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	03/09/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure staff signed out controlled medications at the time of administration, failed to ensure medication administration records matched administration records for controlled medications, and failed to have accurate documentation of liquid morphine for 3 of 3 residents (R1, R2, & R3) reviewed for medications in the sample of 4.The findings include:1. On 3/8/26 at 9:40 AM, the B/C hall Narcotic Book was reviewed and showed the Shift Change Controlled Substance Inventory Sheet in the book had not been signed by the night nurse at 6:00 AM. The count sheet was to have two nurse sign off at shift change. The day nurse signed the sheet.On 3/8/26 at 9:42 AM V3 (Licensed Practical Nurse/Assistant Director of Nursing) reviewed the Shift Change Controlled Substance Inventory Sheet with a start date of 3/7/26. V3 reviewed the 3/8/26 at 6:00 AM entry and stated V4 (Licensed Practical Nurse/LPN) was the off going nurse and she did not sign the form. V3 stated both nurses are to sign the form at shift change. V3 stated at shift change they count the number of sheets (controlled substance proof of use forms) and the number of cards and document that on the form (Shift Change Controlled Substance Inventory Sheet).On 3/9/26 at 3:45 PM, V1 (Administrator) and V3 reviewed the B/C hall Shift Change Controlled Substance Inventory Sheet for 3/8/26 at 6:00 AM and they confirmed that both nurses should have signed the form. They stated nurses were to sign off on the form as they do the narcotic count. This is to verify that everything is correct, and they are both okay with the counts.The facility's Narcotic/Controlled Substances - Counting Policy (3/2026) showed, always participate in the counting of the controlled substances at the beginning and ending of your shift. General Procedure for Counting Controlled Substances, follow your facilities specific guidelines and use their specific log sheet.2. On 3/8/26 at 10:28 AM, V5 (LPN) reconciled narcotic medications with the surveyor. There was a card in the medication cart locked drawer for R2's hydrocodone/APAP (Norco), take 1-2 tablets every four hours as needed for severe pain. There wasn't a Controlled Substance Proof of Use form in the narcotic book for this medication. The form was on the nurse's desk and showed the nurse signed out the 11:00 AM medication - 2 pills which brought the count to zero on the form. The medication had not been given yet but was signed out. V5 confirmed she pre-signed the medication as being given to the resident. R3's card of pregabalin (Lyrica) 75mg showed there were 16 pills in the card. The card was compared to the Controlled Substance Proof of Use form which showed V5 signed out the 12:00 PM dose and dropped the count to 15 pills on the form. V5 confirmed she signed out the medication ahead of time. V5 stated she knows they are not supposed to do that.On 3/8/26 at 3:45 PM, V3 (Assistant Director of Nursing/LPN) and V1 (Administrator) stated staff are not to pre-sign medications; they are to be signed as they are being administered. V3 stated you never know if something will happen or if they will be here the whole shift. V1 stated staff are supposed to sign the medication out as they go, that's how it is supposed to be.3. On 3/8/26 at 10:43 AM, V5 (LPN) reconciled R1's liquid Morphine 100 mg/5 ml with the Controlled Drug Receipt/Record/Disposition Form dated 10/9/25 for R1's liquid Morphine 100 mg/5 ml. R1's morphine bottle showed there was 24 ml in the bottle. The Controlled Drug Receipt/Record/Disposition Form dated 10/9/25 for R1's liquid Morphine showed on 12/26/25 at 4:00 AM there was 27.5 ml of morphine in the bottle; on 12/27/25 at (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:00 AM .25 ml was given, and it went to 27.25 ml; on 12/30/25 at 12:00 AM 0.25 ml was given and there was 26.75 ml documented as being in the bottle. There should have been 27 ml in the bottle. There was no documentation as to why there was a discrepancy. The Controlled Drug Receipt/Record/Disposition Form dated 10/9/25 for R1's liquid Morphine showed the doses were signed out on the form on 12/22/25 and 12/27/25. R1's Medication Administration Record for December 2025 did not show the doses documented as being given. R1's Progress notes were reviewed and on 12/22/25 there weren't any notes showing morphine had been given to R1. There was a note on 12/27/25 at 10:49 AM that showed that morphine was given.The Controlled Drug Receipt/Record/Disposition Form dated 10/9/25 for R1's liquid Morphine showed a dose of medication was signed out on the form on 1/19/25. R1's January 2026 MAR did not show any dose of morphine given on 1/19/25. R1's Progress Notes were reviewed and did not show any note on 1/19/26 for the administration of morphine.The Controlled Drug Receipt/Record/Disposition Form dated 10/9/25 for R1's liquid Morphine showed on 2/27/26 there was 25 ml of morphine in the bottle. On 3/2/26 it was documented that there was 24 ml in the bottle and said count correction next to the entry done by V2 (Director of Nursing/DON). There was no documented administration of the medication between 2/27/26 and the count correction on 3/2/26.On 3/8/26 at 10:43 AM, V5 (LPN) stated a clarification of the amount of morphine was done with V2 (DON) because it looked like there was 24 ml in the bottle of morphine. They thought maybe the morphine wasn't being subtracted correctly. V5 stated she did not know what V2 found out when she looked into it.On 3/8/26 at 3:45 PM, V1 (Administrator) and V3 (Assistant Director of Nursing/LPN) reviewed the Controlled Drug Receipt/Record/Disposition Form dated 10/9/25 for R1's liquid Morphine and stated they should have noticed the other discrepancy on the form and not just the one reconciled by the DON. V1 stated whenever there is a discrepancy, whoever is on call is notified. The discrepancy is investigated. V1 stated their Regional Corporate person looked at R1's morphine and said that staff were subtracting wrong in comparison to the liquid morphine in the bottle. V1 stated the residents MAR, and narcotic sheet should match for administration of the medications.The facility's Medication Administration Policy (3/2026) showed documentation of medication administration is recorded on the Medication Administration Record - MAR or Treatment Record and includes the date, time, and initials of the licensed nurse or certified medication aide who administered the medication. When class II medications are administered, the medication is a. recorded on the medication administration record by a licensed nurse and b. accounted for on the resident's individual Control Substance Record by a licensed nurse.