STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145968	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Kewanee	144 Junior Avenue Kewanee, IL 61443

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 0558 Level of Harm - Actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident was provided with an appropriately sized wheelchair and appropriate equipment to receive showers for one of three residents (R57) reviewed for accommodation of needs in the sample of 35. This failure resulted in R57 being confined to her room, unable to access the shower room, receiving bed bathing in lieu of scheduled showers, and being required to sit on the side of the bed to eat, negatively impacting R57's safety, dignity, comfort, and quality of life.Findings include: The Ombudsman's undated Resident Rights policy documented, As an individual living in a long-term care facility, you retain the same rights as every citizen of Illinois and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities: You have the right to make your own choices. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health at their highest practical levels.R57's Census Line documents R57 was admitted to the facility on [DATE].R57's Medical Diagnosis List documents R57 has Morbid (severe) Obesity and Depression.R57's Minimum Data Set (MDS), dated [DATE], documents R57 is cognitively intact, requires two staff with transfers, and one to two assists for showers. This same MDS documents R57 requires a wheelchair for mobility.R57's current Care Plan documents R57 has Depression and the target goal for R57 is that R57 will not refuse to come out of her room, get out of bed and socialize with others. This same Care Plan documents R57 requires one to two assistances from staff for showers.R57's Shower and Bathing Task, dated 12/12/25 through 1/4/26, documents R57 has only received one shower on 12/19/25.R57's Occupational Therapy Treatment Encounter Note, dated 12/25/25, does not contain documentation that a wheelchair assessment was completed for R57.R57's Medical Record does not include a wheelchair assessment for R57. There is no further documentation of a wheelchair assessment documented for R57.On 1/3/26 at 9:45 AM, R57 stated, The facility does not have a wheelchair that will fit me so I'm stuck in my room and can't get around. R57 further stated the facility did not have appropriate equipment to provide showers and reported, I (R57) had to bring my own shower chair from home because the facility had no way to give me a shower, but they still can't use the one I brought in because they said it wasn't safe. R57 stated she had only been showered one time since admission and reported, I (R57) was supposed to receive a shower last night and the aide told me they were too busy so it would have to be done another time. R57 stated she feels very secluded in her room and has no other option but to lay in bed most of the time because she has no way to leave her room. R57 further stated she was able to get up in a recliner at home and take a shower and would like to be able to get up out of bed and go to the shower room to take a shower.On 1/4/26 at 10:00 AM, V1 (Administrator) stated two different wheelchairs were purchased when R57 was admitted to the facility but neither of them fit R57 comfortably. V1 confirmed the facilities Vendor Rental History Report for R57 documents two bariatric wheelchairs were (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 0558 Level of Harm - Actual harm Residents Affected - Few	delivered to the facility for R57 on 12/9/25 and 12/12/25 and that there have been no further wheelchair deliveries for R57. V1 verified R57 was unable to utilize the two bariatric wheelchairs ordered and still does not have an appropriate fitting wheelchair for R57.On 1/4/26 at approximately 11:00 AM, V3 (Assistant Director of Nursing/ADON) stated the wheelchair available was too tall for R57 and caused discomfort. V3 stated the facility was limited to wheelchair sizes, while R57 required a larger size, stating, So far we have been unable to find one. V3 stated R57's family provided a shower chair that was not safe to use, and the facility was unable to locate a shower chair to safely accommodate R57.On 1/6/26 at 10:50 AM, V9 (Certified Nursing Assistant/CNA) stated R57 does not have a wheelchair at the facility that fits her.On 1/6/26 at 11:00 AM, V10 (CNA) stated R57 is unable to go to the shower room because R57 does not have a wheelchair or shower chair, stating, So we wash (R57) in her bed in the morning.On 1/6/26 at approximately 11:10 AM, V11 (CNA) stated R57 has no wheelchair at the facility so R57 sits on the side of the bed when she eats.On 1/6/26 at 12:45 PM, R57 pivot transferred from her bed with a walker and assistance of V3 (ADON) and V11 (CNA) to a bariatric wheelchair. R57 was unable to scoot to the back of the chair and stated that she could not get comfortable and breathe in the chair. V3 verified at this time R57 would not be safe to sit in the wheelchair by herself.On 1/6/26 at 2:10 PM, V3 (ADON) verified there was only one shower documented as being given to R57 since R57's admission. V3 stated, If the staff didn't document any other showers, then it didn't happen.On 1/6/26 at 3:00 PM, V2 (Interim Director of Nursing) verified R57's medical record and therapy notes does not contain evidence of wheelchair assessment being completed to recommend a proper wheelchair and proper wheelchair positioning for R57.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was provided thorough skin assessments to monitor for pressure injury with the use of a CPAP (Continuous Positive Airway Pressure) device, identify a new pressure wound, and provide a proper treatment and care plan interventions for a pressure injury for one (R57) of three residents reviewed for pressure injury out of a sample list of 35. Findings include:The facility's Pressure Injury and Skin Condition Assessment policy revised 1/2018 documents pressure ulcers and other ulcers will be assessed and measured at least every seven days by a licensed nurse and documented in the resident's clinical record. A wound assessment will be initiated and documented in the resident chart when a pressure ulcer is identified by a licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. At the earliest sign of a pressure injury or other skin problems, 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.The facility's Pressure Ulcer Prevention revised 1/2018 documents to prevent pressure sores/pressure injury inspect the skin several times a daily during bathing, hygiene, and repositioning measures.R57's census and clinical record documented admission to the facility on [DATE].R57's MDS (Minimum Data Set) assessment dated [DATE] documented that R57 was cognitively intact.R57's Braden Scale Assessments dated 12/15/25, 12/23/25, 12/27/25, and 01/05/26 documented that R57 is at a moderate risk for developing pressure ulcers. These same assessments did not document a pressure ulcer to the bridge of R57's nose.R57's admission Skin assessment dated [DATE] does not document a pressure ulcer or skin alteration on the bridge of R57's nose.On 1/04/26 at 9:30 AM, R57 was lying in bed asleep with a CPAP device in place.On 1/04/26 at 9:45 AM, R57 was sitting on the edge of her bed with a bright red area approximately the size of a dime noted on the bridge of her nose. R57 stated the area had been present for over one week, was painful, and R57 reported it to staff approximately one week earlier. R57 stated the only thing that was done was someone put a band aide over the area. R57 further stated the skin breakdown was caused by her CPAP mask due to the absence of a cushion, and reported the area hurt when touched or when R57's mask was touching the area.R57's electronic medical record does not contain documentation of the area on R57's nose or that a band aide was applied to the bridge of R57's nose.On 1/04/25 at 1:00 PM, V3 (Assistant Director of Nursing) stated that the previous Friday, R57 had a bandage over the bridge of her nose. V3 also stated she was not aware that R57 had developed an ulcer on the bridge of her nose and confirmed the area on R57's nose. V3 stated she would complete a skin report and notify the wound physician so a treatment could be put in place. At this same time, R57 reported to V3 that the area was painful.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a diagnosis of Diabetes Mellitus was administered physician ordered insulin and blood glucose monitoring for one (R57) of three residents reviewed for medication administration out of a sample of 35.Findings include:The facility's Medication Administration Policy dated 1/2015 documents medications must be administered in accordance with a physician's order, the right resident, right medication, right dosage, right route, and right time. Documentation of medication administration is recorded on the Medication Administration Record.R57's Census Line documents R57 was admitted to the facility on [DATE].R57's Medical Diagnoses dated 12/11/25 documents Type 2 Diabetes Mellitus and Long-Term Insulin use.R57's MDS (Minimum Data set) dated 12/25/25 documents R57 is cognitively intact.R57's Physician Orders dated 12/11/25 documents Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart) Inject 30 unit subcutaneously after meals for Type two Diabetes.R57's Hospital Discharge Medication List dated 12/11/25 documents R57 was prescribed 30 units of Insulin Aspart this evening because an evening dose was not given in hospital.On 1/04/25 at 9:45 AM, R57 stated that on 12/11/25, the facility did not have her medications or her scheduled insulin. R57 stated it took two days before she received her medications.R57's Electronic Administration Record (eMAR) dated 12/11/25 does not contain documentation that R57 received her scheduled 30 units of insulin Aspart or received her bedtime blood sugar check.On 1/06/25 at 2:10 PM, V3 (Assistant Director of Nursing) stated that if medications are not marked off the eMAR, they were not given and V3 confirmed that R57 did not receive her evening or bedtime medications on 12/11/25, including Insulin Aspart 30 units as ordered on her hospital discharge medication list. V3 confirmed R57 admitted to the facility on [DATE] at 6:49 PM.