hospital for psychiatric evaluation. When I requested to have R3 and R4 placed in different rooms, the admission director told me that there is no other place to move R4.</p> <p>On 05/14/2025, at 9:56 AM, V1 (administrator) stated, On 04/25/25, R3 was lying in bed and R4, who was R3's roommate at the time, came to R3's bedside to talk to R3. They were having a conversation and R3 did not like the way the conversation was going. R3 threw water at R4. When R3 threw water at R4, R4 stuck her hands out in self-defense. The staff heard R3 yelling and then R4 started yelling. Staff went into the room and immediately intervened. R4 started spiraling and going into psychosis. R4 was sent out the hospital for psychiatric evaluation and she did not return back to the facility. R4 was a resident in a wheelchair just like R3. I was not aware that R3 and R4 had several prior conflicts. If I was aware, I would make sure that R3 and R4 are separated in different rooms. V6 (admissions director) is the one that is responsible to assigning a different room to residents.</p> <p>On 05/14/2025, at 11:24AM, V6 (admissions director) stated, R3 and R4 had conflict. I am only aware of one conflict between R3 and R4 and that's the incident that turned physical on 04/25/2025. Prior to 04/25/2025, I did not have any knowledge of there being a conflict between R3 and R4. R3 and R4 were roommates. I was never asked to do any room changes for either R3 or R4.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/14/2025, at 12:05 PM, V4 (social service director) stated, I am aware of small bickering between R3 and R4 before the physical altercation that took place on 04/25/2025. R3 and R4 would argue and make up after that. I am not aware of staff having to intervene to stop R3 and R4 from arguing. I am not aware of a room change being requested for R3 and R4 prior to the physical altercation. I think that R3 has moments of responding to auditory illusions and R3 and R4 were not understanding one another.</p> <p>On 05/14/2025, at 3:24 PM, V8 (licensed practical nurse) stated, I was nurse on duty on 04/25/25, when the incident occurred between R3 and R4. From what I remember, the certified nursing assistant told me that something happened in the room. I went into R3 and R4's room. I remember R4 being really angry and upset because R3 was saying that R4 is not able to have kids. R4 said that R3 and R4 were arguing back and forth. R4 told me that they basically had an altercation. I saw a little bit of dried blood on R3's lip. R4 denied hitting R3, but R4 claimed that R3 pushed her. I told R4 that I'm going to be sending R4 out because she should not have touched R3. I filed a police report and R4 was sent to the hospital for psychiatric evaluation. R3 told me that basically R4 hit R3. I am not aware of any prior incidents between R3 and R4.</p> <p>On 05/14/2025, at 11:39 AM, V11 (certified nursing assistant) stated, On 04/25/2025, I was working on the 2nd floor. V12 (certified nursing assistant) was assigned to R3 and R4. I heard V12 informing the nurse that R3 said that R4 hit her and that R3 was bleeding. I did not see the incident and I did not see anything else.</p> <p>R3's Progress Note (dated 04/25/2025) documents, Writer was told by staff that resident was hit in the mouth by another resident. Nurse assessed resident and found no injuries. The police were called and the other resident sent out for evaluation. Director of nursing, abuse coordinator, hospice was notified, and family. No new orders given. Will continue plan of care.</p> <p>R4's Progress Note (dated 04/25/2025) documents, Resident was involved in a peer-to-peer altercation with another resident. Resident assessed. No injuries noted. Resident is responsible party. Police notified. Physician notified. Director of nursing and administrator notified.</p> <p>R4's Progress Note (dated 04/25/2025) documents, R4 discharged to community hospital 04/25/2025, 12:00 AM. Reason for transfer: behavior-psychosis. Vitals were stable. The following people were notified of transfer: Physician, Nurse Practitioner. Yes - Current reconciled medication list provided to the subsequent provider.</p> <p>Facility's Final Investigation Report (dated 04/02/2025) documents in part: On March 27, 2025, staff observed an interaction between residents R5 and R6 that involved a brief verbal and physical exchange. R5 allegedly made a comment toward R6, and R6 allegedly responded by making soft physical contact with R5. A head-to-toe assessment was completed, and no new injuries were noted. Staff responded promptly, calmly separated the residents, and ensured the safety and well-being of both individuals.</p> <p>R5's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Muscle wasting and atrophy, acquired absence of right leg below knee, acquired absence of left leg below knee, bipolar disorder, major depressive disorder, essential (primary) hypertension.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Archer Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  4437 South Cicero Chicago, IL 60632	
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Minimum Data Set Section (MDS) section C (dated [DATE]) documents that R5 has an Interview for Mental Status (BIMS) score of 13, indicating that R5's cognition is intact.</p> <p>Care plan (dated 05/12/2025) documents that R5 presents with moderate to intense anger related to: Symptoms of mood distress (i.e., anger, sadness, loss of interest, lack of pleasurable experiences, poor appetite or excessive eating, impaired sleep), This problem/need is manifested by: Poor listening skills (often becoming angry, defensive, oppositional when assistance &amp; suggestions are provided),. This problem/need is manifested by: Verbal expressions of distress., This problem/need is manifested by: Persistent worry.</p> <p>R6's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Metabolic encephalopathy, type 2 diabetes mellitus, altered mental status, peripheral vascular disease, essential (primary) hypertension.</p> <p>Care plan (03/27/2025) documents that R6 has diabetes mellitus &amp; the potential for complications related to: History of uncontrolled diabetic status.</p> <p>On 05/13/2025, at 2:50 PM, surveyor observed R5 sitting in her wheelchair. Surveyor interviewed R5 regarding the physical altercation that took place in the 1st floor dining room on 03/27/2025, between R5 and another resident, R6. R5 stated, R6 kept calling me names. R6 and I had an argument and R6 came at me and punched me in my cheek. After that, R6 grabbed me by my hair and I fell out of my wheelchair to the ground. I did not know R6 before this altercation occurred. R6 and I did not have any issues prior to the fight. We were swearing at each other, and I think that's why R6 hit me. R6 is the one that escalated the argument into physical violence. I feel safe in the facility. I can't recall why the argument started.</p> <p>On 05/14/2025, at 10:06 AM, V1 (administrator) stated, On 03/27/2025, R5 called R6 a bi***. R6 was standing right by R5. R6 pushed R5. Staff were right there because it took place in the dining room and staff immediate intervened. R5 apologized to R6 right away. R5 said that R5 was experiencing anxiety and regret about the situation. R6 also apologized to R5. The staff who witnessed the incident reported that they witnessed R6 pulling R5 by her hair and they witnessed R6 punching R5. R5 and R6 did not have any prior issues. R6 was a new admission to the facility. R6 discharged herself against medical advice the same day that the incident occurred. R5 initiated the incident by calling R6 out of her name and R6 responded with physically hurting R5.</p> <p>On 05/14/2025, at 1:05 PM, V10 (certified nursing assistant) stated, On 03/27/2025, it was early morning, and the breakfast trays were coming up to the 1st floor. I was with the trays. When I went into the dining room, I saw commotion going on. When I asked what happened, the residents in the dining room reported that R6 pulled R5's hair and that R6 punched R5. I did not see the incident, but the other residents told me that's what happened.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/14/2025, at 2:05 PM, V9 (licensed practical nurse) stated, On 03/27/2025, I was doing my medication administration on the 1st floor. I heard yelling coming from the dining room. I went into the dining room, R5 and R6 were no longer fighting, but I was informed by other residents that R5 and R6 were fighting. I separated R5 and R6 immediately. It was reported to me by R6 that R5 called R6 a B****. R6 said that she punched R5 and pulled R5's hair. R5 told me that R5 slid out of her chair when R6 pulled R5's hair. R5 told me that R5 called R6 out of her name and R6 responded by pulling R5's hair and punching R5. R5 did not appear to have any blood and R5 did not complain of any pain. R5 and R6 apologized to each other and R5 and R6 did not have any prior conflict. R6 was a new resident to the facility.</p> <p>R5's Progress Note (dated 03/27/2025) documents, Patient involved in physical altercation with another patient. Patients separated and later apologized and reconciled. No injuries involved. Patient in stable condition.</p> <p>R6's Progress Note (dated 03/27/2025) documents, Patient involved in physical altercation with another patient. Patients separated and later apologized and reconciled. No injuries involved. Patient in stable condition.</p> <p>Abuse Prevention Policy (dated 01/2024) documents in part: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.</p> <p>Resident Rights Policy (revised 11/2018) states in part: You must not be abused, neglected, or exploited by anyone-financially, physically, verbally, mentally or sexually.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40061</p> <p>Based on observation, interviews, and record reviews the facility failed to a). provide supervision and immediately intervene during an incident between two residents (R10, R11) which led to R11 being hit by R10 and b). provide the necessary fall interventions determined upon assessment for one resident (R9). This affected two (R9, R11) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>R10's Admission Record documents in part diagnoses of dementia with behavioral disturbances.</p> <p>R10's Care Plan documents in part that R10 has impaired cognitive function/dementia or impaired thought processes related to diagnosis (initiated 2/20/2024). It also documents that R10 has history of severe mental illness of major depressive disorder and symptoms are manifested by psychosis and disorganized/delusional thoughts (initiated 3/07/2025). Care plan also documents that R10 has physical aggression and has displayed physical aggression towards peers on five separate occasions (last revision 10/30/2023). Intervention includes to utilize behavioral approaches when providing care; reassurance, redirection, task segmentation, cueing, reminder, reapproach, reality orientation, etc. (last revised 7/13/2023). R10's care plan also documents in part that R10 is a risk for potential abuse related to mental/emotional challenges as evidenced by dementia diagnosis and impaired cognition (last revised 10/30/2023). Intervention includes to Monitor resident behaviors (last revised 7/13/2023).</p> <p>Attempted to interview R10 multiple times including on 5/14/2024, at 11:59 AM, 12:42 PM, and 3:20 PM. Also attempted to interview R10 on 5/15/2025, at 9:37 AM, and 11:49 AM. During attempts, R10 did not answer surveyor's questions either verbally or by shaking head yes or no. Observed R10 have multiple episodes of placing self on the floor and rocking left and right. R10 would also lie in bed rocking from left to right.</p> <p>R11's Admission Record documents in part diagnoses of Alzheimer's Disease, dementia with behavioral disturbances, and lack of coordination.</p> <p>R11's Care Plan documents in part that R11 is at risk for potential abuse related to mental and emotional challenges as evidenced by R11's display of confusion and disorientation frequently (last revised 10/16/2024).</p> <p>R11's 2/12/2025 and 5/7/2025 Quarterly MDS (Minimum Data Set) assessments document in part that R11 uses a wheelchair for mobility device.</p> <p>Attempted to interview R11 about the incident on 5/14/2025, at 11:54 AM, and 5/15/2025, at 9:35 AM. R11 was alert and oriented to self and city during both interviews but could not recall the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's Final Reportable to IDPH (Illinois Department of Public Health) submitted 4/15/2025, at 4:08 PM, documents in part: [R11] was ambulating on the unit in [R11's] wheelchair and [R10] thought it was [R10's] chair. When [R11] exited [R11's] chair, [R10] moved toward [R11] and sat down in the chair. Upon getting into the chair, [R10] bumped [R11] in the head.</p> <p>Employee statement form signed by V5 (CNA) on 4/09/2025, documents in part: I was sitting at the nursing station when the hospice CNA notified me that [R10] was hitting [R11]. I went right over and separated them both. After I separated [R10], [R10] set down in [R11's] wheelchair. (Facility could not provide hospice CNA's name or phone number at the conclusion of this survey. Facility also did not have a witness statement from hospice CNA.)</p> <p>Employee statement form signed by V31 (CNA) on 4/09/2025, documents in part: [R11] was in [R11's] [wheelchair] rolling pass [R10]. [R10] stood up and started hitting [R11] in the head and started to take [R11's] [wheelchair].</p> <p>On 5/14/2025, at 12:35 PM, V22 (CNA-Certified Nurse Aide) stated I was coming out of the fourth-floor dining room with another resident, when V22 saw R11 standing in front of R10 trying to get R11's wheelchair back from R10. R10 was sitting in R11's wheelchair. V22 stated R11 was very upset. V22 instructed R10 to grab R10's walker, which was nearby, and return to R10's bedroom.</p> <p>Reviewed facility's 4/09/2025, Daily Staffing form. The nurses working the unit at the time of the incident were V18 and V23. The CNAs working were V5, V19, V21, V22, and V26.</p> <p>Interviewed V18 and V23 separately. Both stated they did not recall what R10 and R11 were doing prior to the incident. Both did not witness the event. V19, V21, and V26 stated they did not witness the incident and were elsewhere in the unit.</p> <p>On 5/14/2025, at 12:14 PM, V18 stated R10 can both be verbally and physically aggressive and can get into it with other residents.</p> <p>During a telephone interview with V23 on 5/14/2025, at 2:07 PM, V23 stated staff need to keep an eye on R10 due to R10's behaviors.</p> <p>On 5/15/2025, at 12:25 PM, V2 (Director of Nursing) stated staff should monitor common areas including the hallway.</p> <p>On 5/15/2025, at 12:45 PM, V1 (Administrator) stated staff are supposed to watch all residents. In general, we try to have eyes on all the residents.</p> <p>When survey team asked for facility's residents' rights policy, facility provided the Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities document (Rev. 11/18). It documents in part: Your facility must be safe, clean, and comfortable and homelike.</p> <p>Facility's Policy &amp; Procedure Safety and Supervision of Residents (issued 9/2021) documents in part: Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45001</p> <p>Findings include:</p> <p>On 5/13/25, at 2:32 PM, observed R9 room; mats on both sides of the bed, a reacher/grabber tool on bed, no side rail(s)</p> <p>On 5/13/25, at 2:36 PM, observed R9 in day room sitting in a wheelchair watching television. R9 said he had two falls. The first fall R9 was sleeping in bed. R9 said he was dreaming he was swimming and rolled out of bed. R9 said he got a [NAME] on his head and a black eye. R9 said there were no side rails on the bed. R9 said They don't have those here.</p> <p>On 5/14/25, at 1:10 PM, V2 (Director of Nursing) stated I am familiar with R9. He has had two falls. The first fall was 4/27/25. The patient said he rolled out of bed. He hit his head and was sent out to the hospital. R9 is care planned for fall risk. According to the fall risk assessment, dated 3/20/25, he is moderate fall risk. The floor nurses do the assessments. They look at history of past falls, medications that they are on, monitor the blood pressure when standing and lying, vision, ambulation/walking, level of consciousness, gait and balance, predisposing disease, and conditions. His fall risk interventions prior to 4/27/25, were a gait belt in use while transferring, call light in reach, encourage the resident to use the call light for assistance, therapy to evaluate, and non-skid slip socks. Post the 4/27/2025, fall the intervention put in place was floor mats on both sides of the bed. We have been known to use side rails if the resident is a candidate upon assessment or upon request from the resident. According to the Side Rail and or Restraint Device Assessment, 3/21/2025, if side rail(s), alarm(s) is checked off it means those are the devices used to keep him from falling and/or for repositioning. R9 did not have side rails and/or alarms in place when he fell [DATE]. R9 was not care planned for side rails and/or alarms. He had other devices in place to prevent fall.</p> <p>On 5/14/25, at 3:25 PM, V9 (Licensed Practical Nurse) stated on the first floor V9 does not have any residents with side rails. Some beds in the facility do have side rails. V9 stated she completed R9's Side Rail and/or Restraint Device Assessment on 3/21/25. If side rail(s) and alarm(s) are checked it that means the side rails and alarms are in use for the resident. R9 definitely can benefit from side rails and alarms. That was my thought process when clicking side rail(s) and alarm(s) on the assessment; what he has versus what he needs. When I completed the assessment, I felt R9 needed side rails and alarms. R9 has left side weakness. The side rails would have been a benefit for support to reposition and to prevent falling out of bed. They would have protected him from falling. I catch R9 quite a bit standing from his chair. The chair alarm would benefit R9. R9 wants to do for himself, but he needs to call for help. The alarm would alert us when he is trying to stand on his own. R9 is a one person to two persons assist. He is alert and oriented. R9 consented to side rails. R9 has mats and non-skid socks as an intervention for falling. The socks would not have prevented him from rolling out of bed. The mats are just a protection for if he does roll out of bed. The side rails would have prevented R8 from rolling out of bed. V9 was R9's nurse for the fall when he rolled out of bed, on 4/27/25. V9 stated R9 did not have side rails at that time. R9 received a knot on his head, and he was sent out for CT (computed tomography) of the head. It came back negative.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/25, at 12:36 PM, V2 (Director of Nursing) stated the purpose of the side rail assessment is to see if the patient needs the side rail at all. If the assessment is completed correctly the side rails should be implemented. The first fall, R9 rolled out of bed. The non-skid socks or the mats on the floor could not have prevented R9 from rolling out of bed. The side rails can prevent a resident from rolling out of bed.</p> <p>On 5/15/25, at 2:00 PM, observed R9 room; mats on both sides of the bed, a reacher/grabber tool on nightstand, no side rail(s)</p> <p>According to R9's face sheet, R9 has diagnoses that include but are not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side; chronic obstructive pulmonary disease; type 2 diabetes mellitus. According to R9's MDS (Minimum Data Set), 3/27/2025, R9 has a BIMS (Brief Interview for Mental Status) score of 13 which indicates intact cognition; and has impairment on one side of upper and lower extremity.</p> <p>R9 Side Rail and/or Restraint Device Assessment and Consent, dated 3/21/25, documents that R9 uses side rail(s) and alarm(s); and that R9 gave verbal consent to the use of the recommended devices.</p> <p>R9 is care planned for risk for falls related to general weakness, history of falls. Interventions include but are not limited to floor mats to the side of the bed and apply non-skid slipper socks. There is no intervention to apply side rail(s) or alarm(s).</p> <p>Facility Policy and Procedure Safety and Supervision of Residents, 11/2024, documents in part: Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident and the MDS. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40061</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide sanitary drinking water and ice by not maintaining their water and ice machines. This has the potential to affect all 199 residents that receive hydration orally.</p> <p>Findings include:</p> <p>On 5/14/2025, at 10:50 AM, V9 (Nurse) showed surveyor the ice and water machine inside the first-floor nourishment room. V9 stated residents are free to grab water and ice from the machine. The machine had streaks of white and tan mineral buildup along the front panel, around the spout where the water and ice dispense, and around the collection tray. There was also white mineral buildup on the counter under the machine. The machine was continuously dripping throughout the interview. V9 stated housekeeping is supposed to clean the machine daily.</p> <p>On 5/14/2025, at 11:17 AM, V13 (Nurse) stated second floor staff get the residents' drinking water and ice from the first or third floor nourishment area.</p> <p>On 5/14/2025, at 11:33 AM, the ice machine in the third-floor nourishment room had white and gray mineral build-up on the inside left wall. There was also white and tan residue on the door of the ice machine.</p> <p>On 5/14/2025, at 11:35 AM, V14 (Nurse) stated third floor staff get the residents' drinking water from the sink in the third-floor dining room.</p> <p>On 5/14/2025, at 11:39 AM, V15 (Certified Nurse Aide-CNA) stated the sink in the third-floor dining room is used for handwashing. V15 gets the residents' drinking water from the first-floor machine or from the sink in the clean utility room. V15 showed the surveyor the sink and it had mineral buildup. V15 stated staff use the same sink for handwashing.</p> <p>On 5/14/2025, at 11:46 AM, V16 (CNA) stated getting the residents' drinking water from the third-floor dining room sink. V16 gets the ice from the nourishment room in the first or third floor.</p> <p>On 5/14/2025, at 12:06 PM, V17 (Nurse) stated the residents receive tap water from the fourth -floor utility room sink.</p> <p>On 5/14/2025, at 12:10 PM, V5 (CNA) stated getting the residents' drinking water from the fourth-floor dining room sink. V5 showed the surveyor the sink and there was a moist towelette and small face towel on top of the sink. V5 stated one of the residents must have left the items there. V5 stated staff and residents also use the same sink for handwashing. V5 stated staff get ice from the kitchen, first floor, or third floor machines.</p> <p>On 5/14/2025, at 12:23 PM, V18 (Nurse) stated getting the residents' drinking water from the med room or the faucets. V18 showed the surveyor the med room sink. There's white, tan, and brown mineral buildup around the faucet base.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/14/2025, at around 2:39 PM, V24 (Maintenance Director) stated he has not called outside company for maintenance work for the water/ice machine on the first floor. V24 believes the last time the facility called an outside company to inspect the machine was before V24 started working for the facility in November 2024. V24 and surveyor went to nourishment room. V24 stated part of the problem is how the staff get the water and ice and how they leave it. V24 stated CNA was just in there and look at how they leave it. The collection tray was filled with ice. V24 stated the piece of panel supporting the machine is also old and dissolving. V24 pointed to the part that the panel was split open and brown residue was coming out of.</p> <p>On 5/15/2025, at 10:57 AM, V20 (First-Floor Housekeeper) stated V30 is supposed to clean the ice/water machine on the first floor daily. V30 stated it is hard to clean it because V30 can't get the mineral buildup off the machine or counter. V30 stated the machine is not good and leaks all the time.</p> <p>On 5/15/2025, at 12:25 PM, V2 (Director of Nursing) did not know when the first-floor ice/water machine was last serviced for maintenance and inspection. V2 stated staff expects maintenance to keep everything fixed and in working condition. V2 also expects housekeeping to keep everything clean and tidy. V2 stated staff are to get residents' drinking water from the kitchen or the first-floor machine. V2 stated staff should not be getting it from where they wash their hands.</p> <p>On 5/15/2025, at 12:37 PM, V27 (Dietary Director) stated [V27] was not in charge of the first-floor water/ice machine maintenance.</p> <p>On 5/15/2025, at 12:45 PM, V1 (Administrator) stated [V1] did not know who was responsible for the first-floor ice/water machine maintenance. V1 stated the facility had a meeting yesterday after the survey team pointed out the issues and moving forward it will be a combination of maintenance and housekeeping that will oversee it.</p> <p>On 5/16/2025, at 11:30 AM, V1 reported that out of the 200 residents in the facility, only one was NPO (nothing by mouth) - R21.</p> <p>When survey team asked for facility's residents' rights policy, facility provided the Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities document (Rev. 11/18). It documents in part: Your facility must be safe, clean, and comfortable and homelike.</p> <p>Facility's Preventative Maintenance Program policy (11/14; review date of 11/2023), documents in part that it is the Maintenance Director and/or Housekeeping Director's responsibility to conduct regular environmental tours/safety audits to identify areas of concern within the facility. They are to do random rounds to review all facility areas are kept clean and in safe condition.</p> <p>Facility's Policy &amp; Procedure Chest/Ice Scoop/Ice Machine Cleaning and Disinfecting (issued 8/2020) documents in part: The ice chest shall be cleaned and sanitized routinely by the Dietary Department. The ice machine will be cleaned and disinfected monthly by the Dietary department.</p>		