

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Arcadia Care Watseka		STREET ADDRESS, CITY, STATE, ZIP CODE 715 East Raymond Road Watsseka, IL 60970	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to use proper equipment to transport a resident (R1) resulting in R1 sustaining an impacted tibia fracture and associated proximal fibula fracture. The facility also failed to follow its incident/accident policy by failing to report a serious injury to the state survey agency and thoroughly investigate an injury to determine the root cause and develop interventions for one (R1) of three residents reviewed for accidents in the sample list of seven.</p> <p>Findings include:</p> <p>On 12/3/24 at 1:56 PM R1 stated on 10/20/24 R1 had a left leg tibia/fibula fracture caused while V9 Certified Nursing Assistant (CNA) was pushing R1 in a shower chair down the hallway, R1 started to slip and attempted to push herself back up and R1's left toe/foot caught on the rug in the hallway. R1 screamed ow and thought it was broken. R1 stated x-rays were not taken for two to three days. R1 stated R1 was seen by V15 Orthopedic Physician on 11/6/24, who told R1 that R1's leg could not be casted as it would worsen R1's foot drop and require amputation, so the bones were left to fuse.</p> <p>On 12/4/24 at 9:24 AM the shower chair was viewed with V7 CNA. The chair was made of plastic piping and had four small caster wheels, and it did not include foot pedals or foot/leg support.</p> <p>R1's Diagnosis List documents R1 has a diagnosis of Multiple Sclerosis and is wheelchair bound. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact, has impaired range of motion to both legs, uses a wheelchair for mobility, and is dependent on staff for transfers.</p> <p>R1's Nursing Note dated 10/21/2024 at 12:35 AM documents R1 received a shower and complained of ankle and knee pain, physician notified and orders received for x-ray. The Incident Investigation Form dated 10/21/24 at 12:30 AM, recorded by V9 CNA, documents V9 was pushing R1 in a shower chair down the hallway after R1's shower when R1's left foot was low to the ground and struck the edge of the carpet rug in front of the patio door. This form documents R1 screamed ow and V9 backed up to assist in moving R1's foot, R1 was brought to her room and the nurse was notified. The Incident Investigation Form dated 10/21/24 at 12:30 AM, recorded by V17 CNA, documents V17 witnessed V9 pushing R1 in a shower chair, R1 yelled ow and R1's toe was stuck underneath the carpet.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's left ankle x-ray dated 10/21/24 documents a questionable hairline fracture of the anterior aspect of the left distal tibial metaphysis and recommends additional radiographs for further evaluation. R1's left ankle x-ray dated 10/22/24 documents R1 has diffuse Osteopenia (decreased bone mineral density) and a subacute nondisplaced fracture of the distal end of the left tibia.</p> <p>R1's Progress Note dated 11/6/24, recorded by V15, documents R1's chief complaint as I (R1) slipped, caught the rug, and it rebroke my (R1's) ankle and hyperextended my (R1's) knee. This note documents based on x-rays completed on 11/6/24 R1 had an impacted left distal tibia fracture with an associated proximal fibula fracture; and R1 is nonambulatory/bed-bound and has contractures to both ankles. This note documents due to R1's significant contractures V15 did not recommend casting and recommended to repeat x-rays of the left leg to ensure that there are no changes in alignment.</p> <p>R1's Care Plan with revised date 12/3/24 does not document R1's injury. There is no documentation that the facility reported R1's incident and fracture to the state survey agency or conducted a thorough investigation to identify root cause and develop/implement interventions to address the incident.</p> <p>On 12/3/24 at 3:32 PM V17 CNA stated V17 witnessed V9 CNA pushing R1 in a shower chair down the hall, R1's toe stubbed against the rug in front of the patio door and R1 yelled Ow. V17 stated R1 was transferred to bed and complained of left shin and ankle pain which was reported to the nurse. V17 stated a lot of times residents' feet brush against the floor when staff use the shower chair to transport residents. V17 stated the staff use the shower chair to transport because there is not enough room in the shower room for the full mechanical lift and R1 uses the mechanical lift for transfers. On 12/4/24 at 9:35 AM V17 described the shower chair used for R1, and it was not a reclining back shower chair and did not have foot rest/support. V17 stated R1's incident happened on 10/20/24 around 10:00 PM.</p> <p>On 12/3/24 at 4:16 PM V1 Administrator stated V1 did not report R1's injury since she did not become aware of the fracture until about a week after the incident happened. V1 confirmed R1's injury should have been reported to the state survey agency and the facility should have investigated the injury/incident. V1 stated V1 obtained staff statements regarding the incident, and staff were educated to slow down when transporting residents in a shower chair and ensure the resident's feet are off of the floor. V1 stated V1 was told by staff that R1's toe got caught on the rug while staff were pushing R1 in the shower chair down the hallway.</p> <p>On 12/4/24 at 9:10 AM V2 Director or Nursing stated V2 updates the care plans and confirmed R1's care plan does not address R1's injury. V2 stated V2 did not investigate R1's injury/incident and stated V2 thought it was acceptable for staff to use shower chairs to transport residents.</p> <p>On 12/4/24 at 1:31 PM V16 (R1's Physician) stated V16 ordered R1's x-rays, V16 saw R1 on 10/31/24 and R1 reported R1's foot got caught and hyperextended her leg while coming back from the shower. V16 confirmed R1's fractures would be consistent with an injury caused from stubbing her toe/foot on the carpet while being transported in a shower chair. V16 stated it would have been safer to use a wheelchair to transfer between locations rather than a shower chair since there is no foot support or pedals, which a wheelchair has.</p> <p>The Owner's Manual for (shower chair), provided by the facility on 12/4/24, dated November 2018 documents This device is NOT intended to be used as a transfer bench or device.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Incident and Accidents policy dated October 2024 documents an incident/accident report will be completed for all serious accidents/incidents of residents and unexpected events that cause actual or potential harm to a resident and will include the date/time of the incident/accident, written statements, possible cause of incident, physical assessment, injuries, vital signs, treatment, and notification of appropriate parties. This policy documents to report actual injuries to the state survey agency within 24 hours of the occurrence and submit a narrative summary of the incident within five working days.		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to routinely assess for pain and develop a care plan to address pain for one (R1) of five residents reviewed for accidents in the sample list of seven.</p> <p>Findings include:</p> <p>The facility's Pain Management Program dated October 2024 documents the pain assessment protocol will be initiated when: the pain assessment identifies pain on admission with changes in condition including incidents associated with potential for pain, identified on the Minimum Data Set (MDS), pain medication is given routinely or pain is not controlled, a change in condition occurs that requires pain control, a significant increase in use of PRN (as needed) pain medication, there is a change in pain related to behavior/cognition/mood, and when there is a diagnosis associated with pain/discomfort. This policy documents to use a pain rating scale to determine level of pain, develop and implement a care plan to address pain, assess for pain during routine medication administrations and document the pain assessment and the resident's response to pain management</p> <p>On 12/3/24 at 1:56 PM R1 stated on 10/20/24 R1 had a left leg tibia/fibula fracture caused while V9 Certified Nursing Assistant (CNA) was pushing R1 in a shower chair down the hallway, R1 started to slip and attempted to push herself back up and R1's left toe/foot caught on the rug in the hallway. R1 stated R1's pain at that time was a 20 on a zero to ten scale and R1's pain did not improve until Ultram was taken frequently.</p> <p>R1's Diagnosis List documents R1 diagnoses include Multiple Sclerosis, Type Two Diabetes Mellitus, Sacral Stage Four Pressure Ulcer, and Osteoarthritis of the hip. R1's MDS dated [DATE] documents R1 is cognitively intact and has impaired range of motion to both legs. This MDS documents R1 does not take scheduled pain medication, only as needed (PRN); within the last five days R1 experienced frequent pain, with the worse pain rated a five, that occasionally interfered with sleep and therapy sessions and frequently interfered with daily activities. R1's Care Plan with revised date 12/3/24 does not include problems, goals, and interventions to address R1's injury and pain.</p> <p>R1's left ankle x-ray dated 10/21/24 documents a questionable hairline fracture of the anterior aspect of the left distal tibial metaphysis and recommends additional radiographs for further evaluation. R1's left ankle x-ray dated 10/22/24 documents R1 has a subacute nondisplaced fracture of the distal end of the left tibia. R1's Progress Note dated 11/6/24, recorded by V15, documents based on x-rays R1 had an impacted left distal tibia fracture with an associated proximal fibula fracture, R1 is nonambulatory/bed-bound and has contractures to both ankles. This note documents due to R1's significant contractures V15 (Orthopedic Physician) did not recommend casting and recommended to repeat x-rays of the left leg to ensure that there are no changes in alignment.</p> <p>R1's Physical Therapy (PT) Note dated 10/21/24 documents R1 was unable to perform left leg active range of motion (AROM) due to left ankle/foot pain. R1's PT Note dated 10/22/24 at 10:03 AM documents R1 rated left leg pain a nine/ten on a zero to ten scale. R1's PT Notes dated 10/24/24, 10/25/24, and 10/28/24-10/31/24 document R1 had left leg pain that impacted treatment or participation in ROM and pain improved on 10/29/24 and 10/30/24.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There are no orders to routinely assess R1's pain every shift. R1's October 2024 Medication Administration Record (MAR) documents an order to administer Ultram 25 milligrams every eight hours as needed and this medication was administered six times for pain rated between three and five, and once on 10/25/24 at 5:20 AM for pain rated an eight. This MAR documents following R1's injury, Ultram was only documented as given on the 22nd at 2:56 AM, 23rd at 1:30 AM, 25th at 5:20 AM, and 29th at 5:26 AM. R1's November 2024 MAR documents Ultram was given ten times for pain rated between zero and eight. R1's Ultram Controlled Substances Proof of Use dated 8/11/24-11/8/24 documents between 10/20/24 and 11/4/24 Ultram was additionally given (not recorded on R1's MAR) on 10/20/24 at 10:00 PM, 10/21/24 at 6:00 AM and 12:00 PM, 10/24/24 at 5:21 AM and 10/30/24 at 12:12 AM. There are no corresponding pain scales pre and post administration for these entries since they are not documented on R1's MAR.</p> <p>On 12/3/24 at 7:53 AM V18 CNA stated R1 would say to be careful with her leg, that it was broken, and R1 would complain of pain which was reported to the nurses. On 12/3/24 at 3:23 PM V10 CNA stated V10 worked night shift on 10/26/24 and 10/27/24 after R1's leg fracture, R1 complained of ankle pain which was reported to the nurse. On 12/3/24 at 3:32 PM V17 CNA stated V17 witnessed V9 CNA pushing R1 in a shower chair down the hall, R1's toe stubbed against the rug in front of the patio door and R1 yelled Ow. V17 stated R1 was transferred to bed and complained of left shin and ankle pain which was reported to the nurse.</p> <p>On 12/4/24 at 9:28 AM V19 Physical Therapy Assistant stated R1 was very stiff and weak so we tried to improve range of motion (ROM) to R1's legs. V19 stated on the morning of 10/21/24 R1 would not allow V19 to do any ROM to the left leg, R1 complained of excruciating pain and said R1's foot got caught on a rug causing R1's knee to hyperextend. V19 stated R1 complained of left leg pain during therapy sessions therefore ROM was not performed, and V19 reported this to the nurses and emphasized the need for pain medication.</p> <p>On 12/4/24 at 9:10 AM V2 Director of Nursing stated pain should be assessed every shift and with PRN medication administration, and documented on the MAR. V2 stated there should have been an order to assess R1's pain every shift. V2 confirmed R1's pain should have been routinely assessed after R1's injury/incident, V2 reviewed R1's MAR and confirmed pain was not assessed every shift. V2 stated V2 updates the care plans and confirmed R1's care plan does not address R1's fracture or pain.</p> <p>On 12/4/24 at 1:31 PM V16 (R1's Physician) stated R1 had chronic pain and an order for Ultram PRN prior to R1's injury. V16 confirmed nursing staff should have routinely assessed R1's pain following R1's injury. V16 stated the Ultram should have automatically been given if R1 was complaining of pain and R1's pain had improved when V16 evaluated R1 on 10/31/24.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>40385</p> <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on observation, interview and record review the facility failed to staff a Registered Nurse (RN) for eight consecutive hours per day. This failure has the potential to affect all 68 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/3/24 at 11:54 AM V3 RN was working on the memory care unit of the facility. V3 stated this is V3's third day working for the facility.</p> <p>The facility's Daily Assignment Sheets dated 11/21/24-11/24/24, 11/27/24, 11/28/24, 11/30/24, and 12/1/24 do not document the facility had an RN on duty for eight consecutive hours each day. The facility's Daily Assignment Sheets dated 11/20/24, 11/25/24, and 11/26/24 document V2 Director of Nursing worked between three and four hours on second shift on these dates and there were no other RNs listed.</p> <p>On 12/3/24 at 2:20 PM the Daily Assignment Sheets were reviewed with V2. V2 confirmed all of the nurses listed on the assignment sheets for 11/21/24-11/24/24, 11/27/24, 11/28/24, 11/30/24, and 12/1/24 are Licensed Practical Nurses (LPNS) and the facility did not have eight consecutive hours of RN coverage each of those days. V2 stated V2 worked the floor on 11/26/24 from 2:00-6:00 PM, 11/25/24 from 3:00-6:00 PM, and 11/20/24 from 2:00-6:00 PM, and confirmed there were no other RNs staffed those days provide eight consecutive hours of RN coverage. V2 stated we have been using a lot of agency nurses, but corporate will only allow us to use LPNs. V2 stated the facility has one full time RN and a part time RN who only works Mondays and Tuesdays.</p> <p>The facility's Midnight Census, provided by V1 Administrator on 12/3/24, documents 68 residents reside in the facility.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>40385</p> <p>Based on observation, interview, and record review the facility failed to administer insulin and diabetic medications timely and as ordered for four (R1, R2, R4, R7) of four residents reviewed for insulin in the sample list of seven.</p> <p>Findings include:</p> <p>The facility's Medication Administration Policy dated October 2024 documents medication administration is documented on the Medication Administration Record (MAR), medications must be administered according to physician's orders including the right time, and to notify the physician of medication errors.</p> <p>The Resident Council Minutes dated 11/27/24 documents concerns with morning medications taking three hours to get and an insulin problem.</p> <p>1.) R1's November 2024 MARs document to administer Humulin R (Regular insulin) U-500 (concentrated) units/milliliter give 40 units subcutaneously three times daily at 8:00 AM, 11:00 AM and 4:00 PM. There is no documentation that this medication was administered as ordered on 11/6/24 for all doses, 11/9/24 at 4:00 PM, 11/11/24 at 4:00 PM, 11/14/24 at 11:00 AM and 4:00 PM, and 11/25/24 at 4:00 PM.</p> <p>R1's Nursing Note dated 11/9/2024 at 5:47 PM documents only partial dose of insulin was administered per R1's request for blood sugar of 157 milligrams/deciliter (mg/dl). R1's Nursing Notes dated 11/24/24 at 6:43 PM and 9:50 PM document due from previous shift for R1's scheduled insulin administrations. There is no documentation in R1's medical record why insulin was not administered on 11/6/24, 11/11/24 and 11/25 or that V16 (R1's Physician) was notified of the missed doses of insulin or adjusted dose on 11/9/24.</p> <p>On 12/4/24 at 12:07 PM V2 Director of Nursing confirmed nurses should notify the physician when insulin/diabetic medications are not given or withheld without an order and this should be documented in a nursing note. V2 stated the agency nurses don't know to contact the physician when a medication is not available, but they should notify the physician and then contact the pharmacy. V2 confirmed nurses should document medication administration on the MAR indicated by a checkmark and it should not be left blank (incomplete).</p> <p>2.) R2's November 2024 MAR documents to administer Insulin Lispro subcutaneously per sliding scale based on blood glucose results before meals and at bedtime. This MAR is blank (incomplete) for R2's insulin administration scheduled at 4:00 PM on the 17th, 25th, and 28th. This MAR documents NA (not applicable) on the 19th for R2's 5:30 AM blood glucose check and refers to the nursing notes for the insulin scheduled at 7:30 AM. There is no documentation in R2's medical record that R2's blood glucose was checked as ordered for these dates.</p> <p>R2's Nursing Note dated 11/19/2024 at 10:25 AM documents R2's Lispro sliding scale dose was not given and the physician was notified. There is no other documentation why R7's insulin was not administered for the other dates listed and that R7's physician was notified.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.) On 12/3/24 at 1:30 PM R4 stated sometimes R4 waits four hours to get his medications and R4's morning medications and insulin have been given at 1:00 PM.</p> <p>R4's November 2024 MAR documents to administer Lantus (insulin) 90 units subcutaneously daily at 8:00 PM, Trulicity (diabetic medication) 1.5 milligrams (mg)/0.5 milliliters (ml) inject 1.5 mg subcutaneously weekly on Saturdays, and Humalog insulin 35 units three times daily before meals at 7:00 AM, 11:00 AM, and 4:00 PM. This MAR is blank for Lantus administrations on 11/6/24 and 11/9/24 and Humalog administrations on 11/6/24 and at 4:00 PM on 11/25/24. This MAR documents NA for Humalog administration on 11/19/24 at 11:00 AM. R4's Humalog 7:00 AM dose was given at 10:31 AM on 11/8/24, 8:44 AM on 11/11/24, 2:46 PM on 11/14/24, 9:22 AM on 11/15/24, 10:47 AM on 11/16/24, 8:28 AM on 11/17/24, 9:18 AM on 11/18/24, 8:45 AM on 11/22/24, and 10:38 AM on 11/22/24. R4's Humalog 11:00 AM dose was given at 4:33 PM on 11/9/24, 12:51 PM on 11/13/24, 3:18 PM on 11/14/24, 12:29 PM on 11/16/24, 12:34 PM on 11/17/24, and 12:39 PM on 11/18/24. R4's Humalog 4:00 PM dose was given at 5:51 PM on 11/16/24, 5:46 PM on 11/16/24, and 5:41 PM on 11/19/24. This MAR does not document Trulicity was administered on 11/9/24 and defers to R4's nursing notes. R4's December 2024 MAR documents on 12/2/24 Lantus was held and defers to R4's nursing notes.</p> <p>R4's Nursing Note dated 11/9/2024 at 5:14 PM documents the facility did not have Trulicity to administer, the pharmacy was notified and the medication was to be delivered that evening. There is no follow up documentation that this medication was delivered and administered as ordered. R4's Nursing Note dated 12/2/24 at 8:43 PM R2's Lantus was held due to blood glucose of 88 mg/dl. There is no documentation that the physician was notified of the missed doses of Trulicity, Humalog, and Lantus.</p> <p>On 12/4/24 at 12:27 PM the medication cart for R4's hall was viewed with V24 Licensed Practical Nurse. V24 was unable to locate R4's Trulicity and Lantus. V24 then checked the medication room and was still unable to locate these medications. V24 stated V24 will have to contact the pharmacy to have the medications delivered.</p> <p>On 12/3/24 at 12:51 PM V13 Activity Director stated during the November 2024 Resident Council Meeting R4 voiced concerns with the timeliness of R4's insulin administration since the facility recently changed to a liberalized medication pass.</p> <p>On 12/4/24 at 12:07 PM V2 stated medications with specified times have to be administered within an hour window before/after the scheduled time and the nurses should record medication administration on the MAR at the time the medication was given. V2 stated the nurse should have given R4's Trulicity when it came in and documented this information in a nursing note or on the MAR.</p> <p>4.) On 12/4/24 at 10:05 AM R7 stated when agency nurses work they don't always check R7's blood glucose, especially at supper time, and then R7 doesn't get R7's scheduled sliding scale insulin. R7 stated this has happened a couple of times.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R7's November 2024 MAR documents to administer Ozempic (diabetic medication) 4 mg/3 ml give 1 mg subcutaneously once weekly on Mondays and this medication was not given on 11/25/24 and defers to R7's nursing notes. R7's November 2024 and December 2024 MARs document to administer Tresiba (diabetic medication) 100 units/ml give 38 units subcutaneously once daily, and this medication was not required on 11/17/24 and 11/23/24, left blank on 11/25/24, and not given with defer to nursing notes on 12/2/24 and 12/3/24. These MARs document to administer Lispro 10 units three times daily with meals and per blood glucose based sliding scale three times daily. These MARs document Lispro 10 units was not required on 11/7/24 at 12:00 PM and 5:00 PM and on 12/1/24 at noon. There is no documentation that R7's blood glucose was checked at noon on 11/23/24 and sliding scale insulin administered as ordered. There are no orders to hold R7's scheduled Tresiba or Lispro 10 units.</p> <p>R7's Nursing Notes document R7's Tresiba was on order on 11/30/24, was not in stock and ordered on 12/2/24, and was not given on 12/3/24 due to low blood glucose. There is no documentation that R7's physician was notified of missed doses of insulin. R7's Nursing Notes document Lispro 10 units was held on 11/23/24 at 4:31 PM due to low blood glucose of 81 mg/dl. There are no other notes to document why Ozempic, Lispro, or Tresiba weren't administered as ordered and that the physician was notified.</p> <p>On 12/4/24 at 12:07 PM V2 stated we were waiting on insurance approval for Tresiba and the physician should have been notified. V2 stated the agency nurses don't know to contact the physician when a medication is not available, but they should notify the physician and then contact the pharmacy.</p>		