STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145623	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Morris	1095 Twilight Drive Morris, IL 60450

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 - Few	Provide and implement an infection prevention and control program. 39182 Based on observation, interview, and record review, the facility failed to perform hand hygiene and follow enhanced barrier precautions. This applies to 3 of 3 (R6, R7 and R12) residents reviewed for infection control in a sample of 25. Findings include: 1. On 4/29/25 at 1:06 PM, observed R6 being wheeled into his room by V8 (CNA-Certified Nursing Assistant), followed by V10 (CNA) with a mechanical lift to transfer R6 from his wheelchair to bed. R6 had a urinary catheter. Outside of R6's room on the wall was a poster stating R6 is on EBP (Enhanced Barrier Precautions). Neither V8 nor V10 wore gowns. V8 provided perineal care to R6 without wearing a gown. After wiping the buttocks and genitals of R6, V8 did not remove the soiled gloves or perform hand hygiene and applied a fresh clean disposable brief. Wearing the same soiled gloves, V8 adjusted R6's bed linen and then, removed her gloves, tied up the garbage bag, touched the door and the doorknob, and left the room, all without performing hand hygiene. On 4/29/25 at 1:15 PM, V6 (LPN-Licensed Practical Nurse) walk into the room of R6 with wound supplies in her hand. V6 did not wear any gown. V6 donned gloves, cleaned the wound on R6's left leg, and placed the soiled gauze on the bedside table. Without changing her gloves, V6 applied a clean adhesive bordered dressing on the wound. Without changing her gloves, V6 handled R6's bedding and covered up R6, removed her gloves, took the soiled used gauze, and without performing any hand hygiene, touched the door and the doorknob on her way out of the room. V6 went to a clean caddy with PPE (Personal Protective Equipment), took a plastic bag from it, put all the soiled items in it, tied and discarded it in the trash can of the shower room at the end of the hallway and used hand sanitizer. On 4/25/25 at 1:14 PM, V5 (RN) stated, when a resident is on EBP, gown and gloves must be worn when providing care for residents with wounds or indwelling medical devices. On 5/1/25 at 9:30 AM, V2 (DON-Director of Nursing) stated transmission precautions and hand hygiene must be followed by all staff as per policy to prevent transmission of infections. (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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(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 - Few	2. On 4/29/25 at 12:15 PM, V7 (LPN) performed blood sugar testing for R7 in his room with gloves on and no gown. R7 had a urinary catheter. Outside of R7's room on the wall was a poster stating he is on EBP. After checking the blood sugar, V7 removed her gloves and held them in her hands and did not perform any hand hygiene. V7 wheeled R7 out of the room and discarded the dirty gloves into the sharp's container on the med cart. Without performing any hand hygiene, V7 touched the laptop on the med cart, and handled a set of keys and put them into her pocket. V7 then placed the blood sugar testing machine back into the cart without cleaning it. Then without performing hand hygiene, V7 locked the cart and wheeled R7 to the dining room for lunch. 3. On 4/30/25 at 1:48 PM, V5 (RN-Registered Nurse) straightened R12's room. Outside R12's room on the wall is a poster stating she is on EBP. R12 had a urinary catheter. V5 came out of the room without performing any hand hygiene, wheeled her medication cart back to the nurse's station and started touching the med cart laptop. Facility policy on EBP revised on 03/2025 showed, .Personal Protective Equipment . Standard Precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing cares like dressing, wound care, perineal care . Points to remember Handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another