STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Aledo	304 S.W. 12th Street Aledo, IL 61231

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30722 Based on observation, record review and interview the facility failed to notify the doctor and obtain wound treatment orders for one resident (R1) and failed to investigate, monitor, and implement new fall interventions for two residents (R1, R2) of three residents reviewed for accidents and injuries in a total sample of three. Findings include: A facility policy titled Incident and Accidents - Illinois last revised 05/2022 documents, The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to resident altercations. A section titled Procedure defines an accident as, any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident/accident report will be completed for all serious accidents or incidents of residents, all unusual occurrences and any condition resulting from an accident requiring first aid, physician visit, or transfer to another health care facility. This policy documents 1. An incident/accident report is to be completed by a RN (Registered Nurse) or LPN (Licensed Practical Nurse) and is to include: a. Date and time of incident/accident; b. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties. 2. An RN or LPN must notify the following if an actual injury occurs: a. Physician; b. Legal representative or interested family member within 24 hours. The policy continues, 4. Documentation in nurses' notes is to include: a. A description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified; b. A minimum of seventy-two (72) hours (longer, if indicated of documentation per day on resident status after the incident (vital signs, mental and physical state, follow-up, tests, procedures, and findings are to be documented. 5. All incident/accident reports are reviewed, signed and investigated by: a. The Administrator; and b. The Director of Nursing or the Assistant Director of Nursing and c. The Medical Director). Routine fall risk audits are to be completed no less than quarterly. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Aledo	304 S.W. 12th Street Aledo, IL 61231

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Pressure Injury and Skin Condition Assessment last revised 01/2018 documents that a skin condition assessment and pressure ulcer assessment will be completed at the time of admission/readmission and that residents identified will have a weekly skin assessment by a licensed nurse. This policy also documents At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes. 1 R1's Brief Interview for Mental Status score dated 09/17/24 is 13, indicating minimal memory impairments. R1's Minimum Data Sheet Section GG documents R1 requires partial/moderate assistance for lower body dressing and undressing. R1 requires partial/moderate assistance for toilet transfers and substantial/maximal assistance in tub/shower transfers. R1's Physician Order Sheet dated November 2024 document R1 has a diagnosis of Mild Intellectual Disability and has an order for skin checks weekly on every Monday on first shift. No skin checks were documented completed on 11/11/24, 11/19/24 (upon readmission from hospital), and 11/25/24. A History and Physical Documentation from R1's ED/Emergency Department visit on 11/15/24 documents R1 has second degree burns on her bilateral inguinal creases reportedly from spilling hot tea on her lap on 11/11 (2024) which was never treated or seen by medical staff. A Progress Note dated 12/2/24 written by V5/LPN (Licensed Practical Nurse) documents, (R1) has 2 new skin issues noted this shift. Open wounds to both inner thighs. (It was) Reported to this nurse that resident spilled hot tea on her lap at the beginning of November. This left 2 blisters on both inner thighs that popped and now are open wounds. Nurse cannot find any information on this happening. Wounds measured and sent to (physician). Waiting on response for treatment but covered wounds with border gauze so resident stops picking at them. On 12/4/24 at 7:06 AM V10/Anonymous ED (Emergency Department) nurse stated they called the facility on 11/15/24 regarding R1's bruises and burns. V10 stated they spoke with V7/Agency LPN who told them R1 had spilled hot tea on her lap on 11/11/24. V10 stated V7 told her the burns had no treatment ordered. V10 described R1's injury as a large fluid blister with additional burned areas to her perineal area and both inner thighs. On 12/4/24 at 3:13 PM V4/LPN/Infection Preventionist changed R1's bilateral inner thigh dressings. R1's right upper inner thigh had an open area which was approximately two inches long and appeared to be in a straight line. There were areas of pink skin which appeared to be recently healed extending from each side of R1's open area. R1's left inner upper thigh had an area which was open and approximately 1.5 inches in length, appearing to be in a straight line. R1 also had pink lines extending from the open wound, appearing to be recently healed skin. V4 stated she just received orders that day from V12/R1's physician to begin dressing changes for R1's burns. On 12/10/24 at 10:15 AM V8/CNA (Certified Nursing Assistant) stated she became aware of the burns on R1's inner thighs after R1 returned to the facility from the hospital on 11/19/24. V8 stated she then notified V4/LPN/Infection Preventionist of R1's skin issue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Aledo	304 S.W. 12th Street Aledo, IL 61231

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 10:38 AM V9/CNA stated she first heard of R1's burns on 11/15/24 when she overheard a phone conversation where V7 told the local ED (Emergency Department) nurse that R1's blisters/burns came from (R1) spilling hot tea on herself. V9 stated that V4 had seen and measured the wounds on R1's thighs and treated them after R1 returned from the hospital but was unsure of the exact day. On 12/10/24 at 10:55 AM V6/Dietary Manager stated on 11/11/24 at approximately 4:30 PM V7/Agency LPN came to the kitchen and told V6 that R1 had been served hot tea which she spilled in her lap. An undated partial investigation conducted 12/4/24 by V3 Regional Director of Operations documents an interview with V4 who stated V4 knew about R1's burn on 11/15/24 and 12/2/24. V3 also documented, (V9) states she was present for the call from the hospital and heard (V7) fill them in on the burn and that is how she (V9) knew about it. On 12/10/24 at 1:45 PM V1, Administrator in Training, confirmed she was not aware of R1's burns until 12/4/24. V1 stated these burns were not reported to the state and she didn't feel they were thoroughly investigated. On 12/10/24 at 3:10 PM V12/R1's physician stated he was first notified of the wound (to R1's inner thighs) last week. On 12/10/24 at 1:45 PM, V2, Director of Nursing, confirmed there is no documentation of R1's wounds including physician orders, measurements, or treatments between 11/11/24 when R1's burn was known to have occurred and 12/2/24. V2 confirmed R1 should have had a skin assessment upon return from her hospitalization on [DATE] and weekly thereafter. V2 stated these assessments, measurements, and treatments were not completed, but should have been addressed immediately after the initial injury on 11/11/24. R1's 9/9/24 Fall Risk Assessment documents R1 scored an 11, indicating R1 is a high fall risk. R1's Progress note dated 11/1/24 at 9:00 PM documents, CNA paged this nurse to North Unit (room number) for a resident incident. Upon entering room this nurse noted (resident) laying on her back with (moderate) amount of bright red blood to mid forehead. Nurse noted a laceration to forehead and had CNA call 911. There were no follow up vital signs documented for the following 72 hours post fall in R1's record. R1's 11/12/24 11:45 AM Progress Note documents, Resident laying on floor by W/C (wheelchair). Trying to transfer and slid onto floor. No injuries. There was no investigation or post fall additional interventions documented to prevent further falls. There were no follow up vital signs documented for the following 72 hours post fall in R1's record. On 11/15/24 at 9:30 AM R1's progress notes state she was very lethargic and hard to arouse. Narcan was administered to R1, and she was sent the local emergency department. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Aledo	304 S.W. 12th Street Aledo, IL 61231

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's History and Physical Documentation dated 11/15/24 from the local ED Emergency Department documents, On arrival in the ED (R1) was noted to have bruises on all four extremities including her wrists, upper arms, knees and hips bilaterally and the bruises are in various stages of healing. She also has a healing laceration to the forehead from a fall and ED visit on 11/1 (2024) and periorbital bruising from that. She has reportedly fallen on at least one other occasion as well and was not treated or sent to the ED for evaluation. A 11/19/24 at 9:38 PM Progress Note documents R1 pushed front door open, attempting to leave the building. CNA heard the door alarming and ran toward resident, resident stood up and began to walk outside when resident lost balance and fell on to her buttocks. There was no investigation or post fall additional interventions documented to prevent further falls. There were no follow up vital signs documented for the following 72 hours post fall in R1's record. A Discharge Summary from the local hospital dated 12/4/24 documents a concern about over sedation from medications at the nursing home. The (patient) had been on Depakote, Buproprion, Trazodone and Clonazepam, all scheduled. Will continue the Bupropion and make Trazodone qhs (every night at bedtime) prn (as needed) for insomnia and decrease Clonazepam to 0.5 mg (milligrams) bid (twice daily) prn anxiety/agitation. This summary also documents a recommendation for Physical and Occupational Therapy due to multiple falls, likely multifactorial due to sedating medications. On 12/10/24 at 10:55 AM, V11/R1's guardian stated she felt R1's falls were due to R1 being over-medicated. V11 stated when she would visit, R1 would have slurred speech and lean far forward in her chair. An undated fall log for November 2024 documents R1 had one fall on 11/1/24. On 12/4/24 at 2:06 PM V2/DON stated she missed entering R1's 11/12/24 fall on the facility fall tracking sheet and was not aware of R1's fall on 11/19/24. 2. R2's 10/3/24 Fall Risk Assessment documents a score of 18, indicating R2 is a high fall risk. R2's Progress Note dated 11/3/24 at 9:30 AM documents R2 had an unwitnessed fall at approximately 8:00 AM when she was found on her buttocks sliding out into the hallway from her room. There was no investigation or post fall additional interventions documented to prevent further falls. There were no follow up vital signs documented for the following 72 hours post fall in R2's record. R2's Progress Note dated 11/16/24 at 8:00 PM documents R2 was on the floor, sitting with no visible injuries. There was no investigation or post fall additional interventions documented to prevent further falls. There were no follow up vital signs documented for the following 72 hours post fall in R2's record. R2's Progress Note dated 11/29/24 at 7:15 PM documents R2 was found on the hallway floor right outside of her doorway on her back holding her forehead. R2's legs were out straight with her bedspread wrapped around her feet. There was blood running down her head from her forehead where she has what appears to be a small cut. There were no follow up vital signs documented for the following 72 hours post fall in R2's record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Aledo	304 S.W. 12th Street Aledo, IL 61231

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 2:06 PM V2/DON stated she missed entering R2's 11/29/24 fall on the fall tracking sheet. On 12/10/24 at 3:10 PM V12/physician stated tracking falls to monitor for trends or patterns would be beneficial in potentially preventing future falls. V12 also stated that orders for physical and occupational therapy as well as a medication review would be recommended. On 12/10/24 at 1:45 PM, V2 confirmed she cannot provide additional documentation for R1 or R2's falls and that the facility currently does not have an accurate system to track and monitor for trends and patterns of falls.