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	03/30/2026

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify physicians of a resident's elevated Lithium level. This resulted in staff's continued administration of Lithium to the residents resulting in a resident's hospitalization with primary diagnosis of Lithium toxicity. The facility also failed to notify physicians and family members of a resident's injury (bruise) after an unwitnessed fall. This applies to 2 of the 6 residents (R1 and R5) reviewed for notification of change in condition and incident/accident in the sample of 9. The findings include:1. Face sheet shows R1 is 65 years-old who has multiple medical diagnoses including hypotension, unspecified, essential (primary) hypertension, hyperlipidemia, unspecified, atherosclerotic heart disease of native coronary artery without angina pectoris, paranoid schizophrenia, retention of urine, unspecified anxiety disorder, unspecified restlessness and agitation. R1's MDS (Minimum Data Set) dated February 16, 2026, shows that R1 is alert and oriented and requires substantial to maximum assistance with ADLs (Activities of Daily Living).R1's Progress Notes dated March 15, 2026, at 7:20 PM, showed R1 was very lethargic, unable to stand or transfer, and unable to answer questions. Vital signs were checked and recorded. V7 (Nurse) placed a call to the physician and V2 (Director of Nursing/DON). R1's progress note dated March 15, 2026, at 8:31 PM, showed R1 remained very lethargic, she was moaning but could not say or utter any words. R1 was unable to answer any questions, even the simple ones. R1's family was at bedside, physician, and V2 was notified. R1 was sent to the hospital via emergency services.R1's POS (Physician Order Summary) dated July 13, 2023, shows a physician's order to administer Lithium 150 mg (milligrams) once a day. On August 18, 2023, R1's Lithium was increased to 300 mg daily, then on March 4, 2026, R1's Lithium was increased to 300 mg twice daily.R1's laboratory result dated March 10, 2026, showed a Lithium level of 1.40 mmol/L (millimoles per liter) which means that it was High. There was no documentation to show R1's physician was notified of the high Lithium level.R1's MAR (Medication Administration Record) showed R1 was administered Lithium 300 mg twice daily from March 5 to March 15, 2026.R1's hospital records showed R1 arrived at the hospital on March 15, 2026, and was admitted with primary diagnosis of Lithium Toxicity. On March 16, 2026, at 5:22 AM, R1's lithium level was 1.73 H* which means that it was critically high.On March 24, 2026, at 3:52 PM, V14 (R1's Psychiatrist) stated he was not aware of R1's elevated Lithium level. V14 also said they order Lithium level for residents who take Lithium, and the facility staff should notify V14 if the Lithium level is high or low. V14 continued to say if he was notified of the Lithium level, he could have changed the dose of Lithium and R1 could have been monitored for change in condition.On March 26, 2026, at 2:21 PM, V20 (Assistant Director of Nursing/ADON) stated that if a staff receives an abnormal or out of range laboratory result, the staff must immediately notify the physician because the resident may be sent to the hospital for a higher level of care or the resident might need adjustment to the dose of medication or need an added treatment.2. Face sheet shows that R5 is 64 years-old who has multiple medical diagnoses including altered mental status, Parkinson's disease without dyskinesia, lack of coordination, muscle wasting and atrophy, difficulty in walking, and unspecified lack of coordination. (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 0580 Level of Harm - Actual harm Residents Affected - Few	R5's MDS dated [DATE], shows that R5 requires total assistance from staff for toileting, hygiene, and dressing. On March 23, 2026, at 2:51 PM, V16 and V17 (Both Certified Nursing Assistant/CNA) assisted R5 to stand up to conduct a full body assessment. There was a big dark purple colored bruise noted that almost covered his whole right buttock. V19 (Power of Attorney/POA/wife) was at bedside during the assessment, she appeared surprised and stated she was not notified about R5's bruising.On March 23, 2026, at 3:05 PM, V6 (Nurse) stated R5 is a high risk for fall. V6 also stated she was not aware of R5's bruise on his right buttock.On March 26, 2026, at 2:45 PM, V6 changed her statement and said she noticed the bruise on R5's buttock and she notified V2 (Director of Nursing/DON).On March 26, 2026, at 3:11 PM, V17 (CNA) said she worked evening shift on March 22, 2026. V17 noticed the bruise which covered R5's whole right buttock and immediately notified V6.On March 26, 2026, at 2:50 PM, V21 (CNA) stated she knew about R5's bruise on his right buttock because V17 endorsed it to her during the shift change and according to V17, V6 was already notified of R5's bruise.On March 26, 2026, at 2:21 PM, V20 (Assistant Director of Nursing/ADON) stated when a staff observes bruising or any unusual change in a resident's condition, then the staff must immediately notify the physician and family.R5's incident report dated March 20, 2026, at 3:45 PM, shows R5 had a fall incident by the nurses' station. There was no injury noted initially, and family and physician were notified. However, R5's post fall follow up assessment of March 23, 2026, at 11:03 AM, does show any documentation that the physician and family member were notified of R5's bruise. Further review of R5's progress notes showed an incident report dated February 23, 2026. It shows that R5 had an unwitnessed fall that resulted in yellow discoloration to the left hip and an abrasion to posterior side of the head. R5's progress notes did not show any documentation that the physician and family member were notified about the above mentioned injury.Facility's Policy and Procedure for Physician-Family Notification- Change in Condition with revision date of December 2025 shows:Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner.Guidelines: The facility will inform the residents; consult with the resident's physician or authorized designee such as Nurse Practitioner, and if known, notify the resident's legal representative or an interested family member when there is:B. A significant change in a resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. C. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and address a resident (R1) who was having a change in condition. The facility also failed to do a complete follow up (post-fall) body assessment for a resident (R5) who had a fall incident.This failure resulted in a resident (R1) being lethargic throughout the morning shift until the early evening shift without appropriate intervention and was later hospitalized with a primary diagnosis of Lithium toxicity.This applies to 2 of 6 residents (R1 and R5) reviewed for change in condition and accident in the sample of 9. The findings include:1. Face sheet shows R1 is 65 years-old who has multiple medical diagnoses including hypotension, unspecified, essential (primary) hypertension, hyperlipidemia, unspecified, atherosclerotic heart disease of native coronary artery without angina pectoris, paranoid schizophrenia, retention of urine, unspecified anxiety disorder, unspecified restlessness and agitation. R1's MDS (Minimum Data Set) dated February 16, 2026, shows that R1 is alert and oriented and requires substantial to maximum assistance with ADLs (Activities of Daily Living).R1's Progress Note dated March 15, 2026, at 1:47 PM, shows after breakfast, R1 was observed leaning to one side while sitting in her wheelchair. V5 (Nurse) instructed the CNA staff to put R1 to bed to prevent potential fall and to rest. V5 assessed R1 and he noticed a bruise on her left shoulder, but there was no further assessment documented about R1's condition. R1's Progress Note dated March 15, 2026, at 7:20 PM, showed R1 was very lethargic, unable to stand or transfer, and unable to answer questions. Vital signs were checked and recorded. V7 (Nurse) placed a call to the physician and V2 (Director of Nursing/DON). R1's progress note dated March 15, 2026, at 8:31 PM, showed R1 remained very lethargic, she was moaning but could not say or utter any words. R1 was unable to answer any questions, even the simple ones. R1's family was at bedside, physician, and V2 was notified. R1 was sent to the hospital via emergency services.R1's hospital records showed R1 arrived at the hospital on March 15, 2026, and was admitted with primary diagnosis of Lithium Toxicity. On March 16, 2026, at 5:22 AM, R1's lithium level was 1.73 H* which means that it was critically high.On March 23, 2026, at 1:40 PM, V5 (Nurse) stated that he took care of R1 on March 15, 2026, it was the first time he took care of her, he did not know R1's baseline. V5 noticed that R1 was leaning on her side while sitting in her wheelchair, she was confused and had difficulty swallowing her food and medication. V5 had to crush her medications, so she could take it. V5 stated nobody told V5 that it was not R1's baseline. The only thing the CNA staff told him was that R1 needed to be placed in bed.On March 23, 2026, at 12:51 PM, V9 (Certified Nursing Assistant/CNA) stated she worked on March 15, 2026, during the day shift. Although she was not assigned to R1 that day, she noticed the change in R1's condition because she used to take care of R1 regularly. V9 noticed that on March 15, 2026, R1 was very lethargic, she was leaning forward and to her side as if she was about to fall out of the wheelchair. V10 (R1's CNA) attempted to give her a shower but was unable to do so due to her severe lethargic condition. R1 was unable to sit up by herself, she was unable to swallow her donut during breakfast, V5 (Nurse) had to swipe out the donut with his fingers from R1's mouth. R1 had a difficult time swallowing the water. When they gave her water, R1 started gagging. R1 used to eat and drink without difficulty. R1 was very lethargic during the whole morning shift, so V5 instructed them to put R1 to bed to rest. They told V5 to assess R1 because that was not her normal self. R1 was later sent to the hospital during the evening shift, and she did not return back to the facility.On March 23, 2026, at 4:38 PM, V8 (CNA) said R1 used to propel herself in her wheelchair and was alert and oriented. On March 15, 2026, during the day shift R1 was very sluggish, she couldn't sit upright in her wheelchair. R1 was leaning forward and to her side as if she was about to fall. V8 notified V5 that R1 was having a change in condition, and that was not R1's normal self.On March 24, 2026, at 9:42 AM, V10 (CNA) stated R1 was alert and oriented and on March 15, 2026, V10 was assigned to R1. R1 couldn't stand up and kept wetting her incontinence briefs. R1 was continent, she uses the bedside commode. V10 informed V5 that R1 was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	acting differently. R1 was unable to sit up straight in her wheelchair, V9 and V10 told V5 to check R1. V5 went to R1's room to see her, but V10 was not sure what he did after he saw her. During breakfast R1 was having difficulty swallowing, V5 saw that she was having a hard time swallowing the donut, so he swiped it out from her mouth. R1 was having difficulty swallowing water. R1's eyes were open, but she seemed to be in a daze. V10 noticed that R1's condition has been deteriorating, that was the worst she had seen her.On March 23, 2026, at 4:06 PM, V7 (Nurse) stated, she saw R1 during shift change. V7 noticed R1's lethargic condition, V7 called out R1's name, but she barely responded. Since that was the first time, she took care of R1, V7 was not sure if that was R1's baseline or not. V7 did not receive any report about R1 having changed in condition. When R1's family came in, they were alarmed of R1's condition. Then V7 asked the CNA staff who were working with her that evening and they said that R1 usually gets up with assistance but that evening they tried to get her up, but she couldn't get up even with help. They also tried to put R1 on the commode, but she was unable to sit despite assistance by 3 staff. V7 took R1's vital signs and the vitals were stable, however, R1 remained lethargic. V7 called R1's physician but physician did not respond. V2 (Director of Nursing/DON) was notified, and he said to go ahead and send her to the hospital but try not to call the emergency services. V7 called four different private ambulances, but none of them were available. V7 called the DON again to let him know that she couldn't get any private ambulance, so V7 had to call emergency services. R1 was sent to the hospital. Later, V7 called the hospital to follow up on R1's status, they informed her that she was being admitted for encephalopathy and Lithium toxicity.R1's laboratory result dated March 10, 2026, showed a Lithium level of 1.40 mmol/L (millimoles per liter) which means that it was High. There was no documentation to show R1's physician was notified of the high Lithium level.On March 24, 2026, at 3:52 PM, V14 (R1's Psychiatrist) stated he was not aware of R1's elevated Lithium level. V14 also said they order Lithium level for residents who take Lithium, and the facility staff should notify V14 if the Lithium level is high or low. V14 continued to say if he was notified of the Lithium level, he could have changed the dose of Lithium and R1 could have been monitored for change in condition.On March 26, 2026, at 2:21 PM, V20 (Assistant Director of Nursing/ADON) stated when a staff observed any unusual change in a resident's condition, the staff must immediately assess the resident, document and describe the residents' condition and notify the physician and family right away. If the staff does timely assessment, then residents will receive timely treatment or intervention. By monitoring changes in condition and notifying physicians, this would determine if residents needed to go to the hospital for a higher level of care.R1's progress notes on March 15, 2026, morning shift, did not show any detailed assessment and frequent monitoring of R1's condition even though the CNA staff were aware there was a change in R1's condition. 2. Face sheet shows that R5 is 64 years-old who has multiple medical diagnoses including altered mental status, Parkinson's disease without dyskinesia, lack of coordination, muscle wasting and atrophy, difficulty in walking, unspecified lack of coordination, dysphagia, oral phase, cognitive communication deficit. Minimum Data Set, dated [DATE], shows that R5 requires total assistance from staff for toileting, hygiene, and dressing. On March 23, 2026, at 2:51 PM, V16 and V17 (Both Certified Nursing Assistants/CNA) assisted R5 to stand up for a full body assessment. There was a big dark purple colored bruise noted that almost covered his whole right buttock.On March 26, 2026, at 12:14 PM, V5 (Nurse) stated he took care of R5 on March 23, 2026, during the morning shift. V5 stated he took R5's vital signs and he did the skin assessment. V5 said when he does skin assessment, he would document anything unusual like a bruise. When asked if he saw the big bruise on R5's right buttock, V5 said he did not see it because he only assessed R5's exposed skin.On March 23, 2026, at 3:05 PM, V6 (nurse who re-admitted R5 from the hospital) stated R5 is a high risk for fall. V6 was not aware of R5's bruise on his right buttock. V6 also said she watched R5 closely and she placed him by the nurses' station because she did not want R5 to fall under her watch. However, on March 26, 2026, at 2:45 PM, V6 changed her statement and said that she did a complete body check on R5 upon his arrival from the hospital on March 22, 2026, and she noted the bruise on R5's right buttock. On March (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	26, 2026, at 3:11 PM, V17 (CNA) said she worked the evening shift on March 22, 2026. R5 came back from the hospital before dinner time and was placed in a wheelchair by the nurses' station. V17 assisted R5 to the toilet after he ate dinner and that is when V17 saw R5's bruise which was dark purple in color and covered his whole right buttock. V17 immediately notified V6 about it.On March 26, 2026, at 2:50 PM, V21 (CNA) stated she knew about R5's bruise on his right buttock because V17 endorsed it to her during shift change, and she was also informed by V17 that V6 was already made aware of R5's bruise. On March 26, 2026, at 2:21 PM, V20 (Assistant Director of Nursing/ADON) stated when a staff member finds a bruise on a resident, the staff must document the size, location, color, and if it is tender or painful. The staff should notify the physician right away when there's an injury or a change in a resident's condition because the resident might need to be sent to the hospital for a higher level of care. R5's incident report dated March 20, 2026, at 3:45 PM, showed R5 had a fall incident by the nurses' station. Three staff members assisted R5 back to his wheelchair. There was no injury noted initially. Because it was an unwitnessed fall and R5 was on a blood thinner, the facility sent R5 to the hospital for further evaluation. However, R5's progress note dated March 22, 2026, at 9:48 PM, showed R5 returned to facility from the hospital. A full body assessment was conducted, and no new skin issues were noted. Further review of R5's post-fall assessments until March 23, 2026, at 11:03 AM, shows R5 has no skin issues noted.The Facility's Accident and Incident Policy and Procedure with revised date of May 2022 shows:Documentation in nurses' notes is to include A description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified. A minimum of 72 hours (longer if indicated) of documentation per day on resident status after the incident. Vital signs, mental, and physical state, follow-up test, and findings are to be documented.