

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Auburn		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p>(continued on next page)</p>		

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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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility failed to ensure room temperatures were within the heat index/apparent temperature guidelines inside the facility and did not exceed 81 degrees Fahrenheit (F), the Facility failed to follow their Heat Emergency Policy as residents were not moved out of their rooms when temperatures were reached over 81 degrees for 4 of 4 residents (R1, R2, R3 and R11) reviewed for room temperatures in the sample of 16. This failure resulted in residents being left in rooms with the heat index indicating extreme caution to the residents. On 8/27/2025 at 9:55 AM, the Immediate Jeopardy/IJ was called with V1, Administrator, V2, Director of Nursing, and V17, Regional Director Operations The Immediate Jeopardy began on 8/7/2025 when resident room temperatures were not within the heat index/apparent temperature guidelines inside the facility and exceeded 81 degrees Fahrenheit (F), the Facility failed to follow their Heat Emergency Policy. The first abatement plan dated 8/27/2025 at 10:03 AM, was not accepted. The second abatement plan dated 8/27/2025 at 12:32 PM, was accepted. The surveyor confirmed by observation, interview, and record that the Immediate Jeopardy was removed on 8/27/2025, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the facility's policies and procedures and in-service training. Findings include: On 8/12/2025 at 9:45 AM, V1, Administrator stated, the air conditioning (AC) broke last Thursday (8/7/2025), and we were waiting for a part. All the air temperatures are good now. The AC repair man is here, and he is fixing everything. We brought in fans and some small AC units to the 500 halls, and we are having staff pass out drinks for hydration. The AC unit on the 500 hall was affected. We are not having issues with the other halls, and we are installing a new unit on the 500-hall unit today. Our maintenance man has been taking temperatures and took temperatures this morning and everything is good. On 8/12/2025 at 10:02 AM, V25, Registered Nurse (RN) was putting an IV (intravenous therapy medication) on a metal pole and quickly pulled her hand back and yelled out. On 8/12/2025 at 10:03 AM, V25 stated, This pole has been in the storage unit, I just took it out and it is so hot in there that this metal pole is hot, I cannot even touch it. It was being stored on the storage unit that is on the North Hall, that one with the broken AC (air conditioning) and it is super-hot! On 8/12/2025 at 10:03 AM, the metal pole was touched and was very hot to the touch and the hand had to be removed immediately. On 8/12/2025 at 10:31 AM, V6, Maintenance Director stated the AC (air conditioning) got struck by lightning on the South/West Hall and we finally got it repaired and up and running and then on Thursday the AC unit went out on the 500 halls. The 500 halls have been without AC for the past six days. I have been taking temperatures in all the rooms, and I have been using a laser thermometer. I did not use a Humidity Meter Hygrometer I do not even know what that is and I did not know I needed to factor in the humidity. I took temperatures this morning before you got here. On 8/12/2025 at 10:41 AM, V31, Contractor for HVAC system stated, we were called on Friday (8/8/2025) by (the facility) telling us they were having problems with their AC unit. I am replacing the thermal expansion valve today. The North Hall unit was out. I needed the parts, which I had to order and am replacing everything today. Hopefully, this will take care of everything for that hall. 1-R2's Physicians Order Sheet (POS) for August 2025 documents diagnoses of Morbid Severe Obesity, Heart Failure, diabetes mellitus 2, kidney Failure, hypertension; chronic pain syndrome; unspecified protein calorie malnutrition; acute kidney failure; shortness of breath; hypertension; and generalized anxiety. R2's Minimum Data Set/MDS dated [DATE] document R2 was cognitively intact for decision making of activities of daily living, uses a wheelchair, and is dependent on staff for most activities of daily living. R2's Care Plan with a start date of 7/29/2024 documents, the resident has an ADL (Activities of daily living) self-care performance deficit r/t (related to) respiratory failure, obesity, chronic pain, depression. The resident has diabetes mellitus start date 8/28/2024; Intervention: Avoid exposure to extreme heat or cold. On 8/13/2025 at 10:03 AM, R2's room was measured with a Humidity Meter Hygrometer and Indoor Digital Thermometer with Temperature Gauge and Humidity Gauge which was calibrated and documented R2's room was 86 degrees with 61 percent humidity = for 91-degree Fahrenheit (F) room (extreme caution). On 8/12/2025 at 12:08 PM, V5, Family of R2 stated, The nursing home has failed to repair the broken air conditioner. It broke on Thursday August 7th, the system stopped functioning in my mom's room. There is no Air conditioning on their wing at all. Nurses have opened the windows and are using what fans they can find. The temperature outside has been in the high 80's and 90's all 5 days the air conditioner has been down. There was a thermometer in her room and her room was 87 degrees inside. My</p>		