

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure competency of the Professional Nursing staff for 1 of 6 (R5) reviewed for Professional Standards in the sample of 50. This failure has the potential to affect all 128 Residents residing in the facility. The immediate jeopardy began on 9/10/25, when V6, Registered Nurse (RN), failed to appropriately respond to an emergent medical event, when R5 displayed symptoms of medical distress and presented with a blood glucose level of 33. V6 failed to follow physician's order of administering Baqsimi (Glucagon) for low blood sugar, and instead disassembled prefilled Epinephrine and Narcan cartridges, combining pieces of both medication cartridges, and administered Epinephrine injection nasally. On 9/16/25 at 2:15 PM, V1, Administrator, and V2, Director of Nursing (DON), were notified of the Immediate Jeopardy. The surveyor confirmed by interview, observation, and record review, the Immediate Jeopardy was removed on 9/17/25, but noncompliance remains at a Level 2 because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The Findings Include: R5's admission Record, dated 9/11/25, documents R5 was admitted to the facility on [DATE] with diagnosis of: Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Hypoxemia, Type 2 Diabetes Mellitus (DM), End Stage Renal Disease (ESRD), Dependent on Dialysis, Hypertension (HTN), anxiety disorder, and schizoaffective disorder. R5's Care Plan, dated 4/1/25, documents R5 has Diabetes Mellitus and Diabetic Neuropathy. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, Monitor/document/report PRN any s/sx (signs/symptoms) of hypoglycemia: Sweating, tremor, increased heart rate (Tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait, Monitor/document/report PRN (as needed) any s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, or coma. R5's Minimum Data Set (MDS), dated [DATE], documents R5 is cognitively intact and is dependent on staff for most ADLs. R5's Physician Order, dated 7/23/25, documents, Baqsimi one pack nasal powder 3 MG (milligram)/dose (Glucagon) 1 pump in nostril as needed for low blood sugar. May repeat in 15-minutes. R5's Medication Administration Record (MAR)-Treatment Administration Record (TAR), dated September 2025, does not document Baqsimi One Pack Nasal Powder 3 MG/Dose (Glucagon) was given to R5. There is no documentation of R5 receiving Narcan or Epinephrine (Epi). R5's SBAR (situation, background, assessment, and recommendation) Note, dated 9/10/25 at 8:08 AM, documents in part, Situation: The Change in Condition (CIC)/s reported on this CIC Evaluation are/were: Altered mental status. At the time of evaluation resident/patient vital signs, weight and blood sugar were:- Blood Pressure: BP 120/70 - 9/10/25 at 8:09 AM,- Pulse: P 70 - 9/10/25 at 8:09 AM, Pulse Type: Regular- RR (respiratory rate): R 18 - 9/10/25- Temp: T 97 - 9/10/25 - Pulse Oximetry: O2 97.0 % - 9/10/25 Method: Oxygen via Nasal Cannula- Blood Glucose: BS 49.0 - 9/10/25 at 7:50 AM. Relevant medical history is: COPD Diabetes. Code Status: Full Code. Resident/Patient is on: Hypoglycemic medication(s)/Insulin. Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:- Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	difficult to arouse)- Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)Nursing observations, evaluation, and recommendations are:Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:A. Recommendations: send for eval.On 9/11/25 at 11:05 AM, V6, Registered Nurse (RN), stated, I went in to see (R5) yesterday morning to check his blood sugar and he was lethargic, would only respond by opening his eyes when his name was called. His blood sugar was 49 at that time so I gave him some Ensure to drink, then got him some Glucagon spray from the E-Kit (Emergency Kit) and gave that to him. I then rechecked (R5's) blood sugar and it had dropped and was now reading 33. I called 911 to transport (R5) to the hospital. I do not recall giving (R5) anything else, including any injections. (V27, Licensed Practical Nurse (LPN) was the other nurse helping me with (R5).On 9/11/25 at 11:55 AM, V27, LPN, stated, (V6) asked me to come help her with (R5) and that she needed the E-Kit. I went and got the E-Kit and handed her a long tube-looking thing and a nasal spray. I saw her take out the long tube looking thing, then put the top from the nasal spray on the long tube thing and she gave it to (R5) in his nose. I did not give any drugs. If that was an Epi Pen, then yes, I handed it to her and that was my fault. I did an incident report, reported it to the NP (Nurse Practitioner) and the DON (Director of Nursing).On 9/11/25 at 12:00 PM, V26, NP, stated, I was just getting to the facility when EMS was taking (R5) out. (R5) had his eyes open when he left here. V27 then came and told me that (V6) gave (R5) Epi by accident. I do not see how they could have given the Epi with a Glucagon Nasal Spray cap on it. (R5) probably did not even get it, which is why his blood sugar never went up for them. It was a med error and a mistake.On 9/11/25 at 1:41 PM, V28, Emergency Medical Technician Paramedic (EMTP), stated, When we arrived at the facility, we had a male unresponsive with a blood sugar of 42. We started an IV (intravenous catheter) and administered D10. When we were moving him from his bed to our stretcher, we found an Epi Pen with a Narcan nasal spray cap on top of it. When I asked the nurse about it, she said she gave him Glucagon. I had two other firefighters look at it and they both verified that it was an Epi Pen. Again, the nurse stated that she knew she gave Glucagon. We put the resident on the stretcher and left the facility and took him to the ER (emergency room). Upon our arrival to the ER, the resident was slightly more alert to verbal stimuli, and his glucose was up to 136. I told the ER and my EMS director about the Epi Pen, and they were going to report it.R5's Emergency Medical Service (EMS) Report, dated 9/10/25, documents in part: Arrived on scene, made entry into the facility and into pt (patient) room to find male pt lying in bed unresponsive. Nurse states pt is diabetic and his blood sugar was low. Nurse states she gave pt intranasal glucagon and placed him on a non-rebreather mask with 15 LPM (liters per minute) of O2 (oxygen). No staff is bedside with pt upon arrival. ALS (advanced life support) had arrived first on scene. Obtained blood glucose level via finger prick method. Value of 42. Started 18g (gauge) angiocath in pt left hand and flushed with saline before locking and securing with Tegaderm. Pt skin is warm and clammy at this time. Started 250 ML (milliliter) bag of D10% (glucose solution) using macro drip tubing. While D10 is infusing, pt is moved to the stretcher from his bed using bed sheet and assistance from FD (fire department). While moving pt, an Epi Auto Injector pen is found in pt. bed. Placed on top was the nasal piece used for intranasal Narcan. When staff nurse was asked why the Epi pen was in the bed, she stated that it was Glucagon, and she had administered it in an attempt to raise pt glucose level. Pen was handed to FD for confirmation. FD also confirmed that pen is an Epi pen and not Glucagon. Nurse continues to argue that it is Glucagon, and it must have been placed in the wrong spot, and she did not confirm before administration.On 9/11/25 at 9:50 AM, V24, Master Social Work (MSW)/Licensed Social Worker (LSW), stated, I was working yesterday when (R5) arrived in the ER. The EMS guys gave us an Epi Pen that had a Narcan Cap from a intranasal administration unit on top of it and was told that the nurse at the facility gave this to (R5). The EMS told the ER staff that (R5) was unresponsive upon their arrival to the facility, they gave some D10 solution to raise his glucose and upon arrival to the ER, (R5) was awake, alert but still groggy. (R5) was admitted to the ICU for observation.On 9/11/25 at 12:05 PM, V6, RN, stated, I have to tell you what happened. I lied to you earlier. (V27) handed me (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	the Epi Pen and Glucagon Nasal Spray and I did not even look at them to see what they were. I put the cap on the pen and tried to give it to (R5). Honestly, I don't even know if he got any of it. So much was going on at that time and the next thing I know, EMS was here and took over. I did give the EMS guys the Epi Pen and Nasal Spray. I'm not that familiar with these types of drugs. This was my first med error, and I feel horrible, especially about lying about it. On 9/11/25 at 2:40 PM, V2, DON, stated, There are tackle boxes with emergency medications in it, including Epi Pens, Narcan, and Baqsimi Nasal Powder. The nurses would grab this for emergency situations. On 9/15/25 at 10:25 AM, V3, LPN, stated, If I found a resident who was unresponsive, I would check their blood sugar, look for orders, and grab the medication that you put up their nose. I can't think of the name of it right now, but if I see it, I will know what it is. It is kept in the tackle box E-Kit. I would not give Epi because it is not an allergic reaction, nor would I give Narcan because it is not an overdose. On 9/15/25 at 10:30 AM, V11, LPN, stated, If I found one of my residents unresponsive, I would check their vital signs and blood sugar. If the blood sugar is low and they are not able to take something by mouth, I would go to the E-Kit and get the Glucagon nasal spray and administer it to them to get their blood sugar up. I would not give Epi for something like this because it is not an allergic reaction. On 9/15/25 at 10:50 AM, V2, DON, brought in an Epi Pen and a Narcan Nasal Spray and attempted to demonstrate how V6 was administering R5's medication. V2 stated, I doubt that he got any of the medication the way she put this together. I feel this is simply incompetent nursing. On 9/15/25 at 2:13 PM, V29, Physician/Medical Director, stated, I was only notified of (R5's) hypoglycemic episode and that he was sent to the hospital. No one mentioned to me that he was not given his glucose and was given something else. I have standing orders for Glucagon to be given and that should have been given. When told of V6 giving R5 an Epi Pen with the Narcan top and spraying up R5's nose, V29 stated, Oh my God, that is unbelievable. I have never heard of such a thing. This could have been detrimental to (R5) and could have been fatal to him. He didn't get his Glucagon that was ordered, and his glucose could have continued to drop. This is truly unbelievable; the lack of competency could have subsequently determined (R5's) outcome, which could have been death in this case. I would expect the Nurse to administer medications as per my orders, and per appropriate route. On 9/11/25 at 2:10 PM, V2, DON, stated, I would expect the nurses to use the five rights of medication administration and to follow physician orders. V2's Investigation, dated 9/11/25, documents, Nursing Description: Nurse called into room and found resident's blood sugar to be 39. Blood sugar was retaken and decreased to 33. Nurse then went to medication room to obtain Glucagon nasal spray and Narcan nasal spray was given in error. Immediate action taken: NP was made aware of the Epi spray being given. VS-120/70, 70, 18, 97.0. Nursing stayed with resident and 911 called to transport resident to ER via stretcher. Resident was alert leaving the unit. V2 stated she is not finished with the investigation and will be in-servicing the nurses. The Facility's Registered Nurse Job Description, dated 10/2024, documents in part The Registered Nurse is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is always maintained. Essential Duties and Responsibilities: Prepare and Administer medications as ordered by the physician. Qualifications: Must be able to make independent decisions when circumstances warrant such action. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities. According to the NIH - National Library of Medicine; SCOPE OF PRACTICE - Nursing Fundamentals - NCBI Bookshelf at https://www.ncbi.nlm.nih.gov/books/NBK610819. The Scope of Practice refers to services a trained health professional is deemed competent to perform and permitted to undertake according to the terms of their professional nursing license. Nursing scope of practice provides a legal framework and structured guidance for activities that practical nurses and registered nurses can perform based on their nursing license. Nurses must also follow standards (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	when providing nursing care. Standards are set by several organizations, including your state's Nurse Practice Act, the American Nurses Association (ANA), agency policies and procedures, and federal regulators. These standards help guide nursing actions with the intent that safe, competent care is provided to the public. Nursing Process: The nursing process is a critical thinking model based on a systematic approach to client-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing client care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses (RNs), regardless of role, population, specialty, and setting, are expected to perform competently. Education: The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking. Quality of Practice: The registered nurse contributes to quality nursing practice. Resource Stewardship: The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and judiciously used. The Immediate Jeopardy that began on 9/10/25 was removed on 9/17/25 when the facility took the following actions to remove the Immediacy: 1. All nurses were educated on the use of Emergency Medications by V2, DON, on 9/17/25. 2. Any nurses that are not available in person have been contacted via phone. If not reachable, will be educated prior to taking shift by DON or designee. 3. 9/15/25 V2, DON, V30, LPN, and V31, RN, ADON reviewed the incident. 4. 100% Nursing staff has been educated on the signs and symptoms of hypoglycemia and hyper glycemia by V2, DON, and R31, RN, ADON on 9/17/25. 5. Any nurses that are not available in person have been contacted via phone. If not reachable, will be educated prior to taking shift by DON or designee. 6. On 9/10/25 NP was notified of the change in condition and MD notified of the resident being hypoglycemia and being sent to ER. 7. V6 and V27 educated on ensuring right medication and dose prior to medication administration by V2, DON, on 9/17/25. 8. The monthly refresher will begin on 9/23/25 at our all-staff meeting. 9. All nursing staff educated on the 5R's of medication administration by V2, DON, on 9/17/25. 10. V6 and V27 were educated and completed competent in medication administration on Narcan, Epinephrine, and Baqsiumi on 9/17/25. 11. 100% of nursing staff was educated on medication administration on 9/17/25. 12. DON or Designees will audit medication administration 2 times a week for 3 months. This began on 9/17/25. 13. DON or Designee will audit 3 residents 2 times weekly to ensure blood sugar are within normal limit per MD orders for 3 months this began on 9/17/25. 14. DON or designee will perform an audit to ensure all emergency was handled correctly. This started on 9/17/25. This will be ongoing for 3 months and reviewed in our QA meeting. 15. The emergency kits and the cart will be audit weekly to ensure educational material is in place. This started on 9/17/25. This will be on going for 3 month and review in our QA meeting. This will be monitor by ADON or designee. 16. ADHOC QA completed with IDT regarding Policy and procedure on 9/15/25. 17. QA to review policy and procedure as part of Quality Assurance Process; next QA meeting. 18. This will be on going for 3 months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide a resident in a crisis condition the correct medication for 1 of 6 residents (R5) reviewed for medication errors in the sample of 50. This failure resulted in the R5 not receiving his Glucagon when needed resulting in his blood sugar dropping to a critical low and being transferred to the hospital and subsequently admitted to the Intensive Care Unit (ICU). The Immediate Jeopardy began on 9/10/25, when V6, Registered Nurse (RN), failed to appropriately respond to an emergent medical event, when R5 displayed symptoms of medical distress and presented with a blood glucose level of 33. V6 failed to follow physician's order of administering Baqsimi (Glucagon) for low blood sugar, and instead disassembled prefilled Epinephrine and Narcan cartridges, combining pieces of both medication cartridges, and administered Epinephrine injection nasally. On 9/16/25 at 2:15 PM, V1, Administrator, and V2, Director of Nursing (DON), were notified of the Immediate Jeopardy. The surveyor confirmed by interview, observation, and record review, the Immediate Jeopardy was removed on 9/17/25, but noncompliance remains at a Level 2 because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The Findings Include: R5's admission Record, dated 9/11/25, documents R5 was admitted to the facility on [DATE] with diagnosis of: Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Hypoxemia, Type 2 Diabetes Mellitus (DM), End Stage Renal Disease (ESRD), Dependent on Dialysis, Hypertension (HTN), anxiety disorder, and schizoaffective disorder. R5's Care Plan, dated 4/1/25, documents R5 has Diabetes Mellitus and Diabetic Neuropathy. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, Monitor/document/report PRN any s/sx (signs/symptoms) of hypoglycemia: Sweating, tremor, increased heart rate (Tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait, Monitor/document/report PRN (as needed) any s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, or coma. R5's Minimum Data Set (MDS), dated [DATE], documents R5 is cognitively intact and is dependent on staff for most Activities of Daily Living (ADLs). R5's Physician Order, dated 7/23/25, documents Baqsimi one pack nasal powder 3 MG (milligram)/dose (Glucagon) 1 pump in nostril as needed for low blood sugar. May repeat in 15-minutes. R5's Medication Administration Record (MAR)-Treatment Administration Record (TAR), dated September 2025, does not document that Baqsimi One Pack Nasal Powder 3 MG/Dose (Glucagon) was given to R5. There is no documentation of R5 receiving Narcan or Epinephrine (Epi). R5's SBAR (situation, background, assessment, and recommendation) Note, dated 9/10/25 at 8:08 AM, documents in part, Situation: The Change in Condition (CIC)/s reported on this CIC Evaluation are/were: Altered mental status. At the time of evaluation resident/patient vital signs and blood sugar were:- Blood Pressure: BP 120/70 - 9/10/25 at 8:09 AM,- Pulse: P 70 - 9/10/25 at 8:09 AM, Pulse Type: Regular- RR (respiratory rate): R 18 - 9/10/25- Temp: T 97 - 9/10/25 - Pulse Oximetry: O2 97.0 % - 9/10/25 Method: Oxygen via Nasal Cannula- Blood Glucose: BS 49.0 - 9/10/25 at 7:50 AM. Relevant medical history is: COPD Diabetes. Code Status: Full Code. Resident/Patient is on: Hypoglycemic medication(s)/Insulin. Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:- Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)- Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Nursing observations, evaluation, and recommendations are: Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: send for eval. On 9/11/25 at 11:05 AM, V6, Registered Nurse (RN), stated, I went in to see (R5) yesterday morning to check his blood sugar and he was lethargic, would only respond by opening his eyes when his name was called. His blood sugar was 49 at that (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time so I gave him some Ensure to drink, then got him some Glucagon spray from the E-Kit (Emergency Kit) and gave that to him. I then rechecked (R5's) blood sugar and it had dropped and was now reading 33. I called 911 to transport (R5) to the hospital. I do not recall giving (R5) anything else, including any injections. (V27, Licensed Practical Nurse (LPN) was the other nurse helping me with (R5).On 9/11/25 at 11:55 AM, V27, LPN, stated, (V6) asked me to come help her with (R5) and that she needed the E-Kit. I went and got the E-Kit and handed her a long tube-looking thing and a nasal spray. I saw her take out the long tube looking thing, then put the top from the nasal spray on the long tube thing and she gave it to (R5) in his nose. I did not give any drugs. If that was an Epi Pen, then yes, I handed it to her and that was my fault. I did an incident report, reported it to the NP (Nurse Practitioner) and the DON (Director of Nursing).On 9/11/25 at 1:41 PM, V28, Emergency Medical Technician Paramedic (EMTP), stated, When we arrived at the facility, we had a male unresponsive with a blood sugar of 42. We started an IV (intravenous catheter) and administered D10. When we were moving him from his bed to our stretcher, we found an Epi Pen with a Narcan nasal spray cap on top of it. When I asked the nurse about it, she said she gave him Glucagon. I had two other firefighters look at it and they both verified that it was an Epi Pen. Again, the nurse stated that she knew she gave Glucagon. We put the resident on the stretcher and left the facility and took him to the ER (emergency room). Upon our arrival to the ER, the resident was slightly more alert to verbal stimuli, and his glucose was up to 136. I told the ER and my EMS director about the Epi Pen, and they were going to report it.R5's Emergency Medical Service (EMS) Report, dated 9/10/25, documents in part: Arrived on scene, made entry into the facility and into pt (patient) room to find male pt lying in bed unresponsive. Nurse states pt is diabetic and his blood sugar was low. Nurse states she gave pt intranasal glucagon and placed him on a non-rebreather mask with 15 LPM (liters per minute) of O2 (oxygen). No staff is bedside with pt upon arrival. ALS (advanced life support) had arrived first on scene. Obtained blood glucose level via finger prick method. Value of 42. Started 18g (gauge) angiocath in pt left hand and flushed with saline before locking and securing with Tegaderm. Pt skin is warm and clammy at this time. Started 250 ML (milliliter) bag of D10% (glucose solution) using macro drip tubing. While D10 is infusing, pt is moved to the stretcher from his bed using bed sheet and assistance from FD (fire department). While moving pt, an Epi Auto Injector pen is found in pt. bed. Placed on top was the nasal piece used for intranasal Narcan. When staff nurse was asked why the Epi pen was in the bed, she stated that it was Glucagon, and she had administered it in an attempt to raise pt glucose level. Pen was handed to FD for confirmation. FD also confirmed that pen is an Epi pen and not Glucagon. Nurse continues to argue that it is Glucagon, and it must have been placed in the wrong spot, and she did not confirm before administration.On 9/11/25 at 9:50 AM, V24, Master Social Work (MSW)/Licensed Social Worker (LSW), stated I was working yesterday when (R5) arrived in the ER. The EMS guys gave us an Epi Pen that had a Narcan Cap from a intranasal administration unit on top of it and was told that the nurse at the facility gave this to (R5). The EMS told the ER staff that (R5) was unresponsive upon their arrival to the facility, they gave some D10 solution to raise his glucose and upon arrival to the ER, (R5) was awake, alert but still groggy. (R5) was admitted to the ICU for observation.On 9/11/25 at 12:05 PM, V6, RN, stated, I have to tell you what happened. I lied to you earlier. (V27) handed me the Epi Pen and Glucagon Nasal Spray and I did not even look at them to see what they were. I put the cap on the pen and tried to give it to (R5). Honestly, I don't even know if he got any of it. So much was going on at that time and the next thing I know, EMS was here and took over. I did give the EMS guys the Epi Pen and Nasal Spray. I'm not that familiar with these types of drugs. This was my first med error, and I feel horrible, especially about lying about it.On 9/11/25 at 2:40 PM, V2, DON, stated, There are tackle boxes with emergency medications in it, including Epi Pens, Narcan, and Baqsimi Nasal Powder. The nurses would grab this for emergency situations.On 9/15/25 at 10:25 AM, V3, LPN, stated, If I found a resident who was unresponsive, I would check their blood sugar, look for orders, and grab the medication that you put up their nose. I can't think of the name of it right now, but if I see it, I will know what it is. It is kept in the tackle box E-Kit. I would not (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	give Epi because it is not an allergic reaction, nor would I give Narcan because it is not an overdose. On 9/15/25 at 10:30 AM, V11, LPN, stated If I found one of my residents unresponsive, I would check their vital signs and blood sugar. If the blood sugar is low and they are not able to take something by mouth, I would go to the E-Kit and get the Glucagon nasal spray and administer it to them to get their blood sugar up. I would not give Epi for something like this because it is not an allergic reaction. On 9/11/25 at 2:10 PM, V2 stated I would expect the nurses to use the five rights of medication administration and follow the physician orders. On 9/15/25 at 10:50 AM, V2 brought in an Epi Pen and a Narcan Nasal Spray and attempted to demonstrate how V6 was administering R5's medication. V2 stated I doubt that he got any of the medication the way she put this together. I feel this is simply incompetent nursing. V2's Investigation, dated 9/11/25, documents Nursing Description: Nurse called into room and found resident's blood sugar to be 39. Blood sugar was retaken and decreased to 33. Nurse then went to medication room to obtain Glucagon nasal spray and Narcan nasal spray was given in error. Immediate action taken: NP was made aware of the Epi spray being given. VS-120/70, 70, 18, 97.0. Nursing stayed with resident and 911 called to transport resident to ER via stretcher. Resident was alert leaving the unit. V2 stated she is not finished with the investigation and will be in-servicing the nurses. On 9/15/25 at 2:13 PM, V29, Physician/Medical Director, stated I was only notified of (R5's) hypoglycemic episode and that he was sent to the hospital. No one mentioned to me that he was not given his glucose and was given something else. I have standing orders for Glucagon to be given and that should have been given. When told of V6 giving R5 an Epi Pen with the Narcan top and spraying up R5's nose, V29 stated Oh my God, that is unbelievable. I have never heard of such a thing. This could have been detrimental to (R5) and could have been fatal to him. He didn't get his Glucagon that was ordered, and his glucose could have continued to drop. This is truly unbelievable; the lack of competency could have subsequently determined (R5's) outcome, which could have been death in this case. I would expect the Nurse to administer medications as per my orders, and per appropriate route. According to the NIH - National Library of Medicine; Nursing Rights of Medication Administration - StatPearls - NCBI Bookshelf at https://www.ncbi.nlm.nih.gov/books/NBK560654/. Nursing Rights of Medication Administration: Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. The five traditional rights in the traditional sequence include: Right Patient, Right Drug, Right Route, Right Time, and Right Dose. According to the NIH - National Library of Medicine; SCOPE OF PRACTICE - Nursing Fundamentals - NCBI Bookshelf at https://www.ncbi.nlm.nih.gov/books/NBK610819. The Scope of Practice refers to services a trained health professional is deemed competent to perform and permitted to undertake according to the terms of their professional nursing license. Nursing scope of practice provides a legal framework and structured guidance for activities that practical nurses and registered nurses can perform based on their nursing license. Nurses must also follow standards when providing nursing care. Standards are set by several organizations, including your state's Nurse Practice Act, the American Nurses Association (ANA), agency policies and procedures, and federal regulators. These standards help guide nursing actions with the intent that safe, competent care is provided to the public. Nursing Process: The nursing process is a critical thinking model based on a systematic approach to client-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing client care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses (RNs), regardless of role, population, specialty, and setting, are expected to perform competently. Education: The registered nurse seeks knowledge and competence that reflects current nursing practice and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	promotes futuristic thinking. Quality of Practice: The registered nurse contributes to quality nursing practice. Resource Stewardship: The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and judiciously used. According to the NIH - National Library of Medicine; Nursing Rights of Medication Administration - Stat Pearls - NCBI Bookshelf at https://www.ncbi.nlm.nih.gov/book/NBK/560654/ documents in part Nursing Rights of Medication Administration. Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. The five traditional rights in the traditional sequence include: Right Patient, Right Drug, Right Route, Right Time, and Right Dose. The Facility's Medication Administration Policy, dated 10/2024, documents in part Administration of Medications: Medications must be administered in accordance with a Physician's order, e.g., the Right Medication, Right Dosage, Right Route, and Right Time. The Immediate Jeopardy that began on 9/10/25 was removed on 9/17/25 when the facility took the following actions to remove the Immediacy: 1. All nurses were educated on the use of Emergency Medications by V2, DON, on 9/11/25. 2. Any nurses that are not available in person have been contacted via phone. If not reachable, will be educated prior to taking shift by DON or designee. 3. 9/15/2025, V2, DON, V30, LPN, and V31, RN, ADON reviewed the incident. 4. 100% Nursing staff has been educated on the signs and symptoms of hypoglycemia and hyper glycemia by V2, DON, and V31, RN, ADON on 9/15/25. 5. Any nurses that are not available in person have been contacted via phone. If not reachable, will be educated prior to taking shift by DON or designee. 6. On 09/10/ 2025 NP was notified of the change in condition and MD notified of the resident being hypoglycemia and being sent to ER. 7. V6 and V27 educated on ensuring right medication and dose prior to medication administration by V2, DON, on 9/15/25. 8. All nursing staff educated on the 5R's of medication administration by V2, DON, on 9/15/25. 9. V6 and V27 were educated and completed competent in medication administration on Narcan, Epinephrine, and Baqsimi on 9/15/25. 10. 100% of nursing staff was educated on medication administration on 9/15/25. 11. DON or Designees will audit medication administration 2 times a week for 3 months. This began on 9/15/25. 12. DON or Designee will audit 3 residents 2 times weekly to ensure blood sugar are within normal limit per MD orders for 3 months this began on 9/15/25. 13. The emergency kits and the cart will be audit weekly to ensure educational material is in place. This started on 09/15/25. This will be on going for 3 month and review in our QA meeting. This will be monitor by ADON or designee. 14. ADHOC QA completed with IDT regarding Policy and procedure on 9/15/25. 15. QA to review policy and procedure as part of Quality Assurance Process; next QA meeting. 16. This will be on going for 3 months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to dispose of an expired Tuberculin vial and to safely secure medications in a medication cart while sitting in the hallway and available for all residents and visitors to get into. Reviewed for medication labeling and storage in the sample of 50. This failure has the potential to affect all residents living in the facility. The Findings Include: 1. On [DATE] at 10:18 AM, the Medication Cart on the end of the 200-hall was observed sitting in the hallway unlocked with no staff member around it. V7, Certified Nursing Assistant (CNA), stated, The Nurse had to go to central supply to get something and should be back soon. On [DATE] at 10:25 AM, V6, Registered Nurse (RN), came back to the cart and stated, The cart is broken, and we are waiting for the pharmacy to come fix it. We are unable to lock it and if we did, we can't get it back open. The drawers on the right side are locked, and we are not able to open those drawers, if needed, we have to go get the med from stock or emergency supply. On [DATE] at 10:30 AM, V8, Regional Nurse Consultant was notified of broken and unlocked medication cart sitting in the hall. V8 stated, I was not aware of that, and we can't have a cart left in the hallway unlocked. I will get this taken care of immediately. On [DATE] at 9:55 AM, R12 stated, The med cart has been broken since last Friday ([DATE]) because the nurse tried to get it open to give him his medications and she couldn't get it open. On [DATE] at 9:57 AM, V12, CNA, stated, (R12) would probably know because he keeps up with what goes on around here. R12's Minimum Data Set (MDS), dated [DATE], documents R12 is cognitively intact. On [DATE] at 11:00 AM, the med cart on the 4th floor was seen unlocked in the hall with no staff around. On [DATE] at 11:12 AM, the med cart on the 3rd floor was seen sitting in the hall unlocked with no staff around. On [DATE] at 2:10 PM, V2, DON, stated I would expect the nurses to use the five rights of medication administration. I would expect the nurses to keep the medication carts locked at all times when walking away from the cart. 2. On [DATE] at 10:46 AM, the 300-hall medication room was checked. In the medication refrigerator, there was an opened multidose bottle of Tuberculin protein derivative Diluted/Aplisol 5TU/0.1 milliliters, 5ML/50 test that was opened on [DATE]. On [DATE] at 10:35 AM, V4, LPN, stated that on the 4th floor, they do not keep the tuberculin testing serum on their floor and that she gets it from either 2nd or 3rd floor medication room. On [DATE] at 10: 55 AM, the 200-hall medication room was checked and there was not a bottle of Tuberculosis testing serum in the refrigerator. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:00 AM V2, Director of Nurses, stated that they have a bottle of tuberculosis test in the 3rd floor medication room that they have been using if there wasn't any in the 200-hall medication room. On [DATE] at 3:15 PM, V1, Administrator stated the bottle of Tuberculin, dated [DATE], should have been thrown away a long time ago. The Facility's Medication Storage Policy, dated 4/2025, documents To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles. 3. General Storage Procedures: 2. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 5. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated [DATE], documents there were 128 residents residing in the facility.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 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. The facility failed to use hair nets while in the kitchen, to provide paper towels for hand hygiene, to label food items stored in the refrigerator, and to dispose of expired food items. This has the potential to affect all residents in the facility. The Findings Include: 1. On 9/7/25 at 8:50 AM, while doing the initial kitchen tour, V18, Dietary Aide, and V19, Dietary Prep, were seen with no hair net on and upon surveyor entrance, both were seen going and getting a hairnet and putting one on. 2. There were no paper towels available for handwashing at the handwashing sink. 3. A large piece of ham was seen in the refrigerator wrapped in plastic wrap and undated. 4. A large pan of sliced tomatoes was seen in the refrigerator covered in plastic wrap and undated. 5. A pan of mixed vegetables was seen in the refrigerator covered in plastic wrap and undated. 6. On the fourth-floor dry food storage room, there were three packages of hot dog buns that expired on 9/4/25. On 9/7/25 at 9:00 AM, V20, Cook, stated The items in the fridge should have been dated, especially since they are prepped and ready to eat items. The delivery guy usually rotates the bread when delivered, so I'm not sure why we have expired buns. On 9/11/25 at 2:15 PM, V21, Dietary Manager, stated I would expect the dietary staff to wear hair nets while in the kitchen, label all food items that are opened and/or prepped and placed in the refrigerator, and to dispose of any food items that are expired. The Facility's Food & Supplies: Storage Policy, dated 1/2024, documents in part Food and supply storage areas shall be maintained in a clean, safe and sanitary manner. 4. Prepared foods stored in the refrigerator until service will be covered, labeled, and dated with an expiration date. 6. All foods will be covered, labeled, and dated. If there is no expiration date on the package or container, a use-by-date must be written on the product. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 9/7/25, documents there were 128 residents residing in the facility.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement enhance barrier precautions and change gloves when soiled for 5 of 32 residents (R1, R4, R12, R40 and R121) reviewed for infection control in the sample of 50. Findings include: 1. On 09/09/2025 at 12:11PM V9 wound nurse and V16 Certified Nursing Assistant (CNA) entered R1's room. V16, CNA did not sanitize hands, don gloves, or gown prior to entering R1's room. Sign on wall beside R1's door documents enhanced barrier precautions. While standing at R1's bedside V16 sanitized hands and donned gloves. V16, CNA did not don a gown. V16 with gloved hands assisted V9 to roll R1 towards V16 for V9, wound nurse to do wound care to R1. Enhanced Barrier Precautions sign documents Stop, everyone must clean their hands, including before entering and when leaving room. Providers and staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: wound care: any skin opening requiring a dressing, central line, urinary catheter, feeding tube tracheostomy. R1's Physician Orders (PO) dated 6/17/2025 documents enhanced barrier precautions. 2. R12's admission Record, dated 9/11/25, documents R12 was admitted to the facility on [DATE] with diagnosis of Furuncle of groin, abscess of groin, infection following a procedure/surgical site, open wound to right lower leg, and Type 2 Diabetes Mellitus. On 9/9/25 at 9:25 AM, V11, Licensed Practical Nurse (LPN), was observed doing wound care on R12. V11 removed the old dressing on R12's right medial calf which was dated 9/7/25 and was not changed prior day (9/8/25). R12 pulled his pants down and assisted V11 to provide wound care to his scrotum/penis area. V11 cleansed R12's wound with Normal Saline (NS) to 4X4 gauzes, then used the same gloves to get a sterile Q-Tip and applied meta-honey to the wound site. V11 doffed her Personal Protective Equipment (PPE) when R12 mentioned that his lateral calf has been oozing for about a week now. V11 examined R12's lateral calf and there was a small open area noted with slight ooze. V11 donned PPE, cleansed the wound with NS and 4X4 gauzes, then used the same gloves and got a sterile Q-Tip and applied meta-honey to the open areas, and then applied a dressing. V11 failed to change gloves when going from soiled, cleaning the wound, to applying meta-honey and then a dressing. 3. R121's admission Record, dated 9/11/25, documents R121 was admitted to the facility on [DATE] with diagnosis of Cerebral Palsy, Paraplegia, and malnutrition. On 9/9/25 at 12:15 PM, V14, CNA, and V15, CNA, was observed providing peri-care on R121. V14 brought in supplies and placed on bedside table. An Enhanced Barrier Precaution (EBP) sign was on the door with PPE hanging on the door. V14 had water running in the sink when V15 called V14 to the door and told V14 that he had to don PPE first, then they both walked in with PPE on. V15 held R121 while V14 provided peri-care and catheter care on R121. During the care, V14 had gloves on which he wiped R121's buttocks and anal area after cleaning feces off once, changed gloves, then wiped R121's buttocks and anal area off again and then using the same soiled gloves, used the remote to the bed and raised the bed slightly, then continued to provide care to R121 including drying, putting clean brief down, and adjusted R121 in bed and covered R121 up with his sheet all with the same soiled gloves on. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/25 at 2:10 PM, V2, DON, stated I would expect all staff to use appropriate hand hygiene and glove changes during resident care. 4. On 09/07/2025 at 10:02 AM V3, Licensed Practical Nurse (LPN) entered R4's room to give a 125 milliliter (ml) water flush. V3 turned off the feeding pump, disconnected the tubing from the G-tube and gave R4 a 125 ml water flush through the G-tube. V3 failed to wear a gown. R4's Physician Order, dated 8/8/25, documents, ENHANCED BARRIER PRECAUTIONS D/T (due to) RISK FACTORS OF: FOLEY CATHETER, G-TUBE & WOUNDS. R4's admission Record, print date of 9/10/25, documents, R4 was admitted on [DATE] and has diagnosis of gastrostomy status. On 9/11/25 at 11:54 AM, V3, Licensed Practical Nurse (LPN), was questioned why she did not wear a gown while caring for R4, V3 stated, I am new here and I have never seen anyone wear a gown. 5. On 9/8/25 at 11:35 AM V9, LPN/Wound Nurse entered R40's room to change his left heel pressure ulcer and change his right upper leg dressings. V9 was wearing gloves, but no gown. V9 opened the door and went back to the wound cart to get a marker, V9 returned and removed the old dressing. V9 change gloves with hand hygiene in-between. V9 cleansed the pressure ulcer, change the right glove only with no hand hygiene in between, applied the Medihoney, and foam dressing. R40's Physician Order, dated 9/2/25, documents, ENHANCED BARRIER PRECAUTIONS D/T RISK FACTORS OF: WX'S (wounds). R40's admission Record, print date of 9/10/25, documents R40 was admitted on [DATE] and has a diagnosis of Emphysema. On 9/11/25 at 12:17 PM, V2, Director of Nurses, stated gowns should be worn with dressing changes and G-tube. V9 told me she didn't wear a gown. The policy Enhanced Barrier Precautions, dated 3/25, documents, Enhanced Barrier Precautions (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: gown and gloves. EBP may be considered and implemented for: Wounds and / or indwelling medical devices. Personal Protective Equipment: 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, Wound Care. The policy hand Hygiene / handwashing, dated 5/25, documents, Examples of When to Perform Hand Hygiene. Before glove placement. After glove removal. The policy Glove Use & Nursing, dated 10/24, documents, 3. Gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0684 Level of Harm - Minimal harm or potential for 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** Based on Interview, Observation, and Record Review, the facility failed to identify and treat a resident's wounds for 1 of 6 residents (R12) reviewed for wound care in the sample of 50. The Findings Include: R12's admission Record, dated 9/11/25, documents R12 was admitted to the facility on [DATE] with diagnosis of Furuncle of groin, Abscess of groin, Infection following a procedure/surgical site, Open wound to right lower leg, Type 2 Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), Atherosclerotic Heart Disease (ASHD), Congestive Heart Failure (CHF), and Hypertension (HTN). R12's Care Plan, dated 7/29/25, documents R12 has a potential for impairment to skin integrity related to decreased mobility. Interventions: Assess/record changes in skin status, follow facility protocols for treatment of injury, pressure relieving/reducing cushion to protect the skin while up in chair, pressure relieving/reducing mattress to protect the skin while in bed, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. It continues 8/14/25: R12 has a surgical incision/ wound. Site: right lateral calf and right medial calf. Interventions: Keep incision site clean/dry, monitor site for signs/symptoms of infection, treatment as ordered. It continues 11/14/24: R12 is on Enhanced barrier precautions related to chronic wounds. It continues 8/14/25: R12 has an unstageable pressure ulcer to left heel. R12 has abrasion to right toes. 9/19/24: R12 no longer wants the facility wound nurse to follow his wounds. R12 feels that she cleans them too hard, and he wants the floor nurses to perform his treatments. Interventions: Administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the Medical Doctor (MD), follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing during cares to ensure it is intact and adhering, report loose dressing to nurse, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. R12's Minimum Data Set (MDS), dated [DATE], documents R12 is cognitively intact and requires supervision/touching assistance for all Activities of Daily Living (ADLs). R12's Physician Order (PO), dated 8/29/25, documents Cleanse open areas to scrotum with NS (normal saline)/house wound cleanser, pat dry, apply medi-honey to open areas only daily and PRN (as needed), every day shift and as needed. R12's PO, dated 8/22/25, documents Skin prep area to right inner heel daily and PRN, every day shift and as needed. R12's PO, dated 5/15/25, documents Weekly Skin Assessment. Every night shift every Mon (Monday) notify MD (medical doctor) if new impairment and complete other skin condition UDA (user defined assessment). R12's PO, dated 9/9/25, documents Cleanse area to right lateral calf with wound cleanser, pat dry, apply medi-honey to wound bed and cover with bordered gauze daily and PRN, every day shift for wound care and as needed for wound care. R12's PO, dated 9/9/25, documents Cleanse right medial leg with wound cleanser, pat dry, apply medi-honey to bed and cover with bordered gauze daily and PRN, every day shift for wound care and as needed for wound care. R12's Skin Condition Report, dated 9/20/24, documents R12 had a new skin concern, pinprick open area, scrotum on left side, pinprick area of bleeding no redness around it and does not appear to be ingrown hair, new orders: foam dressing to cover daily and PRN. There is no other skin condition report completed until 9/9/25. R12's Skin Condition Report, dated 9/9/25, documents R12 has a new skin concern, Excoriation/Denuded Skin, open areas caused by edema, right lower leg (front) Medial 14.2x2.0x0.1, right lower leg (front) Lateral 1.1x0.3x0.1, no ss (signs/symptoms) of infection. Wound bed pink, scant serosanguinous exudate, cleanse daily apply medi-honey and bordered gauze. R12's Monthly Charting document (assessment), dated 8/22/25, does not document anything for R12's skin conditions. R12's Monthly Charting document (assessment), dated 7/22/25, documents No new changes to skin integrity noted. On 9/7/25 at 9:52 AM, R12 stated he does not wear pants due to edema to his scrotum and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right leg. R12 has an old undated dressing to his right leg with the gauze wrap falling to his ankle and old xeroform packing stuck to the open sites to his medial calf. The dressing appeared to be very heavily soiled, brown in color with oozing from wound. R12 stated they haven't changed his dressing in a while and doesn't remember last time it was changed. R12 stated they are supposed to change it every day. On 9/8/25 at 10:05 AM, R12 observed lying in bed with a new dressing to his right medial calf and now dated 9/7/25. On 9/9/25 at 9:25 AM, V11, Licensed Practical Nurse (LPN), was advised that R12 needed wound care done. V11 stated she was not aware of R12's dressing to his right leg. V2, Director of Nursing (DON), was standing at the med cart reviewing R12's orders and stated that she did not see any orders for wound care or dressing changes to R12's Right Lower Extremity (RLE). V11 removed the old dressing from R12's right medial calf which was dated 9/7/25 and was not changed yesterday (9/8/25). V11 used NS to a 4X4 gauze and wiped R12's right medial calf wound which measured at 14.2 CM (centimeters) long X 2 CM wide X 0 CM deep. R12 pulled his pants down and assisted V11 to provide wound care to his scrotum/penis area. V11 cleansed R12 scrotum/penis area with NS on 4X4 gauzes, then used the same gloves to get a sterile Q-Tip to apply medi-honey to site. V11 doffed her PPE when R12 mentioned his lateral calf has been oozing for about a week now, V11 examined R12's lateral calf and there was a small open area noted with slight ooze and measured at 1.1 CM long X 0.3 CM wide X 0 CM deep. V11 wiped the wound with NS on 4X4 gauzes, then used the same gloves and got a sterile Q-Tip to apply medi-honey to the open area and then applied a dressing. V11 stated she was not aware of either of R12's wounds to his right leg and will have to let the doctor know. V11 failed to change gloves when going from soiled areas, cleaning the wounds, to applying meta-honey and then a dressing. On 9/9/25 at 2:25 PM, V9, LPN/Wound Nurse, stated I was off for the past week and was not made aware of (R12's) wounds to his right calf. I did educate the nurses that if they find a new wound during skin assessments, they are to put something (a wound care order) in place temporarily, then notify me so I can assess the wound and determine if the appropriate wound care orders were in place. I would notify the physician and discuss the wound and care needed. I did not know about (R12's) wounds until today. Those are new wounds for (R12) because he did not have them the last time I took care of him. I don't know how long he has had them or who found them. The DON (Director of Nursing) told me about (R12's) wounds and that there were no orders in place to take care of them. On 9/15/25 at 9:35 AM, V2 stated I would expect the nurses and/or CNAs to report any new wounds or skin conditions to the wound nurse in order to obtain physician orders for treatment. The Facility's Skin Condition Assessment and Monitoring - Pressure and Non-Pressure, dated 4/2025, documents in part Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) will be assessed for healing progress and signs of complications or infection weekly. A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. Residents identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. 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 charge nurse who will perform the detailed assessment. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing/25 progress notes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to prevent and assess a pressure ulcer for 1 of 7 residents (R10) reviewed for pressure ulcers in the sample of 50. Findings include: R10's admission record, print date of 9/11/25, documents R10 was admitted on [DATE] and has diagnoses of Multiple Sclerosis and Traumatic Brain Injury. R10's Minimum Data Set, dated [DATE], documents R10 is moderately cognitively impaired, requires partial to moderate assistance with dressing, toileting, bed mobility, and transfers. R10's Braden Observation, dated 6/6/25, documents R10 is at moderate risk for pressure ulcers. R10's Nursing Note, dated 7/17/25, documents, Writer obtained consent from resident for res (resident) to be seen and treated by (wound clinic). Services are to begin 7/24/25. R10's, undated, Wound Summary documents R10 has a Facility Acquired Pressure ulcer on the coccyx that was identified on 7/16/25. R10's, undated, Wound Summary documents on 7/21/25 R10's coccyx pressure ulcer was partial thickness of slough white fibrinous tissue with scant serosanguineous drainage measuring 2.5 cm (centimeters) in length x 3 cm wide. R10's, undated, Wound Summary documents on 7/28/25 R10's coccyx pressure ulcer was unstageable with 30% slough white fibrinous tissue and 70% necrotic soft tissue measuring 3.4 cm in length and 2 cm wide. R10's Electronic Medical Record fails to document a coccyx pressure ulcer assessment on 7/16/25 or 7/17/25. R10's July 2025 Treatment Administration Record, documents Cleanse area to coccyx with normal saline/house wound cleanser, pat dry, apply calcium alginate cut to size and cover with mepilex daily and PRN (as needed) every day shift -Start Date of 07/17/2025 0600.R10's Nursing Note, dated 9/4/25, documents, Wound culture obtained on coccyx wound this AM while rounding with wound MD. Wound has slough and foul odor noted. On 9/9/25 at 1:12 PM, V9 Licensed Practical Nurse/ Wound Nurse, removed R10's coccyx dressing. The dressing had serous drainage on it. The wound had a foul odor. The wound bed was cleansed with normal saline. The wound bed is brown with white slough. The peri wound is bright red. The pressure ulcer measures 3.7 cm in length, 2.6 cm wide, and 1.9 cm deep. On 9/8/25 at 2:30 PM, V2, Director of Nurses, stated that there was not an initial assessment of R10's coccyx pressure ulcer and there should have been one done when it was found. On 9/9/25 at 1:10 PM, R10 stated that his buttocks hurt, and he does not know when he got the pressure ulcer. On 9/9/25 at 1:17 PM, V9 stated that the wound culture was rejected by the laboratory because the specimen was not collected on the labs swab. The lab never notified the facility that the culture wasn't accepted. We were just waiting for the results because it takes a while for a culture. R10 is being sent to the hospital so they can culture it. V9 stated R10 had C.Diff (chloridoids difficile colitis), and he became weaker with the C Diff and being weaker he got the pressure ulcer and then it just grew. The Skin Condition Assessment & Monitoring - Pressure and Non - Pressure, dated 04/2025, documents, A wound assessment will be initiated and documented in the resident chart when pressure and / or other non-pressure skin conditions are identified by licensed nurse. It continues, The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to check for placement or residual of a Gastrostomy tube (G-tube) for 1 of 2 residents (R4) reviewed for G-tubes in the sample of 50. Findings include: On 09/07/2025 at 10:02 AM V3, Licensed Practical Nurse entered R4's room to give a 125 milliliter (ml) water flush. V3 turned off the feeding pump, disconnected the tubing from the G-tube and gave R4 a 125 ml water flush through the G-tube. V3 failed to check for residual.R4's admission Record, print date of 9/10/25, documents, R4 was admitted on [DATE] and has diagnosis of gastrostomy status.R4's Physician Order, dated 8/16/24, documents, Enteral Feed Order every shift Enteral - Check Tube Placement before feeding, Flush and Meds (medications).On 9/11/25 at 11:54 AM, V3, Licensed Practical Nurse (LPN), was questioned why she did not check for residual before giving the water flush. V3 stated, I checked for residual, then left the room, and then came back to give the water.On 9/11/25 at 12:17 PM, V2, Director of Nurses, stated the residual should have been checked before giving the water flush.The policy Medication Administration - gastrostomy or Nasogastric Tube, dated 8/202, document, Check tube for proper placement: Gastrostomy Tube: Aspirate to visually verify stomach contents.		