STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145452	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Dwight	300 East Mazon Avenue Dwight, IL 60420

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 31642 Based on observation, interview, and record review the facility failed to follow pharmacy/hormone replacement medication guidance, for one of eight residents (R32) reviewed during medication administration observation. The facility had three medication errors out of 30 opportunities resulting in a 10 percent medication error rate. Findings include: R32's Medication Administration Record (MAR) dated 04/01/2025- 4/30/2025 documents the following: Levothyroxine Sodium (hormone replacement medication) Oral Tablet, 75 MCG (micrograms), give 75 mcg by mouth in the morning, related to Hypothyroidism. Unspecified, Omeprazole (proton-pump inhibitor medication) Oral Tablet, Delayed Release, 20 MG (milligrams), give 1 tablet by mouth in the morning for acid reflux, and Acetaminophen (pain medication) Oral Tablet, give 1000 mg by mouth every 8 hours as needed for pain rated 1-5. The same MAR documents V19's initial indicated document R32 was scheduled to receive both Levothyroxine and Omeprazole during Liberal AM, medication time frame of 4:00 am - 6:00 am. R32's same MAR documents V19 initials also document Acetaminophen was administered during the same Liberal AM medication time frame of 4:00 am - 6:00 am. On 4/17/25 at 5:00 am, V19, Licensed Practical Nurse (LPN) administered R32's Levothyroxine 75 mcg tablet, Omeprazole delayed release 20 mg tablet, and two tablets of Tylenol 500 mg (1000 mg). A detailed electronic medical record (EMR) report dated 4/17/205 at 12:02 pm, signed by V2, Director of Nursing, documents the following times the above medications were signed out as administered during the Liberal AM medication pass time frame: Omeprazole oral tablet, Delayed Release 20 MG (milligrams) was administered on 4/17/25 at 5:02 am, Levothyroxine Sodium oral, 75 mcg tablet was signed out as administered the same time at 4/17/25 at 5:02 am, and Acetaminophen Oral Tablet, 1000 mg was signed out as administered four minutes later, at 5:06 am. On 4/17/25 at 11:45 am V2, Director of Nursing stated Levothyroxine should not be administered with any other medication. Yes, those are medication errors. (continued on next page)

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

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Medication Error Report dated 4/17/25 documents: a physician (unidentified) was notified Omeprazole Oral Tablet Delayed Release 20 MG (milligrams), Levothyroxine Sodium Oral, 75 mcg and Acetaminophen Oral Tablet, 1000 mg were given together in error, and Synthroid (name brand for Levothyroxine) is to me given on an empty stomach, prior to other medication. The same report documents the type of error was medications given at the wrong time and caused by a transcription error (scheduled at the same time). The facility pharmacy pamphlet undated insert for Levothyroxine (thyroid hormone replacement) directs the administration of the medication to be administered once daily, preferably on an empty stomach, one-half to one hour before breakfast and at least four hours before or after other medication, that can interfere with absorption of the Levothyroxine medication.

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 34058 Based on observation, interview, and record review, the facility failed to provide a clinically qualified director of food and nutrition services. This failure has the potential to affect all 87 residents residing in the facility. Findings include: On 4/15/25 at 9:20 AM, V9, Dietary Manager, introduced herself as the dietary manager. During the ensuing tour of the facility kitchen, V9 was actively managing and directing kitchen support personnel and their food preparation and food storage activities. V9's food service certificate, issued 8/27/21, documents V9 was certified as a Food Service Manager. V9 stated the requirements for this certificate were to review course material for approximately eight hours in a single day and take a test. V9 stated the certificate course was directed for cooking sanitation. V9 further stated there was not any clinical information such as how nutrition is involved with healing pressure ulcers, reducing weight loss, gastrostomy tube feeding requirements, or for residents receiving dialysis. V9 then stated she had been told by the facility administration that she needs to get signed up for the CDM (Certified Dietary Manager) course ASAP (as soon as possible). V9 stated she understands the CDM course is 6 months to a year long and includes the clinical aspects of nutrition, not simply cooking sanitation. V9 then stated the facility Registered Dietician (V13) would only work on a consultant basis. V9 concluded by confirming she did not meet the State requirements for a Director of Food Services, or definition of a Dietetic Service Supervisor, by stating she was not a Registered Dietician, had not graduated from an authorized dietetic and nutrition program, had no food service experience prior to 1990, had not completed the course study as a CDM and was not a CDM, and had no military service. The facility's Resident Roster and Form 802 Resident Matrix, both dated 4/15/25, document 87 residents reside in the facility, all of whom receive nutritional services in the facility. R11 was one resident who receives no food by mouth but rather receives gastrostomy feedings.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on interview and record review, the facility failed to provide certified food handlers for the meal service and food preparation operations. This failure has the potential to affect all 87 residents residing in the facility. Findings include: On 4/15/25 at 9:20 AM, V9, Dietary Manager, stated there were three Dietary Aides (V10, V11, and V12) who did not yet have a Food Handler's certificate. The Illinois Public Act [PHONE NUMBER], documents a food handler or food employee is defined as any individual working with unpackaged food, food equipment, utensils, or food contact surfaces. This Act documents all food handlers working in non-restaurants such as nursing homes, must have the food handler's training by 7/1/2016 with enforcement beginning 1/1/2017. On 4/16/25 at 11:47 AM, V9 confirmed V10, V11, and V12 had been working in the facility kitchen and dining room and did engage in meal service activities serving food trays and plates to residents, rolled service utensils into napkins for resident meal preparations, and V11 also operated the dishwasher. The facility's Resident Roster and Form 802 Resident Matrix, both dated 4/15/25, document 87 residents residing in the facility, all of whom, with the exception of R11 who receives no food by mouth, consume food prepared and served from the facility kitchen.

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 34058 Based on observation, interview, and record review, the facility failed to provide meal service in the posted service times. This failure affects six residents (R14, R15, R21, R47, R59, and R195) of six residents who received meal trays in their rooms, on the sample list of 34. Findings include: On 4/15/25 between 11:00 AM and 12:45 PM, R14, R15, R21, R47, and R195, were identified as waiting in their rooms for meal service on the facility's A Hall. Each of the identified residents stated the food is consistently late for the hall trays delivered to rooms. Each resident identified that breakfast is due around 7:30 AM, lunch around 11:30 AM, and supper around 4:30 PM. Each resident stated the meals actually arrive around 9:00 AM, lunch around 1:00 PM, and supper around 6:00 PM. On 4/15/25 at 1:10 PM, the cart containing the meal trays arrived on the facility's A Hall. On 4/15/25 at 1:14 PM, V8, Certified Nursing Assistant, stated the meals are often served late because there weren't enough kitchen staff. V8 stated at least three days per week the breakfast goes out for the hall trays around 9:00 AM and lunch is right around this time (1:10 to 1:15 PM). V8 stated she did not work the evening shift and could not speak as to when supper was delivered to the residents eating in their rooms. On 4/16/25 at 8:25 AM, V9, Dietary Manager, stated the kitchen serves any resident who comes to the dining room between 6:30 AM and 8:30 AM, then they can determine which residents need a hall tray. V9 stated for lunch, the kitchen serves the A and D Halls in the dining room starting at 11:30 AM, then the B and C Halls in the dining room starting at 12:15 PM. V9 stated after the dining room is finished serving, they start preparing the meal carts that go out to the residents eating in their rooms. V9 stated a similar routine happens during the supper meal service with A and D Hall starting in the dining room at 4:30 PM, then the B and C Halls at 5:15 PM, then determine which residents did not come to the dining room and prepare to serve the trays to the residents eating in their rooms. The facility's posted signs in the hallway leading to the dining room, on the Care Plan Coordinator's office door, and in the central rotunda, all document meal service times for breakfast for all halls 6:30 AM through 8:30 AM, lunch for A and D Hall at 11:30 AM, B and C Halls at 12:15 PM, and dinner A and D Hall at 4:30 PM, and B and C Hall at 5:15 PM. On 4/16/25 at 12:20 PM, V29, Dietary Aide, was able to identify the residents who were requesting to eat in their rooms and would need to be provided a hall tray. On 4/16/25 at 12:57 PM, in addition to the aforementioned five residents, R59 (A Hall) also stated she had not yet been served lunch and the meals have been coming late routinely.