STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145136	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Auburn	304 Maple Avenue Auburn, IL 62615

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43847 Based on interviews and record review the facility failed to notify family/Power of Attorney (POA) of a fall and fully discuss residents declining medical condition with POA for POA to make decisions on resident's medical treatment options for one of three residents (R2) reviewed for notification in the sample of 8. This failure resulted in no discussion of possible Hospice treatment to address R2's overall decline in health and ongoing pain. Findings include: R2's Face Sheet, dated [DATE] documents admitted [DATE] with diagnosis of end stage renal disease, malignant neoplasm of the kidney, peripheral vascular disease, acute and chronic respiratory failure. R2's Face Sheet documents R2 advance directives as CPR/ cardiopulmonary resuscitation. R2's Minimum Data Set, dated dated dated [DATE] documents that R2 is moderately cognitively impaired. R2's Hospital Record contain Power of Attorney (POA) document dated [DATE] naming V17, R2's family, as POA of health care. R2's Progress Note, dated [DATE] at 12:00 PM, written by V16, Registered Nurse/RN, documents R2 sustained a fall on [DATE] at 6:00 AM. The Note documented the incident occurred in the R2's room. The Note documented, R2 is alert and disoriented per usual baseline. The Note documented no changes in range of motion from normal baseline. The Note documented V10, Medical Director/R2's Physician, notified on [DATE] at 7:00 AM. On [DATE] at 10:00 AM, V16 stated she was present on [DATE] when R2 fell , and she did not notify the family. R2's Progress Note, dated [DATE] at 12:24 PM, written by V2, Director of Nursing, documents Interdisciplinary Team (IDT) met to discuss fall. The Note documents Care plan and interventions reviewed. The Progress Note documents probable root cause found to be R2 attempted transfer from bed unassisted and found sitting next to bed. The Note documented MD and POA notified. (continued on next page)

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

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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 0580 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:30 PM V2 stated on [DATE] at the time of the fall she had tried to call the daughter, but the daughter did not answer. V2 stated that R2's daughter was not notified of the fall on [DATE]. R2's Progress Note, dated [DATE] at 8:01 PM, written by V9, Nurse Practitioner, documented Called facility and spoke with nurse at 7:57 PM. Discussed CXR (chest Xray) results revealing moderate pleural effusion, nurse to notify POA and relay recommendation to send resident to hospital for evaluation. R2's Progress Note, dated [DATE] at 8:5PM documents ambulance here to transport R2 to emergency room (ER) for evaluation and treatment related to chest Xray results back with pleural effusion results. The Note documented R2 in agreeance to go. The Note documented call to V17 to inform of above and message left to call facility. R2's Progress Note, written by, V11, Podiatrist, dated [DATE], documents staff requests R2 be seen due to a very painful left foot. The Note documents R2 is to have vascular studies performed on her lower extremities and has wound care nurses taking care of the left foot, also painful are both feet. The Note documented R2 was seen for initial assessment at today's visit left dorsalis pedis nonpalpable, left posterior tibial nonpalpable, right dorsalis pedis nonpalpable, right posterior tibial nonpalpable. The Note documented R2's left foot was ice cold from the distal digits to the ankle, hair growth absent, bilaterally, cyanotic bilaterally. The entire hallux left foot was showing lines of demarcation for gangrenous changes. The note documented Discussed with nursing staff that patient is in the stages of dry gangrene of the lower extremities. The Note documented V11 requested a vascular consultation and staff replied that the order is already in. The Note documented that staff also stated that the wound care doctor was in yesterday and looked at her feet and didn't mention anything wrong with R2's feet. The Note documented The ABI's (ankle brachial index) ordered will confirm my diagnosis of vascular disease. R2's Physician's Progress Note, dated [DATE] from V10, R2's Physician/Medical Director, documents R2 has bilateral lower extremity swelling some discoloration of her toes in the right lower extremity. PVD (peripheral vascular disease) progressive worsening, R2 has significant pain in her lower extremity likely related to her PVD as well as due to her swelling, pain not controlled with her Norco ,d+[DATE]mg dose increase to ,d+[DATE]mg every 4 hours as needed. R2 has seen vascular surgery before refer R2 to vascular surgery for further evaluation however with her multiple comorbidities R2 will be high risk for any procedure. R2 and daughter not ready for hospice yet. R2's ABI results, dated [DATE], that documents pain to feet and toes, no pedal pulses present, right great toenail removed, heels mushy and toes are darkened. Findings are bilateral ABI's of 0.58 which lie within the claudication range. R2's Progress Note, dated [DATE] from V9 documents R2 has had continued progressive decline since admission both cognitively and physically. The Note documented evaluation of her feet reveal left great toe dark dry hard appears necrotic wound to left 2nd toes with ulcer draining edema. The Note documented right foot ,d+[DATE] toes dark, dry hard appear necrotic. The Note documented pitting edema recent ABI's show claudication. The Note documented R2 would benefit from referral to vascular surgery or referral to hospice to better control her pain. (continued on next page)

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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 0580 Level of Harm - Actual harm Residents Affected - Few	R2's Progress Note, dated [DATE] at 10:50 AM, from V16, Registered Nurse/RN, documents left great toe is mottled, black-necrotic, hard, cold, cannot find a cap refill. Right ,d+[DATE]th toes are mottled, black-necrotic, hard, and cold. +3 pitting edema in BLE (bilateral lower extremities). V9 notified and aware. R2's Progress Note dated [DATE] at 9:15 AM documents R2 is constantly screaming out in pain, unable to obtain SPO2 level with Oxygen therapy at 4L/Liters per NC/nasal cannula. Resident uncooperative with taking meds, not wanting to open mouth to swallow meds. R2's Progress Note dated [DATE] at 8:30 AM documents R2 has been screaming out, Lord help me. PRN/as needed pain medication given. Attempted to reposition pt/patient to get her to calm, this didn't help. R2 having difficulty swallowing her meds. R2's Progress Note, dated [DATE] at 3:07 PM documents Received new orders from (V10) to have resident's vascular Dr/doctor, see resident regarding bilateral toes. The Note documented transport aware and to make appt. R2's Progress Note, dated [DATE] at 1:25 PM documents Patient has been yelling out all day. Pain meds were given and still yelling out in pain. NP (Nurse Practitioner) aware. Wound Dr. aware. R2's Wound Evaluation & Management Summary, dated [DATE] from V8, Wound Physician, documents Discussed in detail with household staff patient insignificant pain should see vascular or made hospice for aggressive pain management - nurse informed they are already trying to talk regarding Hospice. The Summary documented Recommend Vascular Consult due to claudication range ABI or patient be made hospice with aggressive pain control - for claudication- will defer to primary physician. On [DATE] at 10:00 AM, V16, Registered Nurse, stated that she took care of R2 and that her legs hurt her really bad. V16 stated that R2's toes were black and necrotic and that on [DATE] she notified V9 of the toes being black and necrotic. V16 stated she felt as if R2 should have been sent to the hospital sooner. V16 stated she had discussed with V9 R2 being sent out but that someone else had decided that R2 needed to be hospice and R2 didn't need to go out. V16 was unsure of who had made that decision. V16 stated she did not notify the family of anything because she was told family was aware already. On[DATE] at 10:42 AM, V5, Social Service Director, stated that she had spoken with V17 on multiple occasions but her discussions with the V17 were about money and R2's discharge plans and that she did not discuss any medical conditions with the V17. On [DATE] at 11:00 AM V9 stated she did not have a conversation with the family about R2's care and prognosis and expected the facility to do that. On [DATE] at 1:00 PM V10, R2's Primary Care Physician/Medical Director, stated he did not speak with the family about the condition of R2 that he expected the facility to do that. On [DATE] at 1:30 PM, V2, Director of Nursing and V3, Nurse Consultant, stated they have no documentation that the family was notified or any discussion with the family of R2's condition. V2 stated R2 was a full code but should have been on hospice. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Facility provided change of condition policy dated ,d+[DATE] documents that facility will consult with doctor and family for any changes in condition. Facility provided advance directive policy dated ,d+[DATE] documents that resident representatives will be informed concerning the right to accept or refuse medical or surgical treatment, and at the resident options to formulate advanced directives.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43847 Based on interviews and record review the facility failed to provide vascular consult timely for one of three residents (R2) reviewed for quality of care in the sample of 8. This failure resulted in R2 experiencing a decrease in circulation to R2's lower extremities, increased pain, and discomfort in R2's lower extremities and hospitalization for septic shock related to decreased circulation and gangrene. Findings include: R2's face sheet, dated [DATE] documents admitted [DATE] with diagnosis of end stage renal disease, malignant neoplasm of the kidney, peripheral vascular disease, acute and chronic respiratory failure. R2's Minimum Data Set (MDS), dated [DATE] documents that R2 is moderately cognitively impaired and is dependent for transfers. R2's Admission Skin assessment dated [DATE] documents left great toenail missing with open wound present with no other skin issues noted to feet. On [DATE] at 10:00 AM, V7, Wound Nurse, stated that R2 was admitted on [DATE] after removal of right great toenail and R2's legs were very edematous but no other skin issues to feet upon admission. R2's Physician Initial Wound Evaluation & Management Summary, dated [DATE], from V8, Wound Physician, that documents left lower extremities foot cool, moderate edema, dark discoloration of toes. R2's right lower extremities foot cool, moderate edema, dark discoloration of toes, right great toenail bed dry. R2's pedal pulses left dorsalis pedis no palpable pulse or doppler signal detected, posterior tibial no palpable pulse or doppler signal detected. R2's pedal pulses right dorsalis pedis no palpable pulse or doppler signal detected, posterior tibial no palpable pulse or doppler signal detected, recommend vascular, end stage renal disease contributing. Complains of ,d+[DATE] pain in both feet/toes. Cool to touch. The Evaluation documents Recommend ABI (ankle brachial index- a diagnostic test used to determine severity of peripheral vascular disease) and vascular consult if considered appropriate by med (medical) director/primary. R2's [DATE] Physician's Order Sheet (POS), documents ABI (Ankle brachial index) to BLE (bilateral lower extremities) due to pain in feet/toes cool to touch, dated [DATE]. R2's Nursing Progress Note, written by V9, Nurse Practitioner, dated [DATE] documents that R2 was seen for evaluation after sustaining an unwitnessed fall this morning and no additional concerns at this time per nursing report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R2's Progress Note, written by V11, Podiatrist, dated [DATE] documents staff requests R2 be seen due to a very painful left foot. The Progress Note documented R2 is to have vascular studies performed on her lower extremities. The Progress Note documented R2 has wound care nurses taking care of the left foot, also painful are both feet. The Progress Note documented R2 also seen for initial assessment at today's visit left dorsalis pedis nonpalpable, left posterior tibial nonpalpable, right dorsalis pedis nonpalpable, right posterior tibial nonpalpable. The Progress Note documented the left foot is ice cold from the distal digits to the ankle, hair growth absent, bilaterally, cyanotic bilaterally. The Progress Note documented the entire hallux left foot is showing lines of demarcation for gangrenous changes. The Progress Note documented Discussed with nursing staff that the patient is in the stages of dry gangrene of the lower extremities. I requested a vascular consultation, and they replied that the order is already in. They also stated that the wound care doctor was in yesterday and looked at her feet and didn't mention anything wrong with (R2's) feet. The ABI's ordered will confirm my diagnosis of vascular disease. R2's Physician's Progress Note, dated [DATE] from V10, R2's Physician/Medical Director, documents R2 has bilateral lower extremity swelling some discoloration of her toes in the right lower extremity. PVD (peripheral vascular disease) progressive worsening, R2 has significant pain in her lower extremity likely related to her PVD as well as due to her swelling, pain not controlled with her Norco ,d+[DATE]mg dose increase to ,d+[DATE]mg every 4 hours as needed. R2 has seen vascular surgery before refer R2 to vascular surgery for further evaluation however with her multiple comorbidities R2 will be high risk for any procedure. R2 and daughter not ready for hospice yet. R2's ABI results, dated [DATE], documents pain to feet and toes, no pedal pulses present, right great toenail removed, heels mushy and toes are darkened. Findings are bilateral ABI's of 0.58 which lie within the claudication (symptom of PVD) range. R2's Progress Note, dated [DATE] from V9 documents R2 has had continued progressive decline since admission both cognitively and physically. The Note documented evaluation of her feet reveal left great toe dark dry hard appears necrotic wound to left 2nd toes with ulcer draining edema. The Note documented right foot ,d+[DATE] toes dark, dry hard appear necrotic. The Note documented pitting edema recent ABI's show claudication. The Note documented R2 would benefit from referral to vascular surgery or referral to hospice to better control her pain. R2's Progress Note, dated [DATE] at 10:50 AM, from V16, Registered Nurse/RN, documents Left Great toe is mottled, black-necrotic, hard, cold. Cannot find a cap refill. Right ,d+[DATE]th toes are mottled, black-necrotic, hard, and cold. +3 pitting edema in BLE (bilateral lower extremities). V9 Notified and Aware. R2's Progress Note, dated [DATE] at 9:15 AM documents R2 is constantly screaming out in pain, unable to obtain SPO2 (oxygen saturation) level with Oxygen therapy at 4L per NC. Resident uncooperative with taking meds, not wanting to open mouth to swallow meds. No documentation that V10 or V9 were notified of R2's constant pain. R2's Progress Note dated [DATE] at 8:30 AM documents R2 has been screaming out, Lord help me. PRN pain medication given. Attempted to reposition pt to get her to calm, this didn't help. R2 having difficulty swallowing her meds. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	R2's Progress Note, dated [DATE] at 3:07pm documents Received new orders from (V10) to have resident's vascular Dr, see resident regarding bilateral toes. The Note documented transport aware and to make appt. R2's Progress Note, dated [DATE] at 1:25pm documents Patient has been yelling out all day. Pain meds were given and still yelling out in pain. NP (Nurse Practitioner) aware. Wound Dr. aware. R2's Wound Evaluation & Management Summary, dated [DATE] from V8, documents Discussed in detail with household staff patient insignificant pain should see vascular or made hospice for aggressive pain management - nurse informed they are already trying to talk regarding Hospice. The Summary documented Recommend Vascular Consult due to Claudication range ABI or Patient be made hospice with aggressive pain control - for claudication- will defer to primary physician. R2's January POS, documents referral to see vascular r/t (related to) bilateral toes dated [DATE]. R2's progress note dated [DATE] from V9 documents R2 is being seen today per nursing request due to uncontrolled pain, R2 is moaning and yelling out Lord please help me and please help me. R2 has had a continued decline since admission, recent bilateral ABI are in the claudication range. Pedal pulses are not palpated. Nursing reports that R2 is having increased difficulty swallowing pills. Full code status, and multiple comorbidities. Refer to vascular. Plan discussed with nursing staff and R2. R2's Progress Note, dated [DATE] at 4:00pm by V2, Director of Nursing/DON, documented a call received from local emergency room . The Note documented R2 was sent to ER from dialysis center and ER was requesting med list be faxed and emergency contact number given. R2's Progress Note, dated [DATE] at 4:26 pm by V5, Social Service Director, documents they were notified that R2 was transferred from dialysis to ER. R2's Hospital emergency room notes dated [DATE] at 1:48pm titled Ambulance service record documents R2 yelling and screaming with no palpable radial pulses, unable to obtain blood pressure. R2's Hospital Emergency physician notes dated [DATE] at 3:34pm documents R2 with bilateral feet with necrotic/gangrenes toes. Skin is sloughing from both legs. R2's Hospital Emergency Physician Notes dated [DATE] at 5:17 PM, documents R2 presents with septic shock and bilateral lower extremity gangrene, right lower extremity wet gangrene will require emergent above knee amputation for source control. The Note documents R2 has a documented history of peripheral arterial disease although there are not clear records of any sort or revascularization procedure being performed in the past. The Note documented R2 is clearly in moderate distress in extreme pain. The Note documented I discussed with family that her legs are no longer salvageable and there are not revascularization options for her at this time. She would need bilateral lower extremity amputations. She is quite sick and unstable at this time. R2's Hospital Emergency physician notes dated [DATE] document R2 expired at 5:50pm. Death certificate unavailable at this time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:00 AM, V5 stated that R2 was sent to the hospital from dialysis on [DATE] and that R2 passed away at the hospital on [DATE]. On [DATE] at 9:45am V2 stated that R2 did not have a POA on file and they were unable to reach V17, R2's family, on several occasions. V2 stated that she had taken care or R2 on the morning of [DATE] and had done her dressing change and her legs were not gangrenous. V2 stated they processed the order of vascular doctor on [DATE]. V2 states they faxed vascular doctor's office on [DATE] but have not obtained an appointment prior to R2 going to the hospital on [DATE]. On [DATE] at 10:00, AM V7, Wound Nurse, stated that R2 was admitted on [DATE] after removal of right great toenail and legs were very edematous but no other skin issues to feet upon admission. V8 saw R2 on [DATE] and [DATE]. V7 stated that V11 had seen R2 on [DATE] and said R2 had gangrene but V8 didn't mention that R2 had gangrene. On [DATE] at 3:04 PM V8 stated that she saw R2 on [DATE] and R2 did not have palpable pedal pulses and V8 ordered ABI and a vascular consult. V8 stated R2 had dry gangrene due to poor blood flow from her PVD. V8 stated ESRD often results in PVD and there really is no medical treatment for it. On [DATE] at 8:25 PM V12, Certified Nursing Assistant (CNA), stated he took care of R2 a lot and that R2 had gotten worse during her stay. V12 stated that R2 used to talk and get out of bed even on non-dialysis days. V12 states R2 would complain about pain in her feet. V12 stated that R2 had blisters on her lower legs and the right leg was wrapped. V12 states R2 was in pain and would moan and groan with movement. V12 stated R2 did not get up on non-dialysis days because she was in too much pain. V12 states he had to help her eat because she wasn't eating and drinking. V12 states R2 was a full body lift for transfers to the wheelchair and that he transferred her to the wheelchair on [DATE] for dialysis around 9:45am that morning. V12 stated R2 would yell out in pain any time we moved her. V12 states on the morning of [DATE] R2 continued to moan/groan even after she was in the wheelchair and was waiting in the lobby for transport to dialysis. V12 states he had told nurse about her pain and the nurses could hear her moaning while in the lobby also. On [DATE] at 8:50 AM V14, CNA, stated that she took care of R2 frequently. V14 stated that over the last month R2 had declined and was very sleepy. V14 stated that R2 would holler/moan/groan out all the time. V14 stated that R2 would say her feet hurt. V14 stated she helped V2 with the dressing change to her lower leg on the morning of [DATE] and that R2's toes were black and cold. V14 states she was told that R2 had gangrene and was supposed to see a vascular doctor. V14 stated that R2 screamed when she put her socks on her on the morning of [DATE]. V14 stated R2 would moan/groan with any movement, that R2 would yell out during transfers with the full body lift to the wheelchair. V14 stated that R2 was hollering the lobby as she waited for transport to dialysis on the morning of [DATE]. V14 stated she would tell the nurses that R2 was in pain and the nurses would give her something. V14 stated that R2 was not eating and had to be fed now but was eating when she first came in. V14 stated the night shift nursing staff would tell her that R2 had yelled all night. On [DATE] at 9:15 AM V15, CNA, stated that R2 would scream out in pain a lot and that she was very tired, that she would have to wake her up to eat. V15 stated R2 used to talk to me but didn't talk much now. V15 stated she had not seen any family visit R2. V15 stated that R2 would say she hurt but not tell her where her pain was at. V15 stated that R2 would moan anytime you moved her. V15 stated nurses could hear her yelling out in pain. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:00 AM, V16, Registered Nurse, stated that she took care of R2 and that her legs hurt her really bad. V16 stated that R2's toes were black and necrotic and that on [DATE] she notified V9 of the toes being black and necrotic. V16 stated she felt as if R2 should have been sent to the hospital sooner. V16 stated she had discussed with V9 R2 being sent out but that someone else had decided that R2 needed to be hospice and R2 didn't need to go out. V16 was unsure of who had made that decision. V16 stated she did not notify the family of anything because she was told family was aware already. On [DATE] at 11:00 AM V9, stated that R2 was supposed to see a vascular doctor and that R2 was already established with a vascular doctor. V9 stated she expected the vascular consult to be done timelier. V9 stated she did not have a conversation with the family about R2's care and prognosis and expected the facility to do that. V9 stated she has no idea what the treatment would have been for R2 if she had been sent to vascular/hospital sooner. V9 stated that R2 had a lot of comorbidities and that she felt like R2 should have been on hospice but understood from the facility that R2's family did not want R2 on hospice and wanted her a full code. On [DATE] at 1:00 PM V10 stated that R2 was to see vascular doctor as soon as possible. V10 stated that facility should have gotten R2 into see vascular doctor sooner. V10 stated that R2 had a lot of co-morbidities, and that surgery probably would not have been likely and that he didn't think the outcome would have been any different for R2. V10 stated he did not speak with the family about the condition of R2 that he expected the facility to do that. On [DATE] at 1:30 PM V2 and V3 (Nurse Consultant) stated they have no documentation that the family was notified or any discussion with the family of R2's condition. V2 stated R2 was a full code but should have been on hospice. On [DATE] at 10:42 AM V5 stated that she had spoken with V17 on multiple occasions but her discussions with the V17 were about money and R2's discharge plans and that she did not discuss any medical conditions with the V17. Facility provided change of condition policy dated ,d+[DATE] documents that facility will consult with doctor and family for any changes in condition.