STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145062	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Streator	1525 East Main Street Streator, IL 61364

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on observation, interview, and record review, the facility failed to ensure the electronic health record included a life sustaining treatment order for one (R16) of 32 residents reviewed for advanced directives in a sample of 48. Findings include: R16's Physician Order for Life Sustaining Treatment (POLST), dated [DATE], was scanned into the electronic health record under the miscellaneous tab which documented R16 did not want to be resuscitated although requested selective treatment options. R16's electronic medical record did not include a physician's order for life sustaining treatment. On [DATE] at 2:00 PM, R16 stated she gave the facility her signed POLST, dated [DATE], and stated I don't want to go on one of those breathing machines, or have them beat on me. On [DATE] at 2:30 PM, V2 (Director of Nursing) stated staff find a resident's code status by the CPR (Cardiopulmonary Resuscitation) List posted at the Nurse's station. The CPR List updated on [DATE] was posted at the nurse's station for the 300, 400 and 500-hall. V2 stated the list was not the most recent list. On [DATE] at 3:00 PM, V25 (Registered Nurse) stated and demonstrated in the electronic health record where she would look for a resident's code (resuscitation) status if needed in an emergency. The code status is generated by the physician's order and would be displayed on each screen next to the resident's name. V25 confirmed R16's code status was not displayed, and there was not a physician's order and should have been. V25 stated she would not rely on the CPR list posted at the nurse's station and stated the postings were not always up to date.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on interview and record review, the facility failed to ensure hot water was available for six of fourteen residents (R16, R18, R21, R198, R199, and R200) reviewed for homelike environment in the sample of 48. Findings include: Resident Council Meeting Minutes, dated 1/31/25, documents Six months no hot water (300-hall) having to go to 500-hall to shower; dated 2/28/25 Hot water still [NAME] (300-hall) and still having to go to other halls; and dated 3/28/25 documents The water is still cool down the SW (Southwest) hall (300-hall), and turned (water) on for 20 min (minutes) and still cold. On 4/22/25 at 11:55 AM, R18 stated there was only cold water coming from the sink faucet. On 4/23/25 at 1:15 PM, R16 stated I can't wash my face in my room (due to the cold water). The aides run down the hall and bring warm water to us just so we can clean up. I can't take a shower unless I go over to the 500-hall. Why am I paying $1800 a month to live here when I don't have hot water? I've been independent my whole life and it's disgusting that I can't get a washcloth and warm water. On 4/23/25 at 2:08 PM, R199 stated the water is always cold in the morning. On 4/23/25 at 2:08 PM, R198 stated there is not hot water. On 4/23/25 at 2:10 PM, R21 stated the water is cold in the morning. On 4/22/25 at 11:30 AM, V17 (Certified Nursing Assistant/CNA) stated R16, R18, R21, R198, R199, and R200 had no hot water in their rooms. V17 stated the aides must go to the rooms in the middle of the hall and take buckets of hot water down to those rooms that only had cold water. Maintenance told us to just let them know when the water was cold and they will do something, but they are not here at 5:30 AM when we start cleaning residents up. On 4/24/25 at 10:30 AM, V18 (CNA) stated early in the morning there is no hot water on the 300 hall, and this morning she had to go down the middle of 300-hall to get hot water for the residents. On 4/24/25 at 10:40 AM, V19 (CNA on the 300 hall) stated there is no hot water in the morning. On 4/24/25 at 12:00 PM, V20 (Maintenance Director) stated water temperatures are taken at different times of the day although not in the mornings when he gets to the facility. At this time, V20 verified hot water temperatures had not been checked in R16, R18, R21, R198, R199, or R200's room. On 4/24/25 at 11:35 AM, V1 (Administrator) stated the water heaters were replaced a few months ago and was unaware that R16, R18, R21, R198, R199, and R200 did not have hot water.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32189 Based on observation, interview, and record review, the facility failed to ensure their dishware was safely sanitized per their policy. This failure has the potential to affect all residents who consume meals prepared by the facility with a current census of 96 residents. Findings include: Facility Resident Census Roster and Facility Matrix/802, dated 4/22/25, documents 96 residents reside in the facility. Facility Kitchen Sanitation Manual, dated 2/2022, documents Fixed equipment, utensils and equipment too large to be cleaned in sink compartments will be washed manually or cleaned with a pressure spray method, rinsed and then sanitized by spraying or swabbing with a chemical sanitizer. The chemical sanitizing solution should have chemical strength of Quaternary ammonia-200 ppm (parts per million). On 4/22/25 at 10:49 AM, V22 (Dietary Cook) demonstrated the procedure for testing the facility sanitizing solution's Quaternary ammonia level utilizing their test strips which resulted at a 400 or greater parts per million. At that same time, V22 verified their test strips result was greater than 400, and stated the sanitizing solution should result between 200 and 400 ppm. On 4/24/25 at 9:30 AM, V23 (Dietary Manager) stated the sanitizing solution Quaternary ammonia test should read at 200 ppm.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 30678 Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions/EBP policy and procedures (R348 and R71) and failed to sanitize a lift between resident use for (R45 and R70) for four of 20 residents reviewed for infection control in a sample of 48. Findings include: The facility's EBP policy and procedure, dated 4/2024, documents EBP: recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Personal Protective Equipment (PPE) of gown and gloves are to be used by personnel when providing direct care. Standard Precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: Dressing, Bathing/Showering, Providing Hygiene, Changing Linens, Incontinence Care, Medical Device Care, or Wound Care. A sign will be posted on the door to notify the resident is on EBP to notify family and visitors. The facility's Enhanced Barrier Precaution sign, which is placed on a resident's door, includes the following instructions in large, bold print: STOP-ENHANCED BARRIER PRECAUTIONS. EVERYONE ENTERING MUST: Clean their hands before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities: Providing Hygiene, Wound Care: any skin opening requiring a dressing. Facility Cleaning and Sanitizing-Wheelchairs and Other Medical Equipment, dated 11/2012, documents Equipment and devices used by more than one resident will be cleaned and sanitized between each use. Nursing Assistants shall be responsible for cleaning and sanitizing the devices/equipment. 1. R348's current physician orders, dated 4/1/25, documents to cleanse R348's coccyx wound, apply calcium alginate, and cover with a bordered foam nightly until healed. R348's current care plan for April 2025 does not document that R348 is to be in EBP. On 4/23/25 at 1:35 PM, R348 was lying in bed without an EBP (Enhanced Barrier Precaution) sign posted on R348's door. On 4/23/25 at 3:45 PM, V14 (LPN/Licensed Practical Nurse) and V6 (ICP/Infection Control Preventionist) entered R348's bedroom without a gown to perform a pressure ulcer treatment to R348's coccyx. Upon removal of the old coccyx wound dressing, a moderate amount of tannish drainage was noted. V6 stated Her wound is very wet and has lots of drainage. On 4/23/25 at 4:05 PM, V6 stated R348 admitted with the pressure ulcer to her coccyx, and We don't require full PPE for her; if it were a chronic, repeat wound, or there was infection we would put her in EBP. On 4/24/25 at 3:30 PM, V5 (Assistant Director of Nursing) stated the facility does not follow Enhanced Barrier Precautions for all residents with open pressure ulcers per their policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31285 2. R71's Medical Record documents R71's diagnoses include the following: Peripheral Vascular Disease; Congestive Heart Disease; a history of Myocardial Infarction (heart attack); and Hypertensive Heart and Chronic Kidney Disease with Heart Failure. R71's Nursing Progress Notes, dated 4/24/25 at 3:18PM, documents the following: Skin: Wound: skin concerns noted. Resident has treatable wounds. Cardiac: Edema present all (extremities) LLE>RLE (Left Lower Leg more than Right Lower Leg) 4+ (plus) very deep pitting edema. On 4/24/25 at 1:10PM there was an 8 X 10 sign on R71's door designating Enhanced Barrier Precautions were in place. At this time, R71 was calm, alert and responsive, and lying in bed. R71's lower legs were very edematous, with 4+ pitting edema present and compression wraps in place to both legs. At this same time, V7 (RN/Registered Nurse) and V15 (LPN/Licensed Practical Nurse) entered R71's room to perform wound care and dressing changes to R71's lower legs. V7 and V15 did not put on protective gowns prior to entering R71's room. V7 verified R71's lower legs are extremely edematous and is weeping fluid. V7 removed R71's ace wraps and padded dressings from both lower legs and verified the padded dressings were soiled with drainage from R71's edematous and weeping lower legs. V7 then cleansed both edematous lower legs and replaced with clean padded dressings and compression wraps to R71's lower legs. No protective gowns or masks were worn by V7 or V15 at any time during wound cares for R71. On 4/25/24 at 9:40AM, V6 (IP and Wound Nurse) stated EBP/Enhanced Barrier Precautions should be initiated when a resident has Any lines, catheters, or chronic wounds. V6 stated only residents with chronic wounds and infected wounds are placed in EBP. V6 stated draining wounds are only under Enhanced Barrier Precautions if the drainage is not contained by the dressing. V6 stated R71 should be under EBP due to the urinary catheter and the weeping legs. V6 also stated EBP requires staff to wear gown and gloves, and Masks are not required- only with spraying wound cleanser and any aerosolized procedures or tasks. On 4/25/25 at 11:05AM, V2 (DON/Director of Nursing) stated she did not know which PPE/Personal Protective Equipment staff should be wearing when entering a resident's room to perform wound care or personal cares when under Enhanced Barrier Precautions. V2 then brought one of the laminated 8 x 10 EBP signs which is placed on the resident's door when EBP is in place and stated staff providing wound cares should wear a protective gown per the EBP signage. 32189 3. On 04/22/25 at 11:05 AM, V17 (Certified Nursing Assistant) was observed to enter R45's room, removed a mechanical lift sling from the machine, place the mechanical lift sling on R45, and then transferred R45 to the bathroom and placed her on the toilet with the sling and the mechanical lift in place. V17 assisted R45 with peri care and dressing, then transferred R45 back to her chair using the mechanical lift, and then removed the sling and placed the sling on top of another sling which was draped over the push handles. V17 removed the mechanical lift from the room without sanitizing the lift or the two slings which were in R45's bathroom during toileting. The mechanical lift was immediately taken into R70's room by V17 and given to V19 (CNA) who then used the same sling and lift to take R70 to bathroom for toileting. The mechanical lift sling and lift were used during toileting on R45 and R70 without sanitizing the lift or the slings between use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/25 at 11:30 PM, V1 (Administrator) agreed equipment or devices used by more than one resident should be cleaned and sanitized between each use.