

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 06/06/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review, facility failed to follow their policy to ensure a call light was within reach for one (R4) out of three residents reviewed for call lights in a total sample of 9.</p> <p>Findings include:</p> <p>R4's MDS (Minimum Data Set) section C (Cognitive Patterns) dated May 28, 2025, documents R4's Brief Interview for Mental Status (BIMS) as 15/15 indicating R4 has intact cognitive functional abilities. MDS Section GG-Functional abilities documents R4 requires Substantial/maximal assistance with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, Lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet, and R4 is a two person assist.</p> <p>On 06/04/2025, at 12:03 PM, R4 was observed trying to sit up in bed, alert, oriented to person, place, time, and situation. R4 was observed trying to get himself into a sitting position and was observed looking for something. R4 stated he was looking for his call light to get staff's attention to get him up and out of bed. R4 was tired of staying in bed and his back was hurting him. R4 stated he could not find his call light. R4 was observed with left hand contractures.</p> <p>On 06/06/2025, at 12:10 PM, V11 (Certified Nursing Assistance-CNA) and surveyor observed R4's call light hanging on top of R4's overhead light far from R4's reach. R4 stated he could not reach the call light. V11 stated R4 would not be able to reach the call light where it was placed. Therefore, he would not be able to use it to get staff's attention for his needs.</p> <p>V11 stated if call lights are not within reach, residents are unable to make their needs known. R4 could have fallen and hurt himself trying to adjust himself or reach for the call light.</p> <p>On 06/04/2025, at 12:24 PM, V3 (Assistant Director of Nursing-ADON) stated call lights should be within residents' reach for residents to use in case of an emergency or to get their needs met. If residents cannot reach the call light in an emergency their needs will not be met and the resident could experience negative outcomes such as falls.</p> <p>On 06/05/2025, at 9:34 AM, V2 (Director of Nursing-DON) stated resident's call lights should be within reach so that the resident can use it to reach staff in case of an emergency or if the resident needs help from staff. V2 stated if the call light is not within resident reach, the resident will not be able to reach staff.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145995	If continuation sheet Page 1 of 3

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4's fall care plan documents: Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly to all requests for assistance.</p> <p>Facility's call light policy dated 1/25 documents: All residents shall have the nurse call light system available and within easy accessibility to the resident at the bedside or other reasonable accessible location.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure medications were administered as ordered by the resident's physician for one (R8) out of three residents in a total sample of nine residents reviewed.</p> <p>Findings include:</p> <p>On 06/04/2025, at 9:42 AM, surveyor located on the second floor of the facility with V7 (Licensed Practical Nurse/LPN). V7 observed with a medication cart and performing a morning medication administration pass. V7 has R8's eMAR/electronic medication administration record deployed on the computer. Surveyor observes the following order for R8 Procardia XL Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine)- Give 1 tablet by mouth one time a day for HTN (high blood pressure). Can hold if blood pressures are persistently 130/80 mmHg. V7 states it is important to measure a resident's blood pressure reading prior to administering any medications that will lower a resident's blood pressure. V7 states this is to establish the resident's blood pressure in an effort to prevent the administration of unnecessary blood pressure medications. V7 states if a resident is administered blood pressure medications and their blood pressure is already low, then this can cause the resident's blood pressure to drop too low. V7 states this can potentially cause a resident to go into cardiac arrest.</p> <p>R8's eMAR documents that R8 is prescribed the antihypertensive blood pressure medication: Procardia XL Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine). R8's eMAR documents that R8's blood pressure reading was not assessed and documented prior to the administration of his antihypertensive medication Procardia on the following dates: 05/11/2025, 05/15/2025, 05/17/2025, 05/18/2025, 05/21/2025, 05/22/2025, 05/26/2025, 05/29/2025, 05/31/2025.</p> <p>On 06/05/2025, at 10:05 AM, V2 (Director of Nursing/DON) states medications should be administered per physician orders. V2 states if a resident is given blood pressure medication and their blood pressure is already low, then the resident's blood pressure could further decrease. V2 states the resident could also become dizzy, faint, and then require emergency medical services. V2 states blood pressure parameters are established by the physician. V2 states blood pressure medications should not be administered outside of the physician orders and parameters. V2 states if blood pressure parameters are not ordered, then the physician should be notified to receive blood pressure parameters. V2 states she does not expect the nurses to administer blood pressure medications to residents without first assessing the resident's blood pressure.</p> <p>Facility document dated 10/25/2014, titled Medication Administration documents in part, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 4) FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration. 12. When possible, the medication administration record (MAR) should contain supplemental information to help assure accurate dosing. 2) Medications are administered in accordance with written orders of the prescriber.</p>		