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	03/20/2025

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396 Based on interview and record review, the facility failed to ensure a resident with new diagnoses of mental illness after admission was referred to the state agency for a level II PASARR (Preadmission Screening and Resident Review) evaluation for one of one resident (R25) reviewed for PASARR screening in the sample of 35. Findings include: The facility's Preadmission Screening and Annual Resident Review (PASARR), dated 11/2018, documents It is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in PASARR level I for all new and readmissions per requirements to determine if the individual meets the criterion for mental disorder (Severe Mental Illness/Severe Mental Disability), intellectual disability or related condition. Annually and with any significant change of status, the facility will complete the PASARR level one screen for those individuals identified per the Level II screen requiring specialized services. R25's current electronic medical record profile and Face Sheet, documents R25 was admitted to the facility on [DATE]. R25's most recent Level I PASARR (PASRR) evaluation, dated 6/23/22, documents at the time of evaluation R25 had mental health diagnoses of: Depression/Depressive Disorder. This same evaluation documents Review Date: 6/23/2022, Level I Outcome: No Level II Required. Resolved symptoms rationale: The Level I screen indicates that a PASRR disability is not present because of the following reason: Low level symptoms are present. However, submitted information supports that they are well controlled and there is no history of serious mental illness. If the individual's symptoms increase or other information suggests a potential serious mental illness, then the nursing facility must submit an updated screen to reevaluate the need for a PASRR Level II behavioral health evaluation. R25's Current Medical Diagnosis list, dated 3/20/25, documents R25 has been diagnosed with following diagnoses at or after admission, Bipolar on 6/25/22, Psychophysiologic Insomnia on 6/25/22, Vascular Dementia with Severe Psychotic Disturbance on 10/1/22, Unspecified Affective Mood Disorder on 1/31/24, Delirium due to known Physiological Condition on 6/25/22, and Unspecified Psychosis not due to Substance or Known Physiological Condition on 9/5/23. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's medical record does not document that R25 has had any further PASARR screening or evaluation since admission to the facility or after R25's new diagnosis of new Severe Mental Illness. On 3/20/25 at 11:35 AM, V8 (Licensed Practical Nurse/Minimum Data Set) confirmed that R25 has not had a PASARR re-screen since admission or a level II screening at all. V8 stated, (R25) was admitted in June 2022 and from the hospital record she only had the diagnosis of Dementia. The PASARR screen was done at the hospital prior to admission and only listed depression for a diagnosis. V8 confirmed R25 has new diagnoses since admission and stated, I don't ever redo the PASARR after they have been admitted and did not realize that it needed to be redone with new diagnoses.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on observation, interview and record review, the facility failed to complete hand hygiene prior to and during urinary catheter care for one of two residents (R38) reviewed for indwelling urinary catheters in the sample of 35. Findings include: The facility's Urinary Catheter Care policy, dated 10/2024, documents Purpose: To establish guidelines to reduce the risk of or prevent infections in resident with an indwelling catheter. Guidelines: 2. Hand hygiene shall be performed before and after touching any part of the urinary catheter drainage system. The facility's Infection Precaution Guidelines, dated 10/2024, documents Standard Precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions, excretions (except sweat), mucous membranes may contain transmissible infectious agents. Standard Precautions consist of a group of infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status, in any stetting in which healthcare is delivered. These include hand hygiene. Standard precautions will be employed by all personnel for all residents at all times. R38's current computerized medical record documents R38 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Retention of Urine, Benign Prostatic Hyperplasia, and Obstructive and Reflux Uropathy. R38's Physician Order Sheet, dated 3/20/25, documents R38 has an indwelling urinary catheter. On 3/19/25 at 2:02 PM V6 (Certified Nursing Assistant/CNA) and V7 (CNA) were preparing to perform R38's urinary indwelling catheter care. V6 and V7 assisted R38 to his bed with gloved hands. V7 pulled R38's privacy curtain with her right hand once R38 was in bed. V6 and V7 both assisted in removing R38's pants and brief with their gloved hands. V7 removed her gloves and reapplied new gloves without washing or sanitizing her hands. V7 then performed urinary catheter care. After V7 performed R38's urinary catheter care, V7 readjusted R38's catheter, removed her gloves and applied new gloves without washing or sanitizing her hands. V7 then applied a new brief on R38. V7 never washed or sanitized her hands throughout R38's entire indwelling urinary catheter care procedure. On 3/19/25 at 2:25 PM V6 and V7 verified they should have washed their hands prior to performing catheter care and in between glove changes when going from dirty to clean areas. V7 stated, I knew I was supposed to use an alcohol-based sanitizer or wash my hands, but I didn't want to bring the huge bottle of alcohol-based sanitizer we (the facility) have into (R38's) room. On 3/20/25 at 9:43 AM V3 (Assistant Director of Nursing/Infection Preventionist) verified that V7 (CNA) should have washed her hands before providing urinary catheter care and during R38's indwelling urinary catheter care procedure.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50627 Based on observation, interview, and record review the facility failed to obtain an order and follow a physician order for oxygen use and ensure an oxygen care plan was developed for two of three residents (R16 and R21) reviewed for oxygen in the sample of 35. Findings include: The Facility's Oxygen Concentration, dated 10/2024, documents Procedure: 1. Verify and understand the physician's order. 2. Know the flow rate and duration of use. The Facility's Medication Administration Policy, dated/revised 01/2015, states Medications must be administered in accordance with a physician's order, e.g. (for example), the right resident, right medication, right dosage, right route, and right time. The Facility's Comprehensive Care Plan Policy, dated/revised 11/2017, states The purpose of this policy is to develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 1. On 3/17/2025 at 10 AM, R21 was lying in bed with oxygen flowing at 4.5L (liters) per nasal cannula. R21's current Physician Order Sheet, dated 3/17/25, does not contain a physician order for the use of oxygen. On 3/17/2025, at 9 AM R21's current care plan did not address R21's oxygen use. On 3/17/2025 at 10:15 AM, V9 (Licensed Practical Nurse/LPN) confirmed R21's oxygen per nasal cannula was set at 4.5 liters. V9 also confirmed R21 had no order for oxygen via nasal cannula. On 3/17/2025 at 10:35 AM V2 (Director of Nursing) verified R21 did not have a current physician order for oxygen or a care plan that address R21's oxygen use. V2 stated, I do not see an order for (R21) to have oxygen. (R21) should have an order for oxygen in order for (R21) to receive oxygen via nasal cannula. V2 added an order for R21 to receive oxygen and updated R21's care plan to reflect R21 receiving oxygen after being made aware. 2. On 3/17/2025 at 10 AM, R16 was lying in bed with oxygen flowing at 4L per nasal cannula. On 3/18/2025 at 1:35 PM, R16 was lying in bed with oxygen flowing at 4L per nasal cannula. R16's current Physician Order Sheet, dated 3/20/2025, states Oxygen at 2L via nasal cannula (wean as tolerated) as needed for prophylactic. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/2025 at 1:40 PM, V10 (LPN) confirmed R16's oxygen per nasal cannula was set at 4L. V10 also confirmed R16's order states Oxygen at 2L via nasal cannula (wean as tolerated) as needed for prophylactic.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49187 Based on observation, interview and record review, the facility failed to ensure a multidose insulin pen injector and a multidose tuberculin vial were labeled and dated when opened. These failures have the potential to affect all 56 residents residing in the facility. Findings include: The facility's Medication Storage Policy, dated 10/2024, documents Purpose: To ensure proper storage, labeling, and expiration dates of medications, biologicals, syringes, and needles. Guidelines: 5. Once any medication or biological package is opened, Facility should follow manufacturer supplier guidelines with respect to expiration dates for opened medications. Facility should record the date opened on the medication container when the medication has a shortened expiration date once opened. The Manufacturer Guidelines for Aplisol (Tuberculin), undated, documents Aplisol vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials in use for more than 30 days should be discarded. The facility's Pharmacy Audit Assistance Service, dated 1/22/2019, documents Tresiba FlexTouch (insulin) 100 units/ml (milliliter) expiration date 56 days after opening. R18's current Physician Order Sheet, dated 3/20/25, documents the following Physician Order: Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml (insulin)- Inject 40 units subcutaneously one time a day. On 03/17/25 at 11:40 AM V11 (Licensed Practical Nurse) opened the top right drawer to B and C Wing medication cart where residents' insulin pens and vials were stored. In this drawer R18's Tresiba FlexTouch 100units/ml insulin pen injector, 1/3 full was not labeled with an open date. V11 then opened the refrigerator located in the B and C Wing medication storage room. Located in the refrigerator was Aplisol (Tuberculin) 5TU (Tuberculin) units/0.1ml,1/2 full and not labeled with an open date. On 3/17/25 at 11:44 AM V11 verified R18's multidose insulin pen and the multidose vial of (Tuberculin) were both open and not labeled with an open date and should have been. V11 stated, The vial of (Tuberculin) is used for any resident in the facility. On 3/17/25 at 1:30 PM V2 (Director of Nursing) verified multidose insulin pens or vials and (Tuberculin) vials should be labeled and dated with an open date.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 49187 Based on observation, interview, and record review the facility failed to ensure greater than 80 square feet per resident in multiple resident rooms. This failure has the potential to effect 31 residents that could reside in these 31 rooms. Findings include: The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 3/18/25 and signed by V1 (Administrator) documents 56 residents currently reside within the facility. An Illinois Department of Public Health Letter, addressed to (the facility) and dated 7/17/2024, documents The waiver is granted for rooms 107-112, 115-119, 201-209, 301-306, 307-311 and is subject to annual review or review at any time the facility does not meet the conditions under the waiver which the waiver was granted. On 3/17/25 at 1:00PM V1 (Administrator) stated the facility does have rooms that do not meet the 80 square foot per resident requirement and gave a floor plan with highlighted rooms that were less than 80 square feet. Those rooms were 107, 108, 109, 110, 111, 112, 115, 116, 117, 118, 119, 201, 202, 203, 204, 205, 206, 207, 208, 209, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, and 311. On 3/20/25 at 11 AM V1 (Administrator) stated the waiver gets sent every year to the State Agency. V1 stated the facility does put two residents in the rooms with the waivers and any resident could be moved to those rooms with a roommate.