Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014641	A. BUILDING: ____ B. WING ____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCHER HEIGHTS HEALTHCARE	**4437 SOUTH CICERO CHICAGO, IL 60632**

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S 000	Initial Comments	S 000		
S9999	Final Observations	S9999		

S 000 Initial Comments

Complaint Investigations:

2486741/IL177111
2486715/IL177081

S9999 Final Observations

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210c)
300.1210d)6)
300.3210t)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to keep a resident (R5) free from abuse in a sample of 6 residents reviewed for abuse. This failure resulted in R4 running over R5's foot with a wheelchair, resulting in R5's foot swelling and pain with a score of 7-9 on a scale of 10.

Findings include:

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R4 is 34 years old with diagnosis of, but not limited to: Schizoaffective Disorder Bipolar Type, Paraplegia, Suicidal Ideation, Mood Affective Disorder, Auditory Hallucinations, Visual Hallucinations, Major Depressive Disorder, Tourette's Disorder.

R5 is 60 years old with diagnosis of, but not limited to: Asthma, Difficulty in Walking.

Facility initial reportable (8/23/24 at 1:59 pm) to state agency regarding R4 and R5 documents in part: Incident Date: 8/22/24 at 9:45 am. Brief Description of Incident: Alleged Resident to resident physical altercation.

R4's (8/22/2024 at 12:33 pm) documents in part: Resident was observed by writer having physical aggression with another peer on same floor, safety precaution in place. Both residents were separated and redirected by writer. Resident was put on 1/1. No injuries noted. Call placed to MD. New order to send to hospital for psychiatric evaluation. Mother, Administrator, DON, Social service Dir. made aware. Will continue with plan of care.

R5's (8/22/2024 at 12:53 pm) progress note documents: Resident noted with right foot pain, r/t (related to) foot being ran over by peer wheelchair. Resident assessed by writer, vitals stable, pain level 7/10. PRN (as needed) pain medication was given. Call placed to MD. New order for x-ray of right foot. ALL parties made aware will continue with plan of care.

On 8/24/24 at 8:40 am R5 was observed in her room. R5 said, on Thursday R4 ran over her right foot on purpose. R5 said, R4 came to the nurses station too late to smoke as his smoking time had

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passed. R5 said, staff told R4 he cannot smoke now, and he got upset. As R4 was leaving he ran over my foot. R5 said, she told R4, "You just ran over my foot". R5 said, her foot still hurts, as R4 ran it over with a wheelchair. R5 said, R4 had behaviors and he should have been watched by staff as she and R4 had words a day before.

On 8/26/24 at 11:05 am, R5 was observed on the smoking patio. R5 was observed to have a boot on her right foot. R5 said, she went to the hospital few days ago and they gave her the boot to wear for few days. R5 said, she is still feeling pain to her foot, her pain is at 9/10. R5 said, R4 ran over her right foot, and she had previous right hip injury. R5 said, her foot is swollen, and she needs to keep it elevated.

On 8/24 at 9:03 am, V17 (LPN) said, she has been here since November. V17 said, the incident between R4 and R5 happened on Thursday (8/22/24) and V17 was the nurse. V17 said, "residents were getting medications at the nurses station. R5 was standing here with another resident talking. R5 was given a chair to sit down". V17 said, R4 came from his room he was flying in the wheelchair, and he ran over R5's foot. V17's back was turned away. V17 said, "when this happened 2 other resident said, "(R4) you could have said excuse me!" R4 said "F*** Y**". V17 said, R5 got up and started walking away to her room. V17 said, she called social services and went down to R5 to ask what happened. V17 said, R5 said R4 ran over her right foot, her pain was 7/10 and V17 called the doctor. V17 said, the director of nursing ordered x-ray of right foot. She called psych doctor about R4, and he petitioned him to hospital. R4 was on this floor a short time. R4 was petitioned prior to this incident to the hospital due to behaviors.

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On 8/24/24 at 9:38 am, V21 (Social Services) said, after the incident between R4 and R5 happened, R4 was placed on 1:1 monitoring before he went out to the hospital. V21 said, he walked with R4 and sat with R4 until the ambulance came. V21 said, no one beat R4 up in the facility, he was petitioned out due to the incident with R5. V21 said, R4 had lots of behaviors. R4 would antagonize other residents and would say it never happened.

On 8/26/24 at 11:37 am with V1 (Administrator) and V20 (Regional Consultant) present, V1 said V1 is the abuse coordinator. V1 said, "when there is abuse resident to resident, staff to resident, staff is suspended. The abuse investigation is initiated, an initial reportable is sent, police are called if warranted, and family and doctor also are called. V1 said, "the incident happened on 8/22/24 between R4 and R5, however the facility reported the incident (send e-mail) on 8/23/24 at 1:59 pm. With the state agency new portal the facility has not been using it". Surveyor asked V1 if the regional email was working for state agency. V1 confirmed it was working, however he sent the incident on 8/23/24.

On 8/26/24 at 1:11 pm V1 said (with V20 Consultant present) regarding R4 and R5, before the 22nd, they were not happy with each other. R5 assumed that R4 cut here in line in front of her". V1 said, "they had tension between them, next day they were passing each other in the hall, he (R4) rolled her (R5) foot. R5 is saying it was done on purpose and R4 said it was accident. R4 maintained that he didn't do it on purpose. R4 did have interaction with R5 before. V1 said, "when R4 came to the facility he was complimentary. Over time he started to exhibit behaviors. If

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something wasn't his way, he would annoy staff. Some people he got annoyed. R4 would manipulate a situation and blame others. Some residents he had no issues with and other residents he rubbed the wrong way". V1 said, "R4 is currently in the hospital, he will not be permitted to return to the facility".

R4's care plan (5/23/24) documents in part: R4 displays manipulative behavior which is disruptive, insensitive and disrespectful to staff and peers. This behavior is related to: Anger and depression., Poor self-esteem, diminished self-worth. Symptoms/problems are manifested by: On-going conflictual relationships, engaging in deceitful/disrespectful practices (confabulation, lying, dishonesty) for personal gain, frequent threats to call state survey agency officials, ombudsman, attorneys, placing unjustified calls to police, and threatening to "report" staff. R4 has a diagnosis & history of severe mental illness (SMI). R4's problems & symptoms are manifested by: Display of known risk factors (e.g., wandering, elopement risk, poor safety awareness, aggressive behavior, self-harm behavior, suicidal ideation), Poor contact with reality, poor judgment, poor insight, impaired decision making. (6/1/24) R4 demonstrates behavioral distress related to: Ineffective coping mechanisms., Problems are manifested by: Verbally abusive behavior when agitated, use of profanity, demeaning statements, verbal threats & yelling at others.

Facility's "Abuse Prevention Program" documents in part: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

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S9999	Continued From page 6 "Residents' Rights for People in Long-term Care Facilities" documents in part: You must not be abused, neglected, or exploited by anyone financially, physically, verbally, mentally or sexually. (B)	S9999		