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 09/05/2024

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		
	Complaint Investigation 2486832/IL177245			
S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
300.1010h)
300.1210b)
300.1210c)
300.1210d)4)A)
300.1220b)3)

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such

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accident, injury or change in condition at the time of notification.

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 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:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for

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each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to monitor a diabetic resident's foot; failed to assess and report a new skin alteration on a diabetic resident's foot; and failed to provide activities of daily living (ADL) care as assessed for a diabetic resident which affected R2 in the sample of three residents reviewed for improper nursing care. These failures resulted in R2's nurse practitioner (V4) assessing for R2's right lower leg redness and swelling; removing R2's moist right sock to see multiple maggots crawling from R2's right foot wound (base of big toe); and R2 being transferred to the hospital for further evaluation of gangrene infection which required surgical amputation of R2's right big toe.

Findings include:

R2's Admission Record documents, in part, diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease and with diabetic peripheral angiopathy without gangrene, dementia, hypertension, hyperlipidemia, peripheral vascular disease, retention of urine, difficulty in walking, lack of coordination, and

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need for assistance with personal care.

R2's Minimum Data Set (MDS), dated 7/29/24, documents, in part, R2's Brief Interview of Mental Status (BIMS) score 15 which indicates R2 is cognitively intact, and R2's Behavior for Refusal of Care with no refusals of care. R2's Functional Ability and Goals (dated 5/17/24 and 7/29/24) documents, in part, the following: "Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self" and "Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear is appropriate for safe mobility" are coded as "2" which signifies "Substantial/maximal assistance-Helper (staff) does more half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort." R2's Mobility documents, in part, a manual wheelchair for R2; and for R2's "Sit to stand," "Chair/bed-to-chair transfer," and "Toilet transfer," R2 is coded as 2" which signifies "Substantial/maximal assistance-Helper (staff) does more half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort."

R2 was discharged to the hospital on 7/30/24, and no longer resides in the facility.

On 9/3/24 at 12:39 pm, V4 (Nurse Practitioner, NP) stated V4 is R2's nurse practitioner in the facility, works Monday through Friday, and routinely visits R2. V4 stated, "The most recent thing I remember was when I was rounding on (R2). I asked, 'How are you?' (R2) said (R2) was going to bathroom and was in (R2's) wheelchair. I saw one leg a little swollen, so I wanted to see (R2's) toes, and then I saw maggots." When asked where was V4 when assessing R2 on 7/29/24, V4 stated it was in R2's room. V4 stated

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R2 was propelling self via wheelchair to the bathroom. V4 stated on 7/29/24, V4 observed R2's right shin was with "redness, shiny. Something was wrong." V4 stated V4 asked R2 about what happened to R2's right leg as V4 was examining R2's leg, and R2 said, "Oh, that hurts." V4 stated V4 was alarmed with R2 having pain, so V4 wanted to fully assess R2's right foot and toes with R2 wearing socks. V4 stated, "When I open it (sock), just wow (V4 is making motion with V4's hands of an explosion)." When asked to explain what V4 means by this, V4 stated, "(R2) had on a thicker sock. I opened up the sock, and there's maggots running out from wound on right big toe." V4 stated V4 informed the nurse (V5, Licensed Practical Nurse, LPN), Director of Nursing (former) and V16 (Wound Care Physician Assistant). V4 stated, "This was a concern to me. Everyone was made aware immediately." V4 stated on 7/29/24, V4 ordered antibiotics, pain management, "maggot medication," and stat laboratory (lab) blood work. When asked about details of what V4 observed on 7/29/24 with R2's right foot, V4 stated, "There were maggots, I remember. Maggots, they came from the wound, and I opened up the sock, and they were crawling. They were just there. There were no maggots in the bed. They were inside the sock, crawling. Many of them." When asked about how many maggots did V4 see, V4 stated, "10 or higher." When asked about the characteristics of R2's right big toe wound, V4 stated, "It was moist. It looked like when you dipped skin in water for hours without drying it. Foot was swollen." V4 stated the right big toe wound didn't have pus-like discharge, but it was moist. V4 stated the wound was under the right big toe joint and looked similar to a "corn callous." V4 stated, "The maggots were in there only, eating part of (R2's) foot. It developed from there,

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the moist part." V4 stated on 7/30/24, V4 assessed R2 in the facility and R2's labs were abnormal, so V4 ordered for transfer to the hospital. V4 stated, "I don't want to wait. (R2) could have possible gangrene or osteomyelitis going on." V4 stated R2's white blood cell (WBC) count and C-reactive protein (CRP) count were elevated indicating infection. V4 stated, "I was concerned with gangrene with diagnosis and (R2) may need MRI (magnetic resonance imaging). It was a concern for amputation. I sent (R2) to hospital for higher level of care." When asked about care specific for a diabetic resident's skin, especially feet, V4 stated, "We do routine foot exam. We have to do it. Podiatrist for cutting the nails. We have a consult for podiatry." When asked about the expectations of staff to assess a diabetic resident's skin, V4 stated, "We have to check the skin. Check more on foot for exam. There is a chance of neuropathy or infection. If they (residents) have a sore, then they will not feel the sore." V4 stated, "Every day, we need to clean and put new socks on." When asked what V4 expects of staff to be doing to prevent R2 from developing a diabetic wound with maggots, V4 stated, "If we (staff) clean (R2) and check (R2's) feet every day. I expect and to change (R2's) socks every. Change every day and open cleaning it. (R2) can help with (R2) upper body, but not bottom part with socks. I don't think (R2) can do that." V4 stated V4 would not expect R2's diabetic wound to ever have a maggot infestation. V4 stated R2's mobility is via a manual wheelchair and R2 propels R2's self in the hallways. V4 stated V4 has never been notified by nursing staff R2 has been noncompliant with wearing socks or shoes while up in the wheelchair.

In R2's Progress Notes, dated 7/29/24 at 7:25

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pm, V4 (NP) documents, in part, "APC (Advanced Practice Clinician) noted with right shin area, below knee redness, edema + (plus), while opening (R2's) sock, noted a lot of maggots crawling, coming from under right great toe small skin area opening, no pus discharge at present, right foot great toe surrounding skin noted moist, macerated, and white skin discoloration."

In R2's Progress Notes, dated 7/30/24 at 2:42 pm, V4 (NP) documents, in part, "F/u (follow up) lab, will Transfer to (hospital) on 7/30/24 (per {V27, Attending Physician}) due to acute right foot ulcer (DM {diabetes mellitus}-2), CRP 224, WBC 34 (prior to IV antibiotic)."

R2's Hospital Records documents, in part, R2's hospital diagnoses of "Right foot wound, Gangrene, and s/p (status post) right hallux (big toe) amputation 7/31/24."

On 9/3/24 at 12:09 pm, V5 (LPN) stated V5 is very familiar with R2, and R2 is alert, orientated with periods of confusion and propels self by wheelchair. V5 stated R2 will transfer R2's self to the wheelchair and the toilet, and "we (staff) did assist with bathing and bed bathing." V5 stated on 7/29/24, V5 was called back to R2's room by V4 (NP). V5 stated with R2's sock on, R2's foot would get moist, and V4 observed R2's right foot skin (on 7/29/24) as "real moist, like (R2's) skin was in water too long." V5 stated R2's right foot wound had "white looking drainage," but V5 is "not good with (wound) treatments." V5 stated V4 saw R2's foot was swollen and's why V4 had checked on R2's right foot. V5 stated, "I didn't see that they (feet) were swollen." V5 stated V4 provided orders that V4 carried out. V5 stated R2's skin "don't take too long for breakdown, with (R2) being diabetic and all the other conditions."

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When asked why it is important for staff to check a diabetics skin, like R2, V5 stated, "The same, so they (diabetic residents) don't end up with an amputation, and they don't know they got it, and they are not left untreated." V5 stated with R2 being "up and about, it's hard to tell if something is going wrong. It's easier when (R2) is in bed." V5 stated CNA (Certified Nursing Assistants) perform the ADL care, and when CNAs are bathing/showering residents, the CNA will call the nurse to come do a full body skin check. V5 stated shower/bed baths are given twice a week.

In R2's Progress Note dated 7/29/24 at 6:24 pm, V5 (LPN) documents, in part, "Resident was noted with a small wound to the right foot, great toe, red in color slightly swollen, with small amount of drainage. NP (V4) saw resident and order ABT (antibiotics) and stat labs, CBC, CMP (comprehensive metabolic panel), CRP. Family may aware."

On 9/3/24 at 2:49 pm, V5 (LPN) stated R2 wore nonskid socks when R2 propelled R2's self in the wheelchair and did not wear shoes. V5 stated V5 could not recall the exact date of the last time V5 performed a full body assessment for R2 during bed bath or shower. When asked if V5 has received a report from a CNA about R2 having new skin alteration on right foot, V5 stated, "No, no report of (R2) skin." V5 stated, "If something did happen (to R2), in one or two days, there can be breakdown."

On 9/3/24 at 12:29 pm, V6 (CNA) stated V6 normally works on R2's floor and is assigned as R2's primary CNA. V6 stated R2 was "alert and (R2) needed assistance." V6 stated at times, R2 would refuse showers, and V6 would tell the nurse. When asked how you handle R2's refusal

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of a shower, V6 stated V6 will tell the nurse, then go back a second time to see if R2 wants it, and if R2 refused again, V6 would tell the nurse so it's documented. V6 stated, "(R2) needed assistance. (R2) would be able to get up and go to the bathroom. (R2) needed help to put clothes on." When asked if V6 checked R2's skin on the feet, V6 said yes, and V6 would take the socks off to check. When asked if R2 had a skin alteration on R2's feet recently near the end of July 2024, V6 stated, "I saw one. It was near right toe. I told the nurse." V6 stated V6 could not remember which nurse V6 notified. V6 stated V6 could not confirm if the date was 7/29/24 (with new right big toe wound). This surveyor stated survey will view the CNA assignment schedules to confirm if V6 was working on 7/29/24. When asked to describe what V6 observed on R2's right foot on this unknown date late July 2024, V6 stated, "Nothing but a little, like it was like a skin tear on the side of her toe. There was redness. No drainage." V6 stated, "I took them (socks) off, when I was getting (R2) ready. Assisting to get (R2) up with dressing." V6 stated, "I reported (R2's) skin tear to nurse." When asked how often is V6 checking R2's skin, V6 stated, "It's a daily thing with care."

Facility document dated 7/29/24 day shift (7 am - 3 pm) and titled "Daily Assignment Sheet" documents, in part, V6 was not working or assigned to R2. V17 was assigned as R2's primary CNA, and V5 (LPN) was R2's primary nurse.

On 9/4/24 at 12:25 pm, V17 (CNA) stated V17 works routinely on R2's floor and confirmedV17 was assigned as R2's primary CNA on 7/29/24. V17 stated R2 was a 1 person staff assist for transfer and needed assistance with dressing for ADL care. V17 stated R2 would propel R2's self

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with R2's feet when in the manual wheelchair and would wear "slippers." When asked on 7/29/24, did V17 notice any redness or swelling to R2's right lower extremity, V17 stated, "Not I can recall." When asked if V17 checked R2's skin during ADL care on 7/29/24, V17 stated, "No, I can't even remember that day. (R2) normally like goes to the bathroom on (R2) own with assist. I can't even remember looking at (R2's) feet." V17 stated V17 will document skin alterations on the "shower sheet" and report it to the nurse. When asked what is V17 looking for on a resident's skin, V17 stated, "To look to see basically any wounds, open wounds or open sores or marks need attention."

On 9/3/24 at 1:47 pm, V7 (Wound Care Coordinator) stated R2 was a diabetic and V7 had provided R2's last wound care treatment in June 2024 where a left heel deep tissue injury was healed. V7 stated V7 was informed on 7/29/24 by V4 (NP) R2 had a new right foot wound. V7 stated V7 performed R2's wound care treatment on 7/30/24, and R2's right big toe wound "was sloughy. Almost all of it. I was thinking how (R2) doesn't feel this. (R2) has diabetic neuropathy. It was yellow tissue. It was a pink crack itself." This surveyor and V7 viewed R2's Treatment Nurse Initial Skin Alteration Review (7/30/24, authored by V7). V7 confirmed the measurement to the right big toe wound was 8 by 11 centimeters (cm). V7 stated the wound was from the right big toe to hallux by ball of the foot. V7 stated, "I didn't understand how (R2) didn't feel it. It looked really mangled." V7 stated V7 classified R2's wound as a non-pressure, diabetic wound. When asked what that means, V7 stated it did "not come from pressure. (R2) moves (R2's) feet. Nothing is sitting on (R2's feet), so it's not the cause" of the wound. V7

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stated, "This kind of wound does not gradually happen. They (staff) need to watch out for diabetic hands and feet and handle them carefully. (Diabetic residents) with neuropathy, and they (staff) must do the care. Staff see the feet and wash the feet then they would see it (wound). They have to be actually doing it." When asked in V7's professional wound care training, how can a wound be infested with maggots, V7 stated if there is a wound and if wound is lacerated or open, the fly can deposit eggs. V7 stated even if the wound is covered, the fly can sit on top of covering (dressing or sock) and lay eggs "27 layers down to infiltrate the area." When are skin assessments being done by staff (nurses/CNAs), V7 stated, "They should have skin checks twice a week with showers. CNA and nurses are responsible. If there's an alteration of skin, nurse will let us (wound care) know. I will use assessment tool."

R2's Treatment Nurse Initial Skin Alteration Review, dated 7/30/24, V7 documents, in part, R2's right great toe extending to plantar hallux wound as a non-stageable, non-pressure injury/diabetic, acquired in the facility with the size of wound being 8 cm by 11 cm by unknown depth with small amount of exudate and peri wound area as edematous and macerated.

On 9/4/24 at 1:18 pm, V2 (Director of Nursing, DON/Regional Nurse Consultant) stated, "Skin should be assessed daily. Staff identify issues during care. CNAs will notify the nurses. If CNA sees something during AM care or PM care, CNA sees the alteration of skin and will notify nurse." When asked how often skin assessments are done, V2 stated, "Weekly skin assessments." When asked when a CNA or nurse is assessing a resident's skin, what are they looking for, V2

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stated, "Open areas, if they see blister or redness." V2 stated bed baths or showers are given weekly, and if the resident refuses, then the staff must "figure out which day is a good for an alternate day." V2 stated the treatment nurse (V7, Wound Care Coordinator) collects the paper shower sheets from the floors to review. This surveyor showed V2 the shower sheet for R2 from 7/24/24 with no documentation of what was done (no skin check or bath/shower was checked). When asked what was done for R2 on this date, V2 stated, "I don't know. I can't answer." V2 stated when residents refuse care, the resident is educated, and the CNA will alert the nurse. V2 stated social services staff will speak to the resident and the refusal of care will be care planned for. When asked about diabetic resident's skin checks, V2 stated, "Again staff should be monitoring overall for skin dryness, redness, excessive moisture. Look at the feet, and the podiatrist is supposed to be seeing them. For diabetics, we want to make sure resident doesn't have skin alteration because of different issues with their health. The toenails are to be clipped. It takes a while for them (diabetics) to heal." V2 stated V2 expects staff "to assess everyone, not just diabetics. When asked why it takes longer for diabetics skin to heal, V2 stated, "Diabetes affects every organ in the body. Tissue perfusion and not getting oxygen to the organs. Edema which can prevent fluid coming in from intra and extra vascular space which can affect healing as well."

R2's Complete Care Plan, with last care plan review date of 8/8/24, documents, in part, a focus of R2 has actual impairment to skin integrity related to comorbidities and medical diagnosis of diabetes mellitus type 2 shows interventions of "keep hands and body parts from excessive

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	IL6014641	A. BUILDING: ____ B. WING ____	C 09/05/2024

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

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moisture (initiated 5/11/24)" and "monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. (the rest) to MD (doctor) (initiated 5/11/24)." R2's Complete Care Plan does not include a focus for refusal of care.

On 9/4/24, R2's Shower Sheets for July 2024 were requested from V2 and provided to this surveyor by V7 (Wound Care Coordinator). R2's "Skin Monitoring: Comprehensive CNA Shower Review," dated 7/17/24, signed by V6 (CNA) documents, in part R2 received a shower with assist. R2's Shower Sheets (titled as "Skin Observation Worksheets") dated 7/21/24 documents R2 refused a bath/shower and on 7/24/24, no documentation is observed R2 received a shower and skin check, skin check or a bath/shower was refused.

Facility policy dated September 2022 and titled "Bath/Shower Schedule" documents, in part, "Policy: A bath or shower will be given to each resident by a Certified Nurse Assistant one time per week as scheduled and prn, per resident preference. Procedure: 1. Charge Nurse makes schedule for Certified Nurse Assistant to include baths or showers are scheduled for respective date and shift. 2. Bath and shower schedule is posted on each floor. 3. Certified Nurse Assistants give bath or shower as scheduled. 4.If resident refuses bath or shower, the Charge Nurse is notified for intervention, follow-up, and documentation. 5. Certified Nurse Assistants are to notify the Charge Nurse of resident's skin changes noted. 6. Bath/Shower sheets are to be completed by the Certified Nurse Assistant upon each bath/ shower scheduled whether accepted or declined. 7. Bath/Shower sheets will be

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maintained by the facility for the current and entire last month and then may be discarded."

Facility policy dated September 2023 and titled Activities of Daily Living (ADL) documents, in part, "Purpose: To preserve ADL function ... Interventions may include (depending on an assessment based on individualized need): ... Dressing: ... Selecting, obtaining, putting on, fastening ... and taking off all items of clothing, and putting on and removing ... socks and shoes."

Facility policy dated November 2022 and titled "Foot Care Assessment" documents, in part, "Policy: It is the policy of the nursing department to perform an assessment of the resident's feet at the time of admission, updated quarterly, and when significant change occurs. Purpose: To identify treatable conditions, prevent infections, provide treatment, and comfort."

Facility policy dated October 2020 and titled "Pressure Ulcer and Skin Condition Assessment Policy" documents, in part, "Policy: It is the policy of this facility pressure and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved wound assessment form. Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure, and other ulcers and assuring interventions are implemented. Standards: ... 3. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the licensed nurse who will perform the initial assessment."

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Facility policy dated 2/1/22 and titled "Change in Resident's Condition" documents, in part, "General: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician/NP and resident's responsible party of a change in condition. Responsible Party: RN, LPN, Social Services. Policy: Nursing will notify the resident's physician or nurse practitioner when: ... b. There is a significant change in the resident's physical, mental or emotional status. c. There is a pattern of refusing treatment or medication ... e. It is deemed necessary or appropriate in the best interest of the resident. 2. Appropriate assessment and documentation will be completed based on the resident's change in condition or indication. 3. Once the physician/NP has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issue and any physician orders. 4. The communication with the resident and their responsible party as well as the physician/NP will be documented in the resident's medical record or other appropriate documents. 5. The Care Plan for the resident will be updated as indicated."

Facility job description (undated) titled "Certified Nursing Assistant" documents, in part, "Job Summary: The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine ... Main Duties: A. Support the facility's philosophy of care and strive to achieve its goals and objectives ... C. Carry out assignments for resident care including (but not limited to): a) bathing b) dressing ... H. Report any changes in resident's condition ... to the charge nurse of the unit ... M. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on

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S9999	Continued From page 15 duty." Facility job description (undated) titled "Charge Nurse" documents, in part, "Job Summary: ... Care for the clinical nursing needs of residents on his/her wing ... Job Requirements: ... 2. Excellence in all aspects of quality nursing including exceptional care ... Main Duties: A. Support the facility's philosophy of care and strive to achieve its goals and objectives ... D. Supervise all aides in performing their duties by checking work closely to ascertain assignments have been completed ... F. Make daily rounds on the wing to ensure individual Care Plans are being followed and assess each resident's status in accord with his/her Care Plan ... P. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duties ... R. At all times abide by policies of the facility and ascertain employees under his/her supervision do the same ... U. Prepare ... reports, events and observations using the EMR (electronic medical record) system." (A)	S9999		