STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145058	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Chillicothe	1028 Hillcrest Drive Chillicothe, IL 61523

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)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview and record review the facility failed to ensure laboratory testing was completed as ordered for 1 of 1 residents reviewed for medical testing in the sample of 5. The findings include: R1's admission record documents he was admitted to the facility on [DATE] with a primary diagnosis of acute respiratory failure with hypoxia (low levels of oxygen). The 1/23/25 follow up visit by V12 (Nurse Practitioner), shows R1 was to have stat lab work, and continue the antibiotic for pneumonia. The order summary sheet shows the lab order was placed in the computer to be completed on 1/24/25. R1 had no labs on record. Progress notes were reviewed and show no documented labs being drawn. On 2/11/25 at 9:53 AM, V3 (R1's daughter) said when R1 was admitted he had been complaining of a cough and sore throat. She said the symptoms were reported to nursing, and obtained an x-ray and he was diagnosed with pneumonia. V3 said she was advised R1 was to have labs done on 1/24/25. When she asked the nurse for his results, the nurse told her the labs were never done. V3 said the nurse offered to change the date of the labs. On 2/11/25 at 10:45 AM, V5 LPN (Licensed Practical Nurse) said when blood work is ordered, a paper form (carbon copy) is filled out and placed in the accordion file, and when lab arrives the day of the lab, they take a copy of the order, and another copy is left at the facility. V5 said the nurse is responsible to getting results and reporting them to the provider. On 2/11/25, at each nurses station, an accordion file was observed to have carbon copy lab slips filed by the date to be drawn. On 2/11/25, V2 DON (Director of Nursing) said the lab work ordered does not appear to be done, and it should have been drawn on 1/24/25. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 10/2024 policy for physician notification of laboratory/radiology/diagnostic results documents its purpose is to assure physician ordered diagnostic test are performed, and to assure test results are reported to the physician so that prompt, appropriate action may be taken if indicated for the resident's care. A licensed nurse is responsible for assuring the laboratory is notified of physicians order for testing. A requisition is to be completed and lab to be drawn on the next scheduled lab draw day unless stat or same day order is received. A nurse is responsible for monitoring the receipt of test results.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on interview and record review the facility failed to ensure diagnostic testing results were reported and reviewed in a timely manner for 1 of 1 residents reviewed for medical testing in the sample of 5. The findings include: R1's admission record documents he was admitted to the facility on [DATE] with a primary diagnosis of acute respiratory failure with hypoxia (low levels of oxygen). The 1/17/25 resident care and screening assessment documents R1 to have moderate cognitive impairment. On 1/13/25, V12 (Nurse Practitioner-NP) ordered R1 to have a repeat chest x-ray with a diagnosis of history of bilateral pleural effusions (fluid in the lung tissues). The order was noted by nursing two days later 1/15/25. The x-ray results of the 1/15/25 chest x-ray show right basilar opacity. Correlate clinically for atelectasis (collapse of a lung or section of a lung), chronic scarring, edema, and/or pneumonia. The 1/15/25 x-ray report shows it was reported on 1/15/25 at 9:24 AM, however, the report with orders shows on 1/21/25, V12 ordered an antibiotic due to a diagnosis of pneumonia. On 2/11/25 at 9:53 AM, V3 (R1's daughter) said when R1 was admitted he had been complaining of a cough and sore throat. She said the symptoms were reported to nursing, and nothing seemed to get done. The nurses were checking R1's lungs, and reporting they were clear. She said eventually a nurse ordered breathing treatments and some cold medication. It was not until she attended the care team meeting with the staff, she learned R1 had a chest x-ray on 1/15/25 that showed pneumonia, but she was not advised of an antibiotic starting until 1/21/25. She said R1 went 6 days without getting any medication. On 2/11/25 at 10:45 AM, V5 LPN (Licensed Practical Nurse) said when an x-ray is ordered, the order is placed in the computer, and it will go to the x-ray company, and they will do the exam and fax the results to the facility. She said the nurse is responsible to getting results and reporting them to the provider. She said if a resident had a result of pneumonia, she would just fax it to the NP. On 2/11/25 at 11:14 AM, V7 RN (Registered Nurse) said when an x-ray is ordered, the order is placed in the computer, and the nurse must call to schedule a time for the exam. When the exam is complete, results are reported right away. Those results are faxed to the NP, and we await orders. On 2/11/25, V2 DON (Director of Nursing) said all x-ray orders are called in and scheduled. Results are faxed typically within a couple of hours. It can be hit or miss as to what number the results are sent; we have educated the staff to forward results to the correct nursing station. When the faxed results are in, they are forwarded to the medical group for review, and they will give direction. They send back the same test results with orders pasted to the bottom of the page. V2 said the original x-ray order should have been processed and completed on 1/13/25 when it was written. V2 said if the x-ray and results were done and reviewed on 1/15/25, R1 could have started the antibiotic earlier. (continued on next page)

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