STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to provide appropriate treatment to a facility acquired stage three pressure ulcer for one of three Residents (R4) reviewed for pressure ulcers in a sample of five.Findings include: R4's Physician Order Sheet/POS, dated 3/4/26, documents diagnoses including Paranoid Schizophrenia, Type Two Diabetes, Hypertension, Muscle Wasting/Atrophy and Unsteadiness on Feet. R4's Treatment Administration Record/TAR, dated 2/23/26 through 3/4/26, documents an order L. buttock: to clean with wound cleanser, apply topical medication (silver sulfadiazine) and cover with gauze dressing daily and as needed.R4's current Care Plan documents: reposition/ambulate as tolerated and at least every two hours; requires substantial/maximal staff assistance for Activities of Daily Living (sitting, transferring, bed mobility, showering, toileting and dressing); incontinent of bowel and bladder and provide peri-care after each incontinent episode and check frequently and assist with toileting as needed; and related to Left Buttock wound, minimize pressure over bony prominence and treatment as ordered.R4's Braden score/risk assessment on 9/8/25 and 12/5/25 were 18 (at risk). On 1/26/26 R4's Braden score/risk assessment was 15 (at risk).The Facility Wound Report, dated 1/1/26 through 3/3/26, documents 9/27/21 as R4's admission date to the Facility. The Wound Report documents a Facility acquired Stage Three Left Buttock Pressure Ulcer was identified on 1/26/26. On 3/3/26, R4's Stage Three Left Buttock Pressure Ulcer measured 1.50 centimeters/cm by 1.0 cm by 0.2 cm.R4's Initial Wound Evaluation and Management Summary, dated 1/26/26, documents an initial wound evaluation and assessment for R4's Left Buttock Stage Three Pressure Ulcer. R4's Left Buttock Stage Three Pressure Ulcer measured 2.2 cm by 1.5 cm by 0.3 cm, with moderate Serous exudate/drainage and fifty percent slough.On 3/4/26 at 9:10 am, V8 (Certified Nursing Assistant/CNA) and V9 (CNA) were transferring R4 with a mechanical lift out of R4's wheelchair. R4's incontinence brief was soiled with urine and R4's Left Buttock did not have a dressing. V8 and V9 applied a clean incontinence brief, without performing perineal care, and pulled up R4's pants and transferred R4 back into the wheelchair without a clean dressing to R4's Left Buttock. R4's bed did not have pressure redistribution mattress.R4's Initial Wound Evaluation and Management Summary, dated 3/2/26, documents an assessment for R4's Left Buttock Stage Three Pressure Ulcer. R4's Left Buttock Stage Three Pressure Ulcer measured 1.5 cm by 1.0 cm by 0.2 cm, with moderate Serous exudate/drainage and seventy-five percent slough.On 3/4/26 at 9:10 am, V8 (CNA) and V9 (CNA) verified that R4 did not have a dressing to R4's Left Buttock.On 3/4/26 at 12:26 pm, V7 (Wound Physician) stated, I have been treating (R4) for (R4's) pressure ulcer. This is a house acquired Stage Three Pressure Ulcer.On 3/4/26 at 10:15 am, V1 (Administrator) verified that R4's Left Buttock pressure ulcer was facility acquired. V1 stated, (R4) does not walk much anymore like (R4) used to. (R4) spends more time in (R4's) wheelchair and we just got a new wheelchair cushion for (R4). In the morning, after (R4) gets up for the day, it is hard to get (R4) out the wheelchair again.The Facility Skin Condition Assessment and Monitoring Pressure and Non-Pressure Policy, dated 12/2025, documents: to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other skin conditions and assuring interventions are implemented; dressings which are applied to pressure ulcers shall include the date of the licensed nurse who performed the procedure and will be (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked daily for placement, cleanliness and signs/symptoms of infection; care plan will be revised as appropriate to reflect alteration of skin integrity, approaches and goals of care; and Physician ordered treatments shall be recorded after each administration.The Facility Resident Rights for People in Long Term Care Facilities, dated 11/2018, documents: Facility must provide equal access to quality care regardless of diagnosis, condition or payment source; and must provide services to keep your physical and mental health, at their highest practical levels.