

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145928	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Arcadia Care Jacksonville		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 North Church Street Jacksonville, IL 62650	

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)
<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636</p> <p>Based on interview, observation and record review, the facility failed to promote residents' dignity by addressing residents' needs timely for 4 of 5 residents (R2, R3, R4, R5) reviewed for dignity in the sample of 5. This failure resulted in R2 feeling humiliated after having to urinate in her water pitcher due to staff not assisting her.</p> <p>Findings include:</p> <p>1. On 8/16/24 at 8:55 AM, R2 was in her bed with a large cow bell and air horn at bedside. R2 stated the call lights are not working and haven't been for a while. R2 stated they are telling her that the part has been ordered and when it comes in, it will be installed but they haven't given her a time frame for when that will occur. R2 stated they gave her a small bell to ring when she needed something, that didn't work, staff didn't come, so they gave her a pressure pad alarm to press to get staff's attention, that didn't work, staff still didn't come, so they gave her a larger cow bell and the staff still don't respond so she bought an air horn. R2 stated the staff don't come in her room unless they must, the only time she can get help is if she goes to her doorway and yells for staff. R2 stated there was one night, unsure of exact date, that she tried to get staff's attention at 2:30 AM and they didn't come until 4:00 AM, she had to urinate in her water pitcher, so she didn't have to urinate on herself. R2 stated about 2 or 3 days after that, she had a UTI (urinary tract infection) because she had to hold her urine for so long.</p> <p>On 8/20/24 at 9:40 AM, R2 stated when she was left in her urine and had to urinate in her water pitcher, this left her feeling humiliated. R2 stated that night, she had the smaller cow bell, and she isn't sure if staff heard it or not or just didn't respond to it. R2 stated they must keep her door closed because she was and is still on isolation for COVID. R2 stated the next day when she complained about it, she was given a pressure pad alarm and had the same problem, then they gave her the bigger cow bell to use. Surveyor left R2's room and moved about on the hallway, there was a resident going by in an electric wheelchair and R2's large cow bell could not be heard until the wheelchair passed and then it was audible but for only a few feet, it would have been unable to have been heard at the nurse's station. After the cow bell was rang, no one came into the room to see if anyone needed anything.</p> <p>R2's Face Sheet, undated, documents R2 has a diagnosis of Fibromyalgia.</p> <p>(continued on next page)</p>

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 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R2 is cognitively intact, R2 requires substantial/maximal assist for toileting and is continent of bowel and bladder.</p> <p>R2's Care Plan, dated 7/10/24, documents R2 has an Activities of Daily Living (ADLs) self-care performance deficit and 8/8/24, R2 is on an antibiotic for UTI.</p> <p>R2's Progress Note, dated 8/7/24 at 11:00 AM, documents R2 has a UTI and will start Ciprofloxacin 500 milligrams (mg) twice daily for 7 days.</p> <p>2. On 8/16/24 at 10:05 AM, R3 was observed up in wheelchair in room, clean, dry and without odors. Hospice aid in room with resident making his bed. Cow bell on bedside table. R3 stated the call system is not working, so they gave him a bell to use but the staff doesn't answer when he rings it. R3 stated he has had to call hospice to have them call the front desk so he could get help.</p> <p>R3's Face Sheet, undated, documents R3 has a diagnosis of CHF (Congestive Heart Failure), COPD (Chronic Obstructive Pulmonary Disease) and UTI.</p> <p>R3's MDS, dated [DATE], documents R3 has a BIMS score of 15, indicating R3 is cognitively intact, requires substantial/maximal assist with toileting, is occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>R3's Care Plan, dated 5/24/24, documents R2 has an ADL self-care performance deficit.</p> <p>3. On 8/16/24 at 10:25 AM, R4 was observed in room in bed, cow bell on bedside table. R4 stated the call lights don't work so they must use a bell, and no one comes in when they do use it. R4 stated they must yell for help, but they don't come in the room unless they must for meals, medications, etc. R4 pointed to her breakfast meal on her table that still needed picked up by the CNAs (Certified Nursing Assistant) but hadn't been because they haven't been in there since they dropped it off earlier this morning. R4 stated her family would have never put her here if they knew how she was being treated, it's more like a psych ward than a nursing home.</p> <p>On 8/20/24 at 9:45 AM, R4 was observed in room. R4 stated it is still a problem getting her cow bell to be answered with the door closed. R4 stated the door must be closed because she is still on isolation for COVID. Surveyor asked R4 to ring the small cow bell once the surveyor shut the door. Small cow bell was audible in the hallway but again only for a few feet and was not audible at the nurse's station.</p> <p>R4's Face Sheet, undated, documents R4 has a diagnosis of COPD, OA (Osteoarthritis) and Fibromyalgia.</p> <p>R4's MDS, dated [DATE], documents R4 has a BIMS score of 15, indicating R4 is cognitively intact, requires supervision or touch assist with toileting, is occasionally incontinent of urine and continent of bowel.</p> <p>R4's Care Plan, dated 4/2/24, documents R4 has an ADL self-care performance deficit.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>4. On 8/16/24 at 2:25 PM, R5 was observed in room in bed with a cow bell on bedside table. R5 stated the call light had a short circuit and isn't working, so she must use that bell to get help. R5 stated staff don't come when you ring it, but they didn't come before when they used the call light either. R5 stated she is clean and dry at this time but has had to sit in her urine for a long time because staff won't come to help her.</p> <p>R5's Face Sheet, undated, documents R5 has a diagnosis of Cerebrovascular Disease, OA, and COPD.</p> <p>R5's MDS, dated [DATE], documents R5 has a BIMS score of 14, indicating R5 is cognitively intact, is dependent with toileting and is frequently incontinent of bowel and bladder.</p> <p>R5's Care Plan, dated 11/5/23, documents R5 has an ADL self-care performance deficit.</p> <p>On 8/20/24 at 10:15 AM, V1 (Administrator) stated the call light system has not been fixed, they are still waiting on the part. V1 stated the residents are still utilizing the cow bells in place of the call lights.</p> <p>On 8/20/24 at 10:20 AM, V10, (RN-Registered Nurse), stated sometimes you can hear the cow bells at the nurse's station, depending on how hard they are rung by the resident, but they are mostly heard on the hallways.</p> <p>On 8/20/24 at 11:50 AM, V1 stated on top of using the cow bells while the call light system is down, they have also implemented 15-minute checks on residents that cannot use the cow bell and staff have been doing extra rounding. V1 stated R2 had voiced concerns when the COVID outbreak started that staff were not responding to the cow bell and she was not receiving care timely. V1 stated R2 voiced that she wasn't sure if it was because the staff couldn't hear it or they were just not responding, so she was given a bigger cow bell, air horn and pressure pad alarm to use when needing assistance.</p> <p>On 8/20/24 at 12:50 PM, V3 (Maintenance Director) stated the call light system is still down, it has been down since 8/4/24. He emailed regarding the part that was ordered and was told that they don't have an estimated date for delivery, but as soon as it is delivered, he will install it. V3 stated they continue to use the cow bells for the residents and staff are always on the hall monitoring them, so they know if they need anything.</p> <p>The Resident Rights Policy, dated 8/2017, documents the following: The purpose of the policy is to promote the exercise of rights for each resident. Residents have a right to dignity and respect.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636</p> <p>Based on interview, observation, and record review, the facility failed to wear personal protective equipment (PPE) to prevent the potential spread of COVID-19. This failure has the potential to affect all 81 residents residing in the facility.</p> <p>Findings include:</p> <p>1. On 8/16/24 at 8:55 AM, R2's room was observed with a sign on the outside of the door indicating R2 was on droplet/contact precautions. Gown, gloves, N95 and face shield/goggles are required when entering room. Gloves and masks are observed on carrier hanging on the door. No gowns were observed. Surveyor had to ask to get a gown prior to entering room. R2 stated she was admitted to the facility short term for therapy, she didn't come out of her room for the first two weeks and then only came out once to get her weight. After that, she tested positive for COVID a couple of days later, so she knows someone brought it in the facility. R2 stated she has a cough and gets short of breath easily. R2 stated she feels that they are treating her a certain way because she was the first one to test positive.</p> <p>R2's Face Sheet, undated, documents R2 has a diagnosis of COVID-19.</p> <p>R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R2 is cognitively intact.</p> <p>R2's Care Plan, dated 8/12/24, documents R2 has a positive COVID-19 result with interventions for droplet/contact isolation and to follow facility protocol for COVID-19 precautions.</p> <p>R2's Progress Note, dated 8/10/24 at 5:26 PM, documents R4 is complaining of feeling bad all over with sinus symptoms. COVID test performed, and resident is positive.</p> <p>R2's Progress Note, dated 8/10/24 at 6:13 PM, documents resident is very upset and told this nurse that she feels that the staff brought it into her: Stated she does not come out of her room.</p> <p>2. On 8/16/24 at 10:25 AM, R4's room was observed with a sign on the outside of the door indicating R4 is on contact/droplet precautions and a gown, gloves, eye protection and N95 are required to enter room. R4 stated staff have been slower to help her since she's had COVID. R3 stated she is weak and tired from it.</p> <p>R4's Face Sheet, undated, documents R4 has a diagnosis of COPD (Chronic Obstructive Pulmonary Disease).</p> <p>R4's MDS, dated [DATE], documents R4 has a BIMS score of 15, indicating she is cognitively intact.</p> <p>R4's Care Plan, dated 8/14/24, documents R4 has a positive COVID-19 result with interventions for droplet/contact isolation and to follow facility protocol for COVID-19 precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R4's Progress Note, dated 8/14/24 at 9:06 AM, documents R4 tested positive for COVID, isolation precautions started.</p> <p>3. On 8/16/24 at 8:55 AM, R5's room is located on the 200-hall. There was a sign outside of the door indicating R5 is on contact/droplet isolation and a gown, gloves, eye protection and an N95 are required to enter room.</p> <p>On 8/16/24 at 2:25 PM, R5 stated she tested positive for COVID during routine testing and didn't have any symptoms. R5 stated she has had all her COVID vaccines and boosters.</p> <p>R5's Face Sheet, undated, documents R5 has a diagnosis of COPD.</p> <p>R5's MDS, dated [DATE], documents R5 has a BIMS score of 14, indicating R5 is cognitively intact.</p> <p>R5's Care Plan, dated 8/20/24, documents R5 has a positive COVID-19 result with interventions for droplet/contact isolation and to follow facility protocol for COVID-19 precautions.</p> <p>R5's Progress Note, dated 8/15/24 at 12:34 PM, documents R5 tested positive for COVID. Resident is on isolation and physician aware.</p> <p>On 8/16/23 at 8:35 AM, V4, Agency Licensed Practical Nurse (LPN), was observed on the 200- hallway with her medication cart. V4 had her mask on but pulled down under her nose. V4 stated no one on her hallway has COVID (this is not a true statement, R5 resides on this hallway). V4 stated staff are to wear a mask, she wears an N95 when on the hallway and if they go into a COVID positive room, they must wear everything, mask, gown, gloves.</p> <p>On 8/16/24 at 8:40 AM, V5, Housekeeping, was observed in the hallway outside the dining room area with a mask on but pulled down under her nose, no residents were in the immediate area. V5 stated she has COPD (Chronic Obstructive Pulmonary Disease) and it is hard for her to breathe in the mask, so she must take breaks to get her breath. V5 stated the facility is in COVID outbreak. V5 stated for her job she wears gloves and a mask because she is cleaning and when she goes into a COVID positive room, she wears a mask, gown, gloves, and eye protection.</p> <p>On 8/16/24 at 8:45 AM, V8, Certified Nurse's Assistant, CNA Supervisor, stated staff are to wear a regular mask on the hallways and an N95, gown, gloves and face shield when going into a COVID positive room.</p> <p>On 8/20/24 at 9:45 AM, V9, Housekeeping, enter R2's and R4's room, who are in a COVID positive isolation room, with only a regular mask on.</p> <p>On 8/20/24 at 10:20 AM, V9, Housekeeping, stated staff are to wear a regular mask on the hallway and full PPE in a COVID positive room.</p> <p>On 8/20/24 at 11:50 AM, V1, Administrator, stated staff are to wear a regular mask in the hallway and an N95, face shield, gloves and gown when going into a COVID positive room.</p> <p>On 8/20/24 at 12:40 PM, V5, Housekeeping, observed in the dining room, with her mask down below her nose and mouth. There was one resident in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/20/24 at 12:45 PM, V13, CNA, was observed at the nurse's station wearing a regular mask pulled down below her nose. V13 stated they are to wear a regular mask in the hall and full PPE when in a COVID positive room.</p> <p>The Resident COVID Line Listing, undated, documents the facility outbreak started on 8/10/24. Currently the facility has 10 COVID positive residents with the last testing positive on 8/20/24.</p> <p>The Infection Control - Interim COVID-19 Policy, dated 3/2020, documents the following: Source control is recommended by those working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection. For residents with confirmed COVID-19 infection, HCP (Health Care Personal) who enter the room of a resident with suspected or confirmed SARS CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection.</p> <p>The Daily Census Report, dated 8/16/24, documents the facility has 81 residents residing in the facility.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636</p> <p>Based on interview, observation and record review, the facility failed to maintain an effective call system to ensure residents can communicate to staff when they need assistance. This failure has the potential to affect all 81 residents residing in the facility.</p> <p>Findings include:</p> <p>1. On 8/16/24 at 8:55 AM, R2 was observed in her bed with a large cow bell and air horn at bedside. R2 stated the call lights are not working and haven't been for a while. R2 stated they are telling her that the part has been ordered and when it comes in, it will be installed but they haven't given her a time frame for when that will occur. R2 stated they gave her a small bell to ring when she needed something, that didn't work, staff didn't come, so they gave her a pressure pad alarm to press to get staff's attention, that didn't work, staff still didn't come, so they gave her a larger cow bell and the staff still don't respond so she bought an air horn. R2 stated the staff don't come in her room unless they must, the only time she can get help is if she goes to her doorway and yells for staff.</p> <p>On 8/20/24 at 9:40 AM, R2 stated when she was left in her urine and had to urinate in her water pitcher, this left her feeling humiliated. R2 stated that night, she had the smaller cow bell, and she isn't sure if staff heard it or not or just didn't respond to it. R2 stated they must keep her door closed because she was and is still on isolation for COVID. R2 stated the next day when she complained about it, she was given a pressure pad alarm and had the same problem, then they gave her the bigger cow bell to use. Surveyor left R2's room and moved about on the hallway, there was a resident going by in an electric wheelchair and R2's large cow bell could not be heard until the wheelchair passed and then it was audible but for only a few feet, it would have been unable to have been heard at the nurse's station. After cow bell was rang, no one came into the room to see if anyone needed anything.</p> <p>R2's Face Sheet, undated, documents R2 has a diagnosis of Fibromyalgia.</p> <p>R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R2 is cognitively intact, R2 requires substantial/maximal assist for toileting and is continent of bowel and bladder.</p> <p>2. On 8/16/24 at 10:05 AM, R3 was observed up in wheelchair in room, clean, dry and without odors. A Hospice aide was in room with R3 making his bed. Cow bell on bedside table. R3 stated the call system is not working, so they gave him a bell to use but the staff doesn't answer when he rings it. R3 stated he has had to call hospice to have them call the front desk so he could get help.</p> <p>R3's Face Sheet, undated, documents R3 has a diagnosis of CHF (Congestive Heart Failure), COPD (Chronic Obstructive Pulmonary Disease and UTI).</p> <p>R3's MDS, dated [DATE], documents R3 has a BIMS score of 15, indicating R3 is cognitively intact, requires substantial/maximal assist with toileting, is occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R3's Care Plan, dated 5/24/24, documents R2 has an ADL self-care performance deficit.</p> <p>3. On 8/16/24 at 10:25 AM, R4 was observed in room in bed, cow bell on bedside table. R4 stated the call lights don't work so they must use a bell, and no one comes in when they do use it. R4 stated they must yell for help, but they don't come in the room unless they must for meals, medications, etc.</p> <p>On 8/20/24 at 9:45 AM, R4 was observed in room. R4 stated it is still a problem getting her cow bell to be answered with the door closed. R4 stated the door must be closed because she is still on isolation for COVID. Surveyor asked R4 to ring the small cow bell once the surveyor shut the door. Small cow bell was audible in the hallway but again only for a few feet and was not audible at the nurse's station.</p> <p>R4's MDS, dated [DATE], documents R4 has a BIMS score of 15, indicating R4 is cognitively intact, requires supervision or touch assist with toileting, is occasionally incontinent of urine and continent of bowel.</p> <p>R4's Care Plan, dated 4/2/24, documents R4 has an ADL self-care performance deficit.</p> <p>4. On 8/16/24 at 2:25 PM, R5 was observed in room in bed with a cow bell on bedside table. R5 stated the call light had a short circuit and isn't working, so she must use that bell to get help.</p> <p>R5's Face Sheet, undated, documents R5 has a diagnosis of Cerebrovascular Disease, OA, and COPD.</p> <p>R5's MDS, dated [DATE], documents R5 has a BIMS score of 14, indicating R5 is cognitively intact, is dependent with toileting and is frequently incontinent of bowel and bladder.</p> <p>R5's Care Plan, dated 11/5/23, documents R5 has an ADL self-care performance deficit.</p> <p>On 8/20/24 at 10:15 AM, V1, Administrator, stated the call light system has not been fixed, they are still waiting on the part. V1 stated the residents are still utilizing the cow bells in place of the call lights.</p> <p>On 8/20/24 at 10:20 AM, V10, Registered Nurse, RN, stated sometimes you can hear the cow bells at the nurse's station, depending on how hard they are rung by the resident, but they are mostly heard on the hallways.</p> <p>On 8/20/24 at 11:50 AM, V1, Administrator, stated on top of using the cow bells while the call light system is down, they have also implemented 15-minute checks on residents that cannot use the cow bell and staff have been doing extra rounding. V1 stated R2 had voiced concerns when the COVID outbreak started that staff were not responding to the cow bell and she was not receiving care timely. V1 stated R2 voiced that she wasn't sure if it was because the staff couldn't hear it or they were just not responding, so she was given a bigger cow bell, air horn and pressure pad alarm to use when needing assistance.</p> <p>On 8/20/24 at 12:50 PM, V3, Maintenance Director, stated the call light system is still down, it has been down since 8/4/24. He emailed regarding the part that was ordered and was told that they don't have an estimated date for delivery, but as soon as it is delivered, he will install it.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Call Light Policy, dated 11/2012, documents the following: The purpose of the policy is to respond to resident's requests and needs in a timely and courteous manner. Call bell system defects will be reported promptly to the Maintenance Department for servicing. Room checks will occur hourly until the system is repaired. Cognitively intact dependent residents will be given hand bells for alerting staff.</p> <p>The Daily Census Report, dated 8/16/24, documents there are 81 residents residing in the facility.</p>		