

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/17/2025
NAME OF PROVIDER OR SUPPLIER  Arcadia Care Morris		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to obtain orders and administer medications as prescribed. This applies to 1 of 3 (R1) resident reviewed for medication administration. The findings include: R1 was admitted to the facility on [DATE] with multiple diagnoses which included rhabdomyolysis, unspecified fall, bacteremia, acute kidney failure, unspecified multiple injuries, right shoulder osteoarthritis, and hypertension, per the face sheet. R1's MDS (Minimum Data Set) dated 07/07/25 showed R1 was cognitively intact and required partial/moderate assistance with ADL's (Activities of Daily Living). The same MDS showed R1 was admitted to the facility with an unstageable pressure ulcer. R1's Skin Impairment Care Plan showed a pressure injury to the right lateral hip. R1's Progress Notes dated 09/08/25 at 7:30 AM, showed Family called an ambulance and had the resident taken to (Hospital) ER (Emergency Room) related to her right hip wound. Progress Notes dated 09/08/25 at 11:11 AM, showed Resident returned from the hospital with family. Awaiting paperwork from family or hospital. Per family, hospital will fax the information to us. Progress Notes dated 09/08/25 12:00 PM, showed Family said they had discharge paperwork but didn't provide it as they felt that hospital should be faxing it over. Progress Notes dated 09/08/25 at 12:02 PM, showed Family is aware that we need the hospital paperwork. We still haven't received it from the family or the hospital. I let the family know that I still have not received a fax from the hospital. Progress Notes dated 09/08/25 at 9:44 PM, showed Family asking if orders were received yet and were informed, they were not received. Family gave this writer two pill bottles from (Doctor) and is requesting nurse to get verbal orders in AM, will endorse to oncoming shift nurse. Progress Notes dated 09/08/25 at 10:21 PM, showed Endorsed to oncoming shift nurse that orders are needed for two antibiotics in top drawer of medication cart as well as indications for both antibiotics, per AM shift nurse WBC (White Blood Cell) count at hospital was WNL (Within Normal Limits) but no labs or discharge paperwork are available in chart at this time. Progress Notes dated 09/09/25 at 9:02 AM, showed DC (Discharge) paperwork with antibiotic orders was not given to nurse by family when resident returned from hospital. Writer pulled DC paperwork from (Hospital) portal; orders entered. Resident to start PO (Oral) ABT (Antibiotic) x 2 for suspected wound infection. Cultures pending. R1's Patient Visit Information from (Hospital) dated 09/08/25 at 10:04 AM, showed You were seen today for Decubitus Ulcer, stage 3 with infection. Prescriptions: Cephalexin 1,000 mg oral every 12 hours for 10 days and Bactrim DS 800-160 mg 1 tablet oral every 12 hours. R1's MAR (Medication Administration Record) for September 2025 showed Bactrim DS 800-160 mg give one tablet by mouth every 12 hours for suspected wound infection for 10 days. Administration times 8:00 AM and 8:00 PM. The first administration time for Bactrim DS was on 09/09/25 at 12:08 PM. R1 was not given Bactrim DS on 09/08/25 at 8:00 PM or 09/09/25 at 8:00 AM as ordered. R1's MAR showed Cephalexin 500 mg give two tablets by mouth every 12 hours for suspected wound infection for 10 days. Administration times 8:00 AM and 8:00 PM. The first administration time for Cephalexin was on 09/09/25 at 12:07 PM. R1 was not given Cephalexin on 09/08/25 at 8:00 PM or 09/09/25 at 8:00 AM. On 09/16/25 at 1:32 PM, V5 (Registered Nurse) stated During my shift, I never received any paperwork or pills. It is not our procedure to call the hospital to get the paperwork. Normally family or paramedics bring us the paperwork back. On 09/16/25 at 2:11 PM, V2 (Director of Nursing) stated We could have called the hospital and asked for the orders. R1 should not have missed the first dose, and we had the medications here in the facility. The first dose was not administered at the appropriate time. V2 stated if medications are not given as prescribed, the residents infection can become worse. V2 stated the facility should follow the doctor's orders. The facility's Medication Administration policy dated 01/2015, next review 05/2025, showed Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time.</p>		