STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145248	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Morton	190 East Queenwood Road Morton, IL 61550

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38805 Based on record review and interview, the facility failed to obtain a Pre-Admission Screening and Resident Review (PASARR) and/or Level II Resident Reviews for three residents (R17, R32, R60) of six residents reviewed for diagnosed mental illness in the sample of 18. Findings include: The facility's Preadmission Screening and Annual Resident Review (PASARR) Policy dated 3/2024 documents: Annually and with any significant change of status, the facility will complete the PASARR Level I screen for those individuals identified per the Level II screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly. 1. R17 was admitted to the facility on [DATE]; R17 was diagnosed with Schizoaffective Disorder with diagnosis date of 2/4/23. R17 does not have a PASARR screening in her current electronic medical records, and there is no evidence that a PASARR was initiated at the time of R17's Schizoaffective Disorder on 2/4/23. 2. R60 was admitted to the facility on [DATE]; R60 was diagnosed with Other Schizoaffective Disorder with diagnosis date of 10/2/23. R60 does not have a PASARR screening for his Other Schizoaffective Disorder in his current electronic medical records; and no evidence that a PASARR was initiated at that time. (Internet definition of Schizoaffective Disorder, dated 2/20/25, documents: Schizoaffective disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression.) On 2/20/25 at 12:15pm, V14 Business Office Manager/BOM stated that the facility's procedure for significant change/new diagnosis for mental illness would be Staff would usually get a psychiatric eval for the residents, check with Nursing regarding new PASARRs, and then would do the agency notifications; this was not done. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At this time, V14 stated that he came to the facility in October 2024; confirmed there were no PASARR Level I's and/or Level II's for R17 or R60's new diagnoses; and confirmed that the screenings should have been done. On 2/20/25 at 12:15pm, V14 stated that R17 was Grandfathered in on OBRA (Omnibus Budget Reconciliation Act) when she was admitted . V14 stated, We do not have PASARR screenings for R17's Schizoaffective disorder. On 2/20/25 at 10:05am, V14 stated that the facility did not do a PASARR for R60 for his new diagnosis; stated that All we have is the grandfathered OBRA screening for R60. 30722 3. R32's OBRA (Omnibus Budget Reconciliation Act) dated 09/10/18 documents R32 was admitted on [DATE] and indicated nursing facility services were appropriate. R32's Diagnosis Sheet documents on 01/24/20, R32 had a diagnosis of Schizophreniform Disorder. There was not a PASARR (Preadmission screening and resident review) II screening for further review after R32 was diagnosed with Schizophreniform Disorder. On 02/20/25 at 10:00 AM V1/Administrator stated he cannot provide a PASARR II for R32.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38805 Based on record review and interview, the facility failed to notify the appropriate state mental health/intellectual disability authorities for newly diagnosed mental illness for two residents (R17, R60) of six residents reviewed for mental illness in the sample of 18. Findings include: The facility's Preadmission Screening and Annual Resident Review (PASARR) Policy dated 3/2024 documents: The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly. F. Coordination of Care: iv. The facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative. 1. R17 was admitted to the facility on [DATE]; R17 was diagnosed with Schizoaffective Disorder on 2/4/23. 2. R60 was admitted to the facility on [DATE]; R60 was diagnosed with Other Schizoaffective Disorder on 10/2/23. On 2/20/25 at 10:05am, V14 Business Office Manager/BOM confirmed that (V14) was responsible for initiating PASARR screenings in coordination with V9 Social Services Director/SSD; and on 2/20/25 at 12:15pm, V14 confirmed that R17 had a new diagnosis of Schizoaffective Disorder and R60 had a new diagnosis of Other Schizoaffective Disorder. On 2/20/25 at 12:15pm, V14 stated that the procedure for these significant change/new diagnoses was: Staff would usually get a psych eval for the residents and check with Nursing regarding new PASARRs, then would do the agency notifications. V14 stated at this time that he became employed at the facility in October 2024; stated there were no PASARR screenings initiated for R17 or R60's newest diagnoses, there were no notifications regarding their significant changes sent to authorities, and stated that these should have been done.

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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. 33975 Based on observation, interview and record review the Facility failed to maintain intact right inner thigh and left inner ankle wound dressings for one Resident (R12) of 18 Residents reviewed for skin conditions in a sample of 30. Findings include: The Facility Skin Condition Assessment and Monitoring (Pressure and Non-Pressure) Policy, revised 6/2018, documents: 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; non-pressure skin conditions 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; dressings which are applied to wounds shall include the date of the licensed nurse who performed the procedure; the dressing will be checked daily for placement, cleanliness and signs/symptoms of infection; and a licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Facility Wound Physician Report, dated 2/18/25, documents R12's right thigh etiology as trauma/injury and R12's left ankle etiology as Diabetic. R12's right thigh measures 6.0 centimeters/cm by 3.0 cm by 0.2 cm and left ankle measure 0.8 cm by 0.8 cm by 0.1 cm. R12's Treatment Administration Record, dated 2/18/25, documents a Physician's treatment order for R12's right inner thigh (cleanse with wound cleanser, medicated covering/hydrocolloid and dry foam dressing) and a treatment to R12's left inner ankle (cleanse with wound cleanser, apply ointment/gentamycin and cover with gauze dressing). On 2/18/25 at 10:12 am and 1:15 pm, R12's right inner thigh did not have a wound dressing. R12's open right inner thigh wound was exposed to R12's incontinent pad and incontinence brief. R12's left inner ankle dressing was not dated/signed and fifty percent/half of the dressing was not adhered to R12's left inner ankle. On 2/18/25 at 10:12 am, R12 stated, I told them a couple hours ago that my dressing on my thigh came off and my ankle dressing is coming off too, but they still have not come in to do the treatments. R12's incontinence brief was soiled and not positioned over R12's peri-area, exposing R12's right inner thigh wound to the soiled incontinence brief. On 2/28/25 at 12:45 pm, R12 stated, They still have not been in to do my treatments. R12's right inner thigh did not have a wound dressing and left inner ankle was not dated/signed and fifty percent/half of the dressing was not adhered. On 2/18/25 at 2:06 pm, R12 stated, The nurse (V5/Licensed Practical Agency Nurse) finally just came in and changed my dressings and I have told them a few times, so they knew they needed changed. This happens all the time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 11:48 am, V5 (License Practical Agency Nurse) verified that R12's dressing had not been changed and stated, I will get to it after I get my 'meds' passed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50962 Based on observation, interview, and record review the facility failed to provide an appropriate indication for use of antipsychotic medication for one of five (R83) with a diagnosis of dementia in a sample of 30. Findings include: The facility's policy titled Psychotropic Medication - Gradual Dosage Reduction, revised 2/2018 documents, To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice and are prescribed at the lowest therapeutic dose to treat such conditions. R83's Admission Record documents that R83's date of admission to the facility was 11/25/24 and her diagnoses on admission include Dementia with other behavioral disturbance, Anxiety Disorder, Delusional Disorders, Depression, Dementia (mild) without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R83's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status score of 7/15, indicating severe cognitive impairment, Section E documents no hallucinations, delusions; behaviors toward others 1-3 days and wandering behaviors 1-3 days. R83's Physician Order dated 11/25/24 documents R83 has an order for Fluphenazine (antipsychotic) 5 milligrams(mg) give one tablet by mouth at bedtime for psychosis. R83's psychiatric note dated 1/28/25, documents that R83 takes Fluphenazine (antipsychotic) for Behavioral and Psychological Symptoms of Dementia (BPSD). R83's Behavior Monitoring and Interventions dated 1/22/25 through 2/20/25 documents no behaviors observed. On 2/18/25 at 10:05am R83 is walking out of her bathroom to her wheelchair. She is dressed in clean clothes, well kempt and calm. On 2/19/25 at 12:30pm R83 sitting in her room in wheelchair eating lunch and she appears calm. On 2/20/25 at 9:20am, V9/Social Services stated, R83 is pleasantly confused. R83 has not had any behaviors since she has been here. On 2/20/25 at 9:23am, V12/Certified Nursing Assistant stated, R83 has no aggressive behaviors or any behaviors for that matter. R83 is sweet as pie. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 9:50am, V2/Director of Nursing stated that R83 admitted to facility on Fluphenazine (antipsychotic) for psychosis. V2 also stated, I cannot speak for psychiatry's diagnosis, we have not received orders to change the diagnosis. V2 stated she (V2) understands that behaviors of dementia are not an appropriate diagnosis for the use of R83's Fluphenazine (antipsychotic).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 33975 Based on observation, interview and record review the facility failed to administer medications as ordered. There were 34 opportunities with eight errors resulting in a 23.53% error rate. This applies to one of seven Residents (R12) observed in the medication pass. Findings include: Facility Medication Administration Policy, revised 1/2025, documents: Licensed Nurse may prepare, administer and record administration of medications; documentation of medication administration is recorded on the Medication Administration Record; and medications must be administered in accordance with a Physician's order. R12's Medication Administration Details, dated 2/18/25, documents Physician Orders for medications to be administered at 8:00 am (Leftunomide 20 milligram/mg one tab by mouth; Glipizide 10 mg one tab by mouth three times a day; Furosemide 20 mg one tab by mouth; Lantus SoloStar 30 units Subcutaneous/SQ two times a day; Oxybutynin Chloride ER 10 mg one tab by mouth; MVI with minerals one tab by mouth; Omeprazole 40 mg one tab by mouth; and Lefluonomide 20 mg one tab by mouth). The Medication Administration Details documents that Leftunomide 20 milligram/mg was administered at 10:38 am; Glipizide 10 mg at 10:41 am; Furosemide 20 mg was administered at 10:38 am,; Lantus SoloStar 30 units Subcutaneous/SQ was offered and refused at 11:02 am; Oxybutynin Chloride ER 10 mg was administered at 10:55 am; MVI with minerals was administered at 10:40 am; Omeprazole 40 mg was administered at 10:40 am; and Lefluonomide 20 mg as administered at 10:38 am. On 2/18/25, at 10:12 am, R12 stated, I already ate my breakfast and I still have not gotten my morning medications. I am Diabetic and I take insulin and diabetic medications. I am supposed to take my insulin and medication before my breakfast. On 2/28/25 at 12:10 pm, R12 stated, (V5/License Practical Agency Nurse) just came in about an hour ago, and tried to give me my morning medications. I told her that I was refusing my insulin because I already ate my breakfast and it is almost lunch time for gosh sakes, I did not want it messing up my other doses. On 2/18/25 at 11:48 am, V5 (License Practical Agency Nurse) stated, I know that I am late passing a lot of my morning medications. I went in to give (R12's) 8:00 am medications around 10:45 am, and (R12) took all of the medications, but refused the insulin. (R12) said it was too close to lunch time for the insulin. On 2/18/25, at 12:15 pm, V2 (Director of Nursing) stated, It looks like (V5) started passing (R12's) 8:00 am medications between 10:30 am and 11:00 am. Medications should be administered according to the Physician's orders and what time is documented on the Treatment Record.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50962 Based on observation, interview, and record review the facility failed to serve food that was visually appealing and palatable to residents. This failure has the potential to affect 78 residents in the facility who are prescribed oral intake. Findings include: Facility Matrix documents 80 residents reside in the facility. Two residents require feeding tubes and do not eat. On 2/18/25 at 11:35am, the lunch meal plating of beef stroganoff, steamed zucchini and chilled pears was observed being served from the kitchen and delivered to the residents in the dining room. During the plating of the food, the pears were in a designated separate bowl. The steamed zucchini was plated without being drained on the same plate as the beef stroganoff, and a moderate amount of standing zucchini water/liquid was mixed with the beef stroganoff causing the plated food to look moderately watery and unappetizing. R37, R39, R43, R52, and R71 did not eat served lunch and requested grilled cheese as an alternative. On 2/19/25 at 10:32am, R22 stated he does not like the food that is served. On 2/19/25 at 10:35am R2, R20, R25, R52 and R66 agreed that the food is often not warm, especially room trays. R22 stated the food is often not pleasing to taste. R38 stated the food is too salty. On 02/19/25 at 11:05am, V10/Ombudsman stated, The food palatability is a recurring issue that is brought up monthly at resident council meetings and often not addressed by staff. V10 also verified that V10 has seen the Resident meal trays, and the food is seldom appealing. On 2/20/25 at 9:30am, V2/Director of Nursing verified that two residents residing in the Facility do not eat and take nothing by mouth.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 50962 Based on observation, interview, and record review, the facility failed to ensure two large trash dumpsters are secured from pest and rodents, in that the lids of the trash dumpsters were not closed. This failure has the potential to affect all 80 residents residing in the facility. Findings include: Facility Policy, titled Trash Disposal, not dated, documents: The dietary department should dispose of trash appropriately and maintain the dumpster area for cleanliness and prevention of rodents. To prevent the spread of infection and deter pests and rodents. 2. The dietary department should ensure the dumpster lids are closed when disposing of trash and that no trash is on the ground surrounding the dumpster. The Department of Health and Human Services Centers for Medicaid and Medicare Services, Form 671-Long-Term Care Facility Application for Medicare and Medicaid, dated 2/18/25, documents 80 residents reside in the facility. On 02/19/25, at 11:01am, during follow-up tour, with V7/Regional Dietary Manager, the two trash dumpsters, located outside, had lids which were open, and one dumpster was over filled with facility trash. On 02/19/25, at 11:10am, V7/Regional Dietary Manager confirmed the trash dumpster lids should have been closed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33975 Based on observation, interview and record review the Facility failed to perform hand hygiene after providing care, when removing contaminated gloves and touching contaminated gloves for one Resident (R51) and failed to follow their policy on Enhanced Barrier Precautions for two residents (R35, R64) of 18 reviewed for Infection Control in a sample of 30. Findings include: Facility Hand Hygiene/Handwashing Policy, revised 3/2023, documents: hand hygiene means cleaning your hands by using either handwashing with soap and water or alcohol based hand sanitizer; perform hand hygiene after direct contact with patient's intact skin, after contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings; after contact with inanimate objects, before glove placement and after glove removal. An Enhanced Barrier Precautions policy last revised 03/2024 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 multi drug resistant organism status This policy also documents, EBP may be considered and implemented for wounds and/or indwelling medical devices (central line, feeding tube, tracheostomy, drains, etc. Personal protective equipment (PPE): Standard precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: medical device care. 1. R51's Physician Order Sheet, dated 2/20/25, documents orders for: enteral feed one time a day (Two Cal 2.0 at 55 milliliters/ml an hour) and to cleanse the feeding tube site with soap and water and apply split gauze; and indwelling urinary suprapubic catheter care every shift. On 2/19/25 at 8:35 am, V2 (Director of Nursing/DON) and V3 (Wound Nurse) were performing indwelling urinary suprapubic catheter care and feeding tube care to R51. Upon entrance to R51's room, a Transmission Based Precaution sign was present on the entrance entrance door to R51's room. While putting on gloves, V2 (DON) dropped a glove on R51's floor, and V2 picked up the glove off of the floor and disposed the glove into the trash can. V2 then retrieved a new glove from a supply cart in R51's room, and put it on and assisted V3 (Wound Nurse) with positioning R51. No hand hygiene was performed. On 2/19/25 at 8:35 am, V3 (Wound Nurse) completed indwelling suprapubic catheter care, changed contaminated gloves and performed hand hygiene. Then V3 performed feeding tube care to R51. V3 removed the contaminated gloves and put on a new pair of gloves, without performing hand hygiene. V2 and V3 positioned R51. V3 then pulled R51's bedding up over R51 and adjusted the bed with the bed controls. No hand hygiene was performed. On 2/20/25 at 1:15 pm, V1 (Administrator) verified that hand hygiene should be performed after contamination of gloves and after glove changes. 30722 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 02/19/25 at 1:51 PM V8/Licensed Practical Nurse entered R35's room. V8 provided catheter care to R35's indwelling urinary catheter wearing gloves and a mask. V8 did not wear a protective gown. On 02/19/25 at 2:47 PM V2/Director of Nursing stated her expectation would be that staff would wear gown and gloves when providing direct care to R35 due to him having an indwelling urinary catheter. 50962 3. R64's admission record documents R64 admitted to facility on 8/16/22 and diagnosis include Quadriplegia C1-C4 Incomplete, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, Neuromuscular Dysfunction of Bladder, and Epilepsy. R64's Minimum Data Set (MDS) assessment, dated 1/6/25, documents, in Section H, R64 has an indwelling catheter. On 2/18/25 at 9:30am, R64's room had no Enhanced Barrier Precaution (EBP) sign on door and no personal protective equipment (PPE) available. On 2/19/25 at 8:53am, R64's room continues to have no EBP sign or PPE available. On 2/19/25 at 2:05pm, V3/Licensed Practical Nurse entered room to perform suprapubic catheter care, no EBP sign or PPE bin available. V3 stated, R64 just moved rooms a while ago, unsure of exact date, but he should have an Enhanced Barrier sign on his door and a personal protective equipment bin outside of room. I'm not sure why or where R64's went.