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	12/04/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33975 Based on observation, interview, and record review the Facility failed to maintain comfortable and safe temperature levels for five of 24 Residents (R1, R10, R20, R26, and R75) reviewed for comfortable and homelike environment in a sample of 33. Findings include: Facility Nursing Home Resident Rights Policy, undated, documents: Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law, the law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination; be treated with consideration, respect and dignity, recognizing each Resident's individuality; quality of life is maintained or improved; a homelike environment; and reasonable accommodation of needs and preferences. Facility Logbook Documentation, dated 11/26/24, documents room temperatures for room [ROOM NUMBER] (66.7 Fahrenheit/F), room [ROOM NUMBER] (69.6 F), room [ROOM NUMBER] (64.8), room [ROOM NUMBER] (66.2 F), Hall to Dining Room (68.4), Hall to Hill (65.5 F), Hall to River (69.4 F), Hill Short (69.3 F). On 12/01/24 at 8:55 am, R26 (alert and oriented) was sitting in the Dining Room wearing a thick insulated jacket. R26 stated The Dining Room is always cold, and I have to wear a heavy jacket to sit in the Dining Room for meals. On 12/02/24 at 1:00 pm, R1, R20 and R75 (alert and oriented) were sitting together at a Dining Room table wearing heavy jackets. R1 stated, This Dining Room is always so cold. R20 stated, This Dining Room is always cold, and we have to wear extra clothing or jackets to keep warm during our meals. See, you can feel the cold air coming through the doors. R75 stated It is always cold in this Dining Room, that is why we are wearing all these jackets. On 12/02/24 at 2:30 pm, there was an approximately 3/8 inch wide gap between the outside double doors from the Dining Room leading to the outdoor smoking area. The gap spanned the height of the double doors and cold air was blowing in through the gap. The outside temperature was 32 degrees Fahrenheit/F at the time. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/03/24 at 2:00 pm, R10 (alert and oriented) was standing in the [NAME] Hallway and stated, My room is down here, and it is always cold in this hallway, it is the coldest part of the building. On 12/3/24 at 8:30 am the Conference Room, located in the middle of the building, was 60 degrees Fahrenheit. On 12/02/24 at 2:05 pm, V7 (Environmental Services Director) tested different areas the Dining Room with readings between 66 and 70 degrees Fahrenheit. The center of the Dining Room tested at 66 degrees Fahrenheit. On 12/4/24 at 11:15 am, V1 (Administrator) verified the low temperatures in areas of the building.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 31285 Based on, observation, interview, and record review the facility failed to accurately document an upper extremity fracture and range of motion impairment in an MDS/Minimum Data Set for one of 24 residents (R82) reviewed for MDS accuracy in a sample of 33. Findings include: The facility was unable to provide an MDS policy. R82's medical record includes a left shoulder X-ray interpretation dated 11/01/24 by V19 (Radiology Physician) documenting an acute fracture of the distal clavicle. R82 was placed in a left arm sling on that date. R82's medical record includes a Progress Noted by V21 (Orthopedic Physician) dated 11/07/24 documents R82 had a comminuted supracondylar fracture of the left humerus and was fitted with a left long arm waterproof cast at that time. R82's medical record included a left elbow X-ray report by V17 (Radiology Physician) dated 11/06/24, documenting R82 had a supracondylar fracture of the distal left humerus/upper arm. R82's medical record includes a Nurses Note by V2 (Director of Nurses/DON), dated 11/07/24 at 3:24pm stating, (R82) returned from (orthopedic) walk in clinic with cast to left forearm. Monitoring orders in place. R82's MDS/Minimum Data Set completed on 11/07/24, does not identify R82's left arm and clavicle fractures, cast placement, and impairment of her upper extremity. On 12/01/24 at 11:45am R82 was sitting in the common area in a wheelchair with a pink fiberglass cast and sling in place to her left arm. R82 was self-propelling using her feet and only her right arm. On 12/03/24 at approximately 10:53am V2 (DON) stated R82's MDS, completed on 11/07/24 is not accurate and should have identified R82's clavicle and left humerus, cast placement, sling and upper extremity impairment. V2 also stated the facility has no onsite MDS Coordinator currently and the Corporate Regional MDS Coordinator is filling in at this time.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50962 Based on interview and record review, the facility failed to notify state mental health authority after a significant change in physical condition of two residents who have a mental disorder and failed to follow facility policy on Preadmission Screening and Annual Resident Review (PASARR) for two residents (R19, R59) of eight residents reviewed for PASARR in a sample of 33. Findings include: The facility's policy titled Preadmission Screening and Annual Resident Review (PASARR), revised 11/2018, documents, Annually and with any significant change of status, the facility will complete the PASARR Level I screen for those individuals identified per the Level II screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly. The objective of the PASARR policy is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified. 1. R19's Admission Record documents R19's date of admission to the facility was 5/26/20 and his diagnoses on admission included: Chronic Obstructive Pulmonary Disease, Cerebral Infarction, Disorganized Schizophrenia, Major Depressive Disorder, and anxiety disorder. R19's Preadmission Screening and Resident Review (PASARR), dated 5/21/20, documents R19 needs Special Services: Professional Observation (Physician/MD, Registered Nurse/RN) for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, and Illness self-management. No further PASARR in medical record. R19's medical record indicated R19 had a significant change 5/22/24 and started on hospice services. R19's census report, dated 5/22/24, documents R19 admitted to hospice. On 12/03/24 at 10:24am, V15 (Business Office Manager/BOM) stated she initiates the PASARR's for residents prior to admission if coming from home, then Social Services proceeds with the rest. V15 (BOM) also stated that she was unsure of facility policy regarding PASARR's being evaluated annually, but Social Services handles the significant change PASARR reviews. V15 (BOM) verified that R19's PASARR has not been done annually. On 12/03/24 at 10:38am, V16 (Social Service Director/SSD) stated she is not sure on the exact process for significant change PASARR reviews. On 12/03/24 at 1:33pm, V15 (BOM) stated the facility is supposed to follow the facility's policy on PASARR's, So I guess we are supposed to re-evaluate yearly. Whatever the policy says. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 2:05pm, V16 (SSD) verified that the state mental health authority was not notified of R19's significant change so a subsequent PASARR review was not conducted. 32189 2. The Admission Minimum Data Set (MDS) dated [DATE], the Annual MDS dated [DATE] and the Quarterly MDS dated [DATE] documented in section I, Psychiatric/Mood Disorder that R59 did not have Depression, Bipolar Disorder, Psychotic Disorder, Schizophrenia or Post Traumatic Stress Disorder. The Discharge Return Anticipated MDS dated [DATE] and each subsequent MDS documented R59 had a Schizophrenia diagnosis. The Care plans between 7/13/22 and 10/10/23 did not have a schizophrenia as a diagnosis or interventions related to a schizophrenia diagnosis. The Care plan dated 3/22/24 to present documented R59 was resistive to cares related to Schizophrenia. The Physician Orders and Medication Administration Records documented Quetiapine Fumarate (a medication to treat Schizophrenia) had been ordered and administered daily since 10/4/24. The Psychiatrist Physicians Note dated 11/28/23 documented a referral for evaluation related an increase in aggressive fighting behaviors due to Paranoid Schizophrenia. The Level I PASARR evaluation dated 6/17/22 documented no level II PASARR was required due to Your Level I screen does not show that you have a serious mental illness or an intellectual/developmental disability (IDD). You do not need more screening unless you have or may have a serious mental illness or an IDD and experience a significant change in treatment needs. R59's medical record does not document that R59 has had any further PASARR screenings or an evaluation since R59's new diagnosis of Schizophrenia in October/November 2023. On 12/1/24 at 1:00 PM, V3 (Assisting Director of Nursing) stated a PASSAR II was not indicated per the PASARR I. On 12/4/24 at 1:00 PM, V1 (Administrator) verified the state mental health authority was not notified of R59's significant change so a subsequent PASARR review was not conducted.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34048 Based on observation, interview, and record review, the facility failed to implement personalized care plans for two of 24 residents (R63, R77) reviewed for care plans in a sample of 33. Findings include: The Facility's Comprehensive Care Plan policy, revised 10/2024, documents that the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. Findings include: 1. R63's Minimum Data Set, dated dated [DATE], documents a diagnosis of Non-Alzheimer's Dementia and Post Traumatic Stress Disorder. R63's current care plan does not document goals or interventions concerning R63's Dementia care or Post Traumatic Stress Disorder. On 12/4/24 at 10:00am, V1 (Administrator) verified that R63's Dementia care and Post Traumatic Stress Disorder should be care planned and but is not. 32189 2. The vital sign monitoring log documented R77 weighed 171.2 pounds on 05/21/2024 and 152.5 pounds on 11/27/2024 which is a -10.92 % (percent) loss in six months. R77 weighed 165.0 pounds on 09/25/2024 and 152.5 pounds on 11/27/2024 which is a -7.58 % loss in three months. The current care plan for R77 did not include weight loss as an identified problem or interventions related to weight loss. On 12/4/24 at 12:30 PM, V1 (Administer) and V6 (Regional Dietary Manager) stated the care plan did not include weight loss as an identified problem, goals or interventions related to weight loss.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on interview and record review, the facility failed to monitor and prevent weight loss for one of five residents (R77) reviewed for weight loss in the sample of 33 residents. The findings include: The Dietician Referrals and Recommendations policy dated 2/2024 documented the dieticians recommendations will be communicated to the medical provider to provide appropriate interventions; review monthly weights; complete nutritional assessments on residents according to annual MDS (Minimum Data Set), high risk criteria consists of unintentional weight loss of greater than 5 percent in one month, greater than 7.5 percent in three months and greater than 10 percent in six months. The Dietician Nutritional Risk Referral policy dated 11/2012 documented the Dietary Manager and/or the Interdisciplinary team may implement nutritional intervention as deemed appropriate with Physician/designee input and approval. The Regional Dietician Consultant will follow up on the effectiveness of nutritional interventions and make recommendations to change nutritional plan as needed, interventions may include a referral to speech therapy, recommendation of supplementation and/or fortified foods and/or recommend protein supplements. R77 was admitted on [DATE] with the following diagnoses: cerebral vascular accident (blood clot which prevents blood flow to the brain) with partial paralysis affecting the right side of the body, a speech disorder and difficulty with swallowing. The vital sign monitoring log documented R77 weighed 171.2 pounds on 05/21/2024 and 152.5 pounds on 11/27/2024 which is a -10.92 % (percent) weight loss in six months. R77 weighed 165.0 pounds on 09/25/2024 and 152.5 pounds on 11/27/2024 which is a -7.58 % weight loss. The Physician's Order dated 6/25/24 ordered a Speech Therapy Evaluation and Treatment due to not eating due to puree diet. R77 did not have a speech therapy evaluation at the facility. On 8/25/24, R77 was hospitalized due to a fall. The hospitalization record documented a swallow study was conducted on 8/27/24 and findings resulted were difficulty swallowing, oral weakness, impaired chewing with whole/unchewed portions of solids swallowed and aspiration (food enters the airway). R77 was discharged back to the facility on pureed diet and thin liquids. The current care plan documented R77 had a nutritional problem or potential nutritional problem, had dysphagia, and required assistance with eating and supervision with meal consumption related to cerebral vascular accident, partial paralysis affecting right side of the body. The Care plan did not document weight loss as an identified problem or interventions related to weight loss. The current care plan documented R77 had a nutritional problem or potential nutritional problem, had dysphagia, and required assistance with eating and supervision with meal consumption related to cerebral vascular accident, partial paralysis affecting right side of the body. The Care plan did not document weight loss as an identified problem or interventions related to weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) section K dated 7/16/24 (Quarterly), 8/25/24 (Discharge Return Anticipated), 10/12/24 (Discharge Return Anticipated) and 10/25/24 (Quarterly) documented R77 had no weight loss. The last Dietician's assessment was conducted on 9/11/24 by V13 (Corporate Dietician). V13 documented R77 had significant weight loss and will recommend house supplement three times daily. The Physician Progress notes dated 9/24/24 and 11/22/24 did not document the physician assessed R77's weight loss, was notified of the dietician's recommendations or ordered interventions specific for weight loss management. 10/28/24 The Mini Nutritional assessment dated [DATE] completed by V11 (MDS/Care plan Coordinator/Licensed Practical Nurse) documented the assessment scored a 12.0 which indicated normal nutrition, had no weight loss and the registered dietician was available for consult if needed. The Significant Weight Loss list dated September 2024 documented R77 had a 13.5 pound weight loss (7. 8%) in the past three months. The Significant Weight Loss list dated November 2024 did not list R77. On 12/3/24 at 9:20 AM, V1 (Administrator) stated the company had three corporate dieticians that visit facilities in their regions on a part time basis and staff could notify them if they had concerns. V1 verbally agreed R77's weight loss had not been monitored by the dieticians, the physician had not been notified, there were no specific interventions related to weight loss management in the care plan and the Nutritional Assessment and the MDS were not accurate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31285 Based on record review, observation and interview, the facility failed to label, or date refrigerated open and stored foods. The facility also failed to maintain a clean kitchen and work environment. This failure has the potential to affect all residents living in the facility except for R42 who does not receive oral intake. Findings include: The facility's Application for Medicaid and Medicare documents the facility's census was 84 on 12/01/24 with one resident who is NPO/taking nothing by mouth. The facility's Daily Cleaning Schedule, provided by V6 (Regional Dietary Manager) documents daily cleaning tasks including to Clean Stovetop/Grill. The facility's Food & Supplies: Storage policy dated 01/2024 documents; food and supply storage areas shall be maintained in a clean, safe, and sanitary manner; prepared foods stored in the refrigerator until service will be covered, labeled, and dated with an expiration date; and all foods will be covered, labeled, and dated. On 12/01/24 at 6:25 AM metal containers with ground ham, chicken nuggets, raw sausage links and sliced turkey were stored in the walk-in refrigerator and were not labeled or dated. V5 (Dietary Cook) verified and stated foods stored in the refrigerator should be labeled and dated. On 12/01/24 at approximately 6:30 AM the facility's kitchen stove's backsplash and back burners were caked with particles of dried food and the adjacent grill was covered with a black sticky substance. The top shelf of the stove was dusty and littered with dark-colored crumbly material. On 12/02/24 at approximately 7:50 AM the particles of food and sticky substances were still present on the backsplash and back burners of the stove. V9 (Dietary Aide) stated, I don't know what that is. On 12/02/24 at approximately 11:45 AM V6 (Regional Dietary Manager) stated the stove and grill are to be cleaned daily by the Dietary staff and documented on the Daily Cleaning Schedule. V6 stated she was aware of the debris present on the kitchen stove and grill.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 32189 Based on observation, interview, and record review, the facility failed to ensure transmission-based precautions and Enhanced Barrier Precautions were initiated and utilized per policy for two of 24 residents (R17, R286). The facility also failed to perform hand hygiene after indwelling urinary catheter care for one of three residents (R18) reviewed with indwelling urinary catheters in a sample of 33 residents. Findings include: The Infection Precaution Guidelines dated 11/2012 documented Transmission Based Precautions/Contact Precautions (TBP) are to be used for residents with known or suspected to be infected with microorganisms such as Clostridium difficile (c-diff) that can be easily transmitted by direct or indirect contact. Precaution signs will be utilized to alert staff and visitors to see the nurse for instructions prior to entering room. The Enhanced Barrier Precautions (EBP) policy dated 4/2024 documented EBP should be considered and implemented for indwelling medical devices and/or at the discretion of the Infection preventionist. 1. R286's Physician's Order dated 11/29/24 ordered to collect a stool specimen for c-diff testing related to diarrhea. The Progress Note dated 11/30/24 documented an antibiotic for c-diff treatment was ordered for five days and if R286 was still having loose stools then restart another round. On 12/1/24 at 7:08 AM, R286's stool specimen collected on 11/29/24 was observed in the medication room refrigerator. On 12/1/24 at 10:24 AM, R286 was observed in his room, lying in bed sleeping and no contact precautions sign was posted. On 12/1/24 at 12:35 PM, V14 (Registered Nurse) stated R286 should be in contact precautions. V14 stated The doctor ordered Flagyl (medication to treat c-diff) on the 29th (11/29/24) because he wanted to start treatment (for c-diff) and knew the specimen wouldn't be processed until Monday (12/2/24). On 12/1/24 at 1:35 PM, V2 (Director of Nursing) confirmed the reason Flagyl was ordered was to treat c-diff prophylactically and contact precautions should have been initiated when c-diff was initially suspected. 34048 2. On 12/2/24 at 11:00 am, R17 pulled up his shirt sleeve to show his dialysis fistula. There was a clean white dressing covering the site. There were no enhanced barrier precaution signs on the door, nor was there personal protective equipment in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17's current Physician Order Sheet documents to check R17's left upper arm dialysis fistula for a bruit and thrill every day and night shift. R17's current care plan documents that R17 receives hemodialysis three times a week related to end stage renal disease. R17's interventions include to check the fistula site for bleeding: if excessive bleeding at the site occurs hold pressure for a minimum of 10 minutes. On 12/4/24 at 9:30 am, V4 (Infection Preventionist/Licensed Practical Nurse) verified that R17 should be on enhanced barrier precautions due to the dialysis fistula. V4 stated that the fistula does have the potential to bleed. 33975 3. Facility Urinary Catheter Care Policy, revised 9/2020, documents to establish guidelines to reduce the risk of or prevent infections in residents with an indwelling catheter; dispose of one-time use gloves shall be worn when performing perineal care; and hand hygiene shall be performed before and after touching any part of the urinary catheter drainage bag. Facility Hand Hygiene/Handwashing Policy, revised 3/3023, documents: hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash or antiseptic handrub (i.e. alcohol based hand sanitizer including foam or gel); before and after having direct contact with a patient's intact skin; after contact with body fluids/excretions or mucous membranes; after contact with inanimate (including medical equipment) in the immediate vicinity of the patient; if hands will be moving from a contaminated body site to a clean body site during patient care; and before glove placement. R18's Physician Order Sheet/POS, dated 12/2/24, documents a Physician's Order for indwelling urinary catheter care every shift and as needed. On 12/3/24 at 10:52 am, V20 (Certified Nursing Assistant) performed and completed R18's indwelling urinary catheter care. V20 then, with the same contaminated gloves that were used during the catheter care, picked up a container of baby powder on R18's bedside table. V20 applied and rubbed the baby powder onto R18's groin area, then placed the container of baby powder back on to R18's bedside table. V20 then pulled up R18's incontinence brief and pants. No glove changing or hand hygiene was performed. On 12/3/24 at 10:52 am, V20 verified that V20's gloves should have been changed and hand hygiene performed immediately following catheter care and before touching R18's baby powder and pants.