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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146023	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arthur Home, The	423 Eberhardt Drive Arthur, IL 61911

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to ensure the dignity of four (R4, R5, R6, R7) residents during meal service out of four residents reviewed for inappropriate staff behavior in a sample list of twelve residents. Findings include: R4's Minimum Data Set (MDS) dated [DATE] documents R4 as cognitively intact. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as moderately cognitively impaired. This same MDS documents R5 requires staff assistance for setting up and eating meals. R5's Electronic Medical Record (EMR) does not list eggs as an allergy nor dislike. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact. R7's Minimum Data Set (MDS) dated [DATE] documents R7 as cognitively intact. On 12/2/24 at 8:00 AM R5 was served and ate eggs for breakfast in the facility dining room designated for residents who require assistance eating. On 11/27/24 at 3:35 PM V16 stated three Certified Nurse Aides (CNA) (V11, V14, V15) all yelled at V16 in front of the dining room full of residents eating breakfast. V16 stated V16 served R5 her breakfast. V16 stated V15 CNA immediately started yelling at V16 from across the room that R5 could not have eggs. V16 stated then V11 and V14 also started yelling at V16 from across the room. V16 stated V11, V14, V15 just kept yelling '(R5) doesn't get eggs. Don't you know that! You (V16) should know that by now. (R5) never gets eggs!'. V16 stated V11, V14 and V15 all used a 'hateful and mean' tone as they were yelling at V16. V16 stated V16 served R5 eggs on 11/23/24 for breakfast and R5 ate all of them. V16 stated R5 is not allergic to eggs and seemed to like them on 11/23/24. V16 stated R5 should be able to have options in her meals and not eat the same meal every day. V16 stated Just because (R5) can't make that choice doesn't mean (R5) should have to eat the same exact thing every breakfast. (R5) liked them on 11/23 so I tried it again. Those girls (V11, V14, V15) were yelling with all those other residents around. Those other residents deserve to have a nice relaxing meal without all of their drama and yelling. V16 stated this incident happened during breakfast when the majority of the residents were in the dining room. (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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NAME OF PROVIDER OR SUPPLIER Arthur Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Eberhardt Drive Arthur, IL 61911	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/27/24 at 4:35 PM V14 Certified Nurse Aide (CNA) stated the dining rooms are separated into two sections. V14 stated one section is meant for people that need assistance eating and the other section is set up for the more independent residents who can feed themselves. V14 stated these two sections are divided by partial walls. V14 stated on 11/24/24 the smaller section where the people who need assistance eating was closed off because it had just been waxed. V14 stated all of the residents were moved into the same room during breakfast. V14 stated V14 was sitting at the corner table with R5. V14 stated V11 CNA delivered R5's breakfast meal to R5 when V14 noticed that R5 was served eggs. V14 stated R5 never gets eggs. V14 stated I did yell across the dining room at (V16) to let her know that (R5) got the wrong meal because of the eggs. I probably should have gotten up and walked over to (V16) but by that time (V15) CNA was yelling at (V16) too so I thought it would be ok. I didn't think about the other residents maybe getting upset. On 11/28/24 at 9:30 AM V15 Certified Nurse Aide (CNA) stated (V16) got (R5's) meal wrong again. (V16) should know that (R5) does not like eggs. It isn't written on (R5's) ticket or anything but everyone knows that. When (R5) was served eggs, I saw that and told (V16). I might have sounded loud but I didn't mean to upset anyone. I was on one side of the room and (V16) was standing by the kitchen doors. I probably should have just walked over to (V16) but I didn't think about it. I was just trying to tell (V16) that (R5) didn't like eggs. I will ask the kitchen to put that on (R5's) diet sheet so everyone knows. On 12/2/24 at 4:00 PM R6 stated I prefer to eat meals in my room now because of all the drama amongst the staff members here. I am sure it happens in the hallways too but I saw it happen for the last time on last Sunday (11/24/24). The staff here (facility) are just full of drama. Who cares if some lady (R5) gets eggs or not. If (R5) eats the d*** (expletive) eggs then feed her the eggs! Just don't yell about it in front of everyone in the dining room. On 12/3/24 at 2:50 PM R4 stated The staff yell at each other all the time. If you ask me, they (staff) all need a good lesson in manners. I don't mind if they (staff) are joking around but when they just yell because they are not listening to each other, that is when it bothers me. The day those girls (V11, V14 V15 V16) were all yelling at each other, it really upset me. I couldn't hardly eat my breakfast. On 12/3/24 at 3:00 PM R7 stated the staff [NAME] and argue amongst themselves in the dining room frequently. R7 stated the staff behavior in the dining room can be disruptive and residents sometimes have to tell them to keep it down. On 12/4/24 at 9:30 AM V20 Interim Dietary Manager stated the incident between V16 Dietary Aide and V11, V14, V15 Certified Nurse Aides (CNA) happened on 12/24/24. V20 stated V20 was not aware of the exact situation but did get a message from V16 stating she was quitting. V20 stated (V16) says she is quitting all the time so I didn't take it seriously. I let (V1) know on 11/25/24 during morning meeting that there had been some type of incident in the dining room. There have been a lot of changes in staff in both of these departments and there are still some changes to be made. We (facility) are trying to make this a better place for all of our residents. This was such an easy fix. Nursing staff should have let the dietary staff know prior to this incident that (R5) did not like eggs. That would have solved everything and avoided this from ever happening. I didn't realize staff yelling at each other over residents could ever be considered potential Abuse or I would have reported this immediately. That won't happen again. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Dignity and Privacy revised 12/6/24 documents every resident residing in the facility should live with dignity, privacy, independence and choice. Living with dignity is a basic human right and one that should be available to every resident in the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to accurately report circumstances of one resident's (R8) unwitnessed fall to the Physician out of six residents reviewed for Accidents in a sample list of twelve residents. Findings include: R8's Minimum Data Set (MDS) dated [DATE] documents R8 as severely cognitively impaired. R8's Post Fall Evaluation dated 12/1/24 documents R8 had an unwitnessed fall on 12/1/24. This same evaluation documents staff noticed R8 was not in her room at 4:40 AM and staff started searching for her at that time. This same evaluation documents R8 was found laying on the floor on her Right side in the kitchen by an outside door. This same evaluation documents R8's wheelchair alarm was not in place. This same evaluation documents the plan of care for R8 should be to apply a wander-guard for when R8 goes near exit doors, check the wheelchair for alarm when R8 self transfers and to keep alarms out of reach of R8. On 12/2/24 at 9:00 AM V21 Licensed Practical Nurse (LPN) stated R8 had an unwitnessed fall in the mechanical room on 12/1/24. V21 stated when they (V28, V29) found R8, she was laying on her Right side in the mechanical room with her wheelchair outside by the dumpster. V21 stated V21 did not see R8 until R8 was back in her room and in bed. V21 stated R8 was not assessed by a Licensed Nurse prior to the staff (V28, V29) moving R8 after her unwitnessed fall. V21 stated I called (V31) Physician and reported (R8's) unwitnessed fall. I didn't report that R8 had been outside in 20 degree F temperature, that R8 had chemical spilled on her or that a nurse had not assessed her prior to moving her. I should have but I was so panicked about the whole situation in general. Those were important details (V31) Physician should know. On 12/2/24 at 1:15 PM V2 Director of Nurses (DON) stated (V21) LPN did not report to me that (R8) had been outside, had chemical spilled on her or that the staff had gotten (R8) up after her unwitnessed fall without having had the nurse (V21) assess her first. All of those things are big problems. (R8) should have been reported to (V31) Physician. On 12/3/24 at 3:40 PM V31 Physician stated the facility called V31 on 12/1/24 to notify V31 of R8's unwitnessed fall. V31 stated V21 Licensed Practical Nurse (LPN) reported to V31 that R8 had an unwitnessed fall in the kitchen with no injuries. V31 stated the facility did not report that R8 had been outside, been exposed to chemicals and not assessed by a nurse prior to moving R8. V31 stated In these extreme cases, it is always best to notify emergency services first and then call the Physician, family and anyone else. It is most important to get the resident the emergency medical attention that they need. Even if they hadn't called 911, I would have absolutely sent (R8) to the emergency room due to being exposed to frigid temperatures and the chemical. Those chemicals should have been stored properly to avoid accidents just like this one.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to ensure a resident with Congestive Heart Failure (CHF) on a fluid restrictions was provided the correct amount of fluids. This failure affects one (R6) out of five residents reviewed for fluid restrictions in a sample list of twelve residents. These failures worsened R6's bilateral lower extremity edema and resulted in hospitalization for treatment of R6's exacerbation of CHF. Findings include: R6's undated Face Sheet documents medical diagnoses of Chronic Respiratory Failure with Hypoxia, Cerebral Infarction, Chronic Diastolic Congestive Heart Failure, Atrial Fibrillation, Chronic Pulmonary Edema, Pneumonia and history of Left Lobe Atelectasis. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact. R6's Electronic Medical Record (EMR) documents R6 was admitted to the hospital from 11/11/24-11/15/24 with medical diagnoses of Pulmonary Edema, Hypertension, Pneumonia, Coronary Artery Disease (CAD) and Atrial Fibrillation (A-Fib). R6's Physician Order Sheet (POS) dated November documents a physician order dated 11/17/24 for R6's 1200 milliliter (ml) daily fluid restriction. This same order documents dietary is to offer 800 ml and nursing to offer 400 ml daily. This same order documents R6's fluids are to be offered and documented each shift 6:15 AM-2:00 PM, 2:15 PM-10:00 PM and 10:15 PM-6:00 AM. This same POS documents a physician order for R6 to wear Oxygen at 3 Liters (L) per nasal cannula continually due to shortness of breath. R6's untitled meal and drink intake dated November 2024 documents R4 was served and drank more than the allotted dietary fluid amount of 800 milliliters (ml) on nine days (11/17, 11/18, 11/19, 11/21-11/26) with ranges from 1060 ml-1100 ml. R6's Medication Administration Record (MAR) dated November 2024 documents the nursing department provided more than the allotted nursing fluid amount of 400 milliliters (ml) five days (11/19, 11/20, 11/21, 11/24 and 11/26) with ranges from 420 ml-480 ml per day. On 11/27/24 at 12:10 PM R6 was sitting at the dining room table eating his lunch. R6 had one large cup full of water, one large cup full of tea and one small cup of juice. On 11/27/24 at 4:00 PM R6 was sitting in his wheelchair in his room. There was a clear hospital style water bottle filled with 150 milliliters (ml) of clear liquid sitting on R6's bedside table. R6's bilateral lower legs were shiny, red and appeared to be swollen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 4:01 PM R6 stated R6 was recently in the hospital for Congestive Heart Failure. R6 stated the staff do not communicate with each other about his fluid restriction. R6 stated When I was in the hospital, they (hospital) reduced my daily fluids so that I am only supposed to have 1200 ml per day. These people (staff) bring me cups full of fluids all the time. Plus the nurses bring me cups full of water each time I take pills and I get to keep my cup filled in my room. I even asked them (staff) about it and they said just don't drink too much. I can drink how much I want to but they (staff) should not be bringing it to me. Of course, I am going to drink it if the staff give it to me. I don't get extra out of the sink or anything like that but if they (staff) bring it to me, I will drink it. They (staff) tell me I am being non-compliant with my fluid restriction. I am not bringing in my own drinks. I am not drinking out of the toilet. I don't even get extra water out of the sink. I am thirsty all the time but I don't want to go back to the hospital again. I am supposed to be getting better, not worse. There is no coordination between departments at this place and it is going to land me right back in the hospital. On 12/2/24 at 4:05 PM R6 was sitting in his wheelchair in his room. There was a clear hospital style water bottle filled with 300 milliliters (ml) of clear liquid sitting on R6's bedside table. R6's bilateral lower legs were shiny, red and appeared to be swollen. On 12/3/24 at 12:05 PM R6 was sitting in his room eating his lunch. R6 had one large cup of water, one large cup of tea and one small cup of juice. R6 stated They (staff) served me all this and then tell me I am not compliant with my fluid restriction. What a joke! On 12/4/24 at 3:05 PM V20 Interim Dietary Manager and V3 Minimum Data Set (MDS)/Licensed Practical Nurse (LPN)/Care Plan Coordinator (CPC) measured out water in four different cups that would typically be served to residents. A small clear plastic cup held 200 milliliters (ml) water with ice, a large clear plastic cup held 360 ml with ice, a blue plastic coffee cup held 220 ml plain water with no ice and a light blue assisted cup with handle held 400 ml with no ice. On 12/4/24 at 3:20 PM V20 Interim Dietary Manager stated the visual poster available to staff does not document the correct amounts of water in each cup. V20 stated the residents could be served incorrect amounts if the staff are using the visual poster to determine which cup holds a specific amount. V20 stated she is working on creating a new poster for staff to follow that is accurate. On 12/4/24 at 4:00 PM V2 Director of Nurses (DON) stated the staff should only offer the amount of fluid that the Physician prescribes in R6's fluid restriction. V2 DON stated R6 is alert and oriented and can make his own decisions. V2 DON stated when the staff are bringing R6 extra fluids, that becomes a facility problem and not a resident problem. V2 DON stated V2 was not aware of R6 being served extra fluids. V2 DON stated V2 would inservice the staff on this so that everyone knows how much each resident on a fluid restriction is supposed to get and from which department. V2 DON stated V2 was not aware that the facility visual for staff to use to document how much glass holds how much fluid was incorrect. V2 DON stated the staff were providing R6 with more fluid than what the Physician ordered due to the visual aid for staff to use was wrong. R6's Discharge and Transfer form dated 12/4/24 documents (R6) was being sent to the emergency room due to weight gain, shortness of breath (SOB), +4 pitting edema. Weeping/Blistering Left ankle. Diagnoses Congestive Heart Failure (CHF)and chronic pulmonary edema. R6's Nurse Progress Note dated 12/6/24 at 1:03 PM documents R6 was admitted to the intensive care unit and required an intravenous administration of Furosemide (diuretic). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 12:20 PM V42 Medical Director stated R6 is alert and oriented. V42 stated the facility staff should be more diligent in following the physician orders for R6's fluid restriction. V42 stated R6's Congestive Heart Failure (CHF) was tenuous. V42 stated the staff providing R6 more fluids than what would be included in his 24 hour allotment played a part in R6's re-hospitalization with a diagnosis of exacerbation of CHF but R6 may have ended up in the hospital even without the extra fluids due to R6's tenuous CHF and multiple comorbidities.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 41970

Failures at this level require more than one deficient practice statement.

A. Based on observation, interview and record review the facility failed to provide adequate supervision for a severely cognitively impaired resident (R8) known to wander about the facility. The facility also failed to: complete a timely resident elopement assessment, implement fall interventions, assess a resident who had an unwitnessed fall prior to moving them, provide a safe environment, and have exit doors monitored. These failures affect one (R8) resident of six residents reviewed for elopement/accidents in the sample list of twelve residents. These failures resulted in R8 exiting the facility unnoticed and unsupervised in the dark exposing R8 to 21-degree Fahrenheit temperatures outside the building, and R8 falling in the facility mechanical room with an improperly stored chemical spilled on R8.

The immediate jeopardy began on [DATE] when R8 had an unwitnessed fall on a concrete floor in the facility mechanical room causing Rinse Additive to spill on R8. R8 was found by staff members who did not ensure R8 was assessed by a Licensed Nurse prior to moving R8 after her unwitnessed fall on a concrete floor. Staff had to retrieve R8's wheelchair which was found outside the mechanical room doors in between the facility dumpster and the exit doors of the mechanical room which had its exit door propped open. The Administrator was notified of the Immediate Jeopardy on [DATE] at 1:25 PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training through ongoing Quality Assurance Performance Improvement (QAPI) review.

Findings include:

a.) R8's undated Face Sheet documents medical diagnoses of Dementia with Agitation, Alzheimer's Disease, Glaucoma, Anxiety, Muscle Weakness, Unsteady on Feet, Need for Assistance with Personal Care and Chronic Pain.

R8's Minimum Data Set (MDS) dated [DATE] documents R8 as severely cognitively impaired. This same MDS documents R8 requires the assistance of one staff member for transfers and is able to propel herself independently in her manual wheelchair.

R8's Physician Order Sheet (POS) dated [DATE] documents a physician order starting [DATE] for Aspirin 81 milligrams (mg) daily. This same POS documents a physician order starting [DATE] for R8 to use a chair sensor pad and for staff to check every shift.

R8's Fall Risk assessment dated [DATE] documents R8 as being at risk for falls.

R8's Careplan intervention dated [DATE] instructs staff to use a bed and chair alarm for R8 and to check it every shift and to replace it as needed if a defect is noted. R8's careplan does not include a focus area, goal nor interventions for R8's known wandering, or history of early rising and entering the kitchen unattended.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R8's Elopement Risk Assessment [DATE] documents R8 as a risk for elopement. R8's medical record documents R8's most recent completed elopement risk assessment as dated [DATE]. R8's Physical Therapy Evaluation and Plan of Treatment dated [DATE] documents R8 was able to ambulate 10 feet, 50 feet and 150 feet with set up or clean up assistance using her roller walker with a normal gait pattern. R8's Nurse Progress Note dated [DATE] at 8:42 AM documents (R8) was noted not in her room around 4:40 AM. Staff began searching for (R8) as she wanders at times. (R8) was found in the kitchen near outside door laying on her Right side. Upon body assessment no injuries were noted. (R8) was unable to explain what she was doing due to her Dementia. Assisted (R8) to bed as she was asking to go to bed. Neurological Assessment initiated per facility protocol for unwitnessed fall. On call nurse (V3) as well as (V2) Director of Nurses (DON) and (V1) Administrator notified due to location of fall. The on call (V32) Physician was notified due to (R8) being on Aspirin and (V32) advised to observe for changes and notify if any worsening noted. R8's Post Fall Evaluation dated [DATE] documents R8 had an unwitnessed fall on [DATE]. This same evaluation documents staff noticed R8 was not in her room at 4:40 AM and staff started searching for her at that time. This same evaluation documents R8 was found laying on the floor on her Right side in the kitchen by an outside door. This same evaluation documents R8's wheelchair alarm was not in place. This same evaluation documents the plan of care for R8 should be to apply a (departure alert system) for when R8 goes near exit doors, check the wheelchair for alarm when R8 self transfers and to keep alarms out of reach of R8. The public website www.timeanddate.com documents the facility location was 21 degrees Fahrenheit (F) at the time of R8's fall on [DATE]. On [DATE] at 2:30 PM R8 was self propelling throughout hallways in the facility. R8 did not have a personal alarm on her wheelchair. On [DATE] at 9:20 AM The facility mechanical room contained multiple kinds of chemicals including floor cleaner, bleach, Rinse Additive, dishwashing detergent, liquid drain opener, insect killer, carpet shampoo, snow and ice melt sprinkles, waste liquefier drain maintainer, oven and grill cleaner and floor finish/sealer all within reach of where R8 fell on [DATE]. Other items in the mechanical room include electrical cords, circuit breakers, floor buffers, boilers, holding tank, sprinkler system and water softeners. There were double doors located directly next to the internal mechanical room door with a red 'EXIT' sign placed above the doors. Outside these doors was a concrete slab that leads to two large generators as tall as the building and beyond that sits a dumpster. The facility dumpster is approximately 20 steps from the exit door of the mechanical room and 25 steps from the back EXIT doors. The double doors that separate the dining rooms from the kitchen were not locked, coded and had no (departure alert) system in place. The facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place. There were multiple chemicals that would be within arms reach of the location of R8's fall. A five gallon bucket was approximately one quarter filled with a blue/green liquid and had no lid present. This same bucket labeled 'Rinse Additive' was propped against another bucket. A large pile approximately three feet tall of white large bath blankets soiled with a blue/green color were laying in a pile next to where R8 had fallen. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:43 AM The facility mechanical room contained all the same chemicals as observed on [DATE]. The five gallon bucket of 'Rinse Additive' was sitting in an upright position with no lid covering the blue/green chemical inside. The double doors that separate the dining rooms from the kitchen were not locked, coded and had no (departure alert) system in place. The facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place. On [DATE] at 11:58 AM The facility kitchen had gallon jugs of bleach, cans of stainless steel cleaner, portable heater, electrical outlets under food preparation table, ovens, warmers, fryer, dry food storage, large metal sheet pans, floor stand mixer and counter microwave that would all be within reach of a person in a wheelchair. The double doors that separate the dining rooms from the kitchen were not locked, coded and had no (departure alert) system in place. The facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place. On [DATE] at 3:00 PM the facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place. On [DATE] at 3:25 PM V32 Certified Nurse Aide (CNA) transferred R8 from her wheelchair to her recliner in R8's room. V32 CNA positioned R8's wheelchair several feet from R8's recliner chair. R8 used her walker to walk six steps with hands off stand by assistance from V32 to her recliner. V32 CNA did not place R8's personal alarm in R8's recliner before leaving R8's room. On [DATE] at 3:35 PM V32 Certified Nurse Aide (CNA) stated R8 is supposed to have her personal alarm underneath R8 when she is sitting in her wheelchair, recliner or when in bed. V32 stated V32 should have placed the alarm in R8's recliner. V32 CNA stated (R8) has had her personal alarms for a year or so but only has one pad alarm so we (staff) have to move it from the wheelchair to the recliner to the bed each time. (R8) really needs one for each because we forget many times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Arthur Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Eberhardt Drive Arthur, IL 61911	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:00 AM V21 Licensed Practical Nurse (LPN) stated R8 had an unwitnessed fall in the mechanical room on [DATE]. V21 stated R8 had been in her recliner in her room prior to her getting up independently. V21 stated V21 was on R8's hall due to another resident having behavior problems. V21 stated V21 did not hear R8's personal alarm sounding. V21 stated I don't know if (R8) shut off her own personal chair alarm or if the staff just didn't put the alarm in her chair. V21 stated R8 routinely will shut off her personal alarm and get up independently. V21 stated R8 frequently gets up at night to look for snacks. V21 stated the staff will offer R8 snacks and drinks but if the staff are busy, R8 will go to the kitchen and help herself to whatever snacks are left out. V21 stated when they (V28, V29 Certified Nursing Assistants) found R8, she was laying on her Right side in the mechanical room, with her wheelchair outside by the dumpster. V21 stated V21 did not see and/or assess R8 until R8 was back in her room and in bed. V21 stated R8 was not assessed by a Licensed Nurse prior to the staff (V28, V29) moving R8 after her unwitnessed fall. V21 stated the staff (V28, V29) told V21 that the back door to the mechanical room was propped open. V21 stated by the time R8 was back in her bed, her skin was warm with no signs of injuries. V21 stated I called (V31) Physician and reported (R8's) unwitnessed fall. I didn't report that R8 had been outside in 20 degree F temperature, that R8 had chemical spilled on her or that a nurse had not assessed her prior to moving her. I should have but I was so panicked about the whole situation in general. Those were important details (V31) Physician should know. On [DATE] at 9:25 AM V27 [NAME] stated V27 clocked in at 4:17 AM on [DATE]. V27 stated (V28, V29) came around 4:30 AM to ask if V27 had seen R8. V27 stated she replied 'No, I have not seen her'. V27 stated she was the only one in the kitchen at that time. V27 stated V27 heard noises coming from the back of the kitchen area so she went to investigate. V27 stated V27 opened the mechanical room door and found V28, V29 CNAs standing over R8 who was laying on the concrete floor. V27 stated the back exit door of the mechanical room was propped open prior to this incident so that V25 Care assistant for Assisted Living area could come in without having to bother any of the staff. V27 [NAME] stated Those girls (V28, V29) were just standing there looking at (R8). I grabbed some blankets and put over her because (R8's) whole body was shivering and her face was gray/blue colored. I told those two (V28, V29) to call an ambulance but they didn't. I used a bunch of bath blankets and shop towels to help clean up the chemical that spilled on (R8). It was all over her pants and side that she was laying on. (R8) also wet herself but that was up over her private area. I saw the open five gallon bucket of Rinse Additive laying right next to her. That is what was spilled on (R8). There were lots of chemicals right there around where (R8) was laying. There are no alarms or locks on our kitchen doors so (R8) or anyone else can just walk through the dining room, into the kitchen, into the mechanical room or through the exit doors without any of us knowing. On [DATE] at 9:53 AM V25 Care Assistant for Assisted Living stated I was walking to work that morning ([DATE]) and saw (R8's) wheelchair sitting half on the concrete and half on the grass out by the dumpster. The back door to the maintenance room was wide open. I could see (V28, V29) standing over (R8) inside the mechanical room. (R8) was shivering and looked very cold. (R8's) face and hands looked blueish. I called (V24) Assisted Living Director to let her know what was going on so she could get help. I didn't know who else to call, so I just called my boss (V24). I got (R8) some blankets and so did (V27) Cook. (V28, V29) just stood there. We (V25, V27) told (V28, V29) to call 911 but they just stood there. I saw (V28, V29) get (R8) back in her wheelchair before a nurse saw (R8). There wasn't a nurse around. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:15 PM V2 Director of Nurses (DON) stated the staff should ensure that any resident with a personal alarm keeps that alarm in place and functioning. V2 stated the staff should have reported that R8 was previously known to remove her personal alarm and also that she had entered the kitchen prior to R8's [DATE] fall. V2 stated anytime a resident falls, that resident should be assessed by the Licensed Nurse prior to assisting the resident up. V2 stated moving a resident who has an unwitnessed fall prior to the nurse assessing that resident could lead to (further) injury. V2 DON stated V21 Licensed Practical Nurse (LPN) called V2 the morning R8 fell on [DATE]. V2 DON stated I was out of town that morning so I referred (V21) to (V1) Administrator since he was closer to the facility. I was told later that (V21) did call (V1) but I don't know what was said during that conversation. I only know that (V21) LPN did not report to me that (R8) had been outside, had chemical spilled on her or that the staff had gotten (R8) up after her unwitnessed fall without having had the nurse (V21) assess her first. All of those things are big problems. (R8) should have been sent to the emergency room for further evaluation. On [DATE] at 2:35 PM V28 Certified Nurse Aide (CNA) stated V29 CNA asked V28 to help look for R8 at 4:30 AM when she was found to not be in her room. V28 stated V28 and V29 CNAs found R8 laying on the concrete floor of the mechanical room at around 4:55 AM on [DATE]. V28 stated staff searched inside and also went outside with flashlights to look for her. V28 stated We (V28, V29) found her laying on the floor in the mechanical room. (R8) looked pretty cold so (V27) [NAME] put some blankets on her. (R8) had her personal blanket over her but her pants and side were wet. I think (R8) had wet herself (urinary incontinence episode) but that big bucket of some kind of blue chemical was also spilled over right next to her. It was all over the side of (R8). The side of the bucket was touching (R8's) leg. I don't know why it didn't have a lid on it but it sure didn't. I was in panic attack mode. I just couldn't believe what I was seeing. (R8) is known to shut off her personal alarms. I said 'Let's go check the kitchen' because (R8) will get herself up early in the morning from 4:00 AM-6:00 AM, go in the kitchen and get some coffee to drink. I don't know why they (facility) don't put locks on those doors. (R8) was wearing her street clothes, not a nightgown. (R8's) wheelchair wasn't in the mechanical room. Somebody got it from outside to bring in so we (V28, V29) could put her in it and take her back to her room. That is when the nurse (V21) assessed her. On [DATE] at 10:45 AM V23 Certified Nurse Aide (CNA) stated V23 was assigned to R8 the night she fell in the mechanical room. V23 stated the last time V23 saw R8 was during routine rounds at 2:30 AM. V23 stated V23 began the next set of rounds at 4:00 AM at the opposite end of the hall from where R8 resides and reached R8's room about 4:30 AM. V23 stated R8 was first noticed not in her room at 4:30 AM. V23 stated V23 told V21 Licensed Practical Nurse (LPN) that R8 was missing at that same time. V23 stated V23, V28 and V29 CNAs started searching for R8. V23 CNAs stated V28 and V29 both found R8 first and V23 arrived a few minutes later. V23 stated V23 saw R8 laying on her Right side on the concrete floor of the mechanical room. V23 stated the mechanical room is located on the back of the kitchen area. V23 stated (R8) was cold. (R8) was shivering and her face was gray looking. There was some kind of blue/green chemical that was spilled all over (R8) on her side and on her legs and buttocks. (R8) had her blanket covering her but it wasn't wet. (R8) had also been incontinent of urine but that was up by her private area. (R8's) pants were wet with chemical not urine. This would have been a few minutes before 5:00 AM. There wasn't a wheelchair in the mechanical room with (R8). (R8) didn't look like she was injured so (V28, V29) got her up into her wheelchair that one of them (V28, V29) brought in from the outside. We (V23, V28, V29) took (R8) back to her room and put her to bed and let (V21) LPN know where (R8) was. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:20 AM V1 Administrator stated V21 Licensed Practical Nurse (LPN) reported to V1 that R8 had an unwitnessed fall in the kitchen area with no injuries. V1 stated V21 did not report that R8 was outside, had a chemical spilled on her nor that R8 was not assessed by a Licensed Nurse prior to getting R8 back up after her fall. V1 stated I am a nurse. That is Nursing 101. Anytime a resident has an unwitnessed fall, the nurse is supposed to assess that resident prior to moving the resident. I didn't find out until a couple of days later that (R8) had chemical spilled on her or was ever outside. The pieces match up though. (R8) had to have exited the facility for her wheelchair to be outside. I also found out that (R8's) personal chair alarm was not in place. Apparently the staff knew that (R8) was removing and/or shutting off her personal alarm and entering the kitchen for coffee prior to (R8's) fall on [DATE]. This should have been reported to management staff so that we (facility) could take precautions for (R8). (R8) has Dementia and is not safe to just wander around the facility into areas that she shouldn't be by herself. There are a lot of facility failures in this incident and I am trying to work through them to get some systems in place so this doesn't happen again. On [DATE] at 11:35 AM V33 Physical Therapy Assistant (PTA) stated R8 was referred to Physical Therapy (PT) for an evaluation and evaluated on [DATE]. V33 stated R8 does not remember to lock her wheelchair and has very poor safety awareness. V33 stated R8 should not be ambulating independently due to her high fall risk. On [DATE] at 3:40 PM V31 Physician stated the facility called V31 on [DATE] to notify V31 of R8's unwitnessed fall. V31 stated V21 Licensed Practical Nurse (LPN) reported to V31 that R8 had an unwitnessed fall in the kitchen with no injuries. V31 stated the facility did not report that R8 had been outside in extreme temperatures, been exposed to chemicals and not assessed by a nurse prior to moving R8. V31 Physician stated R8 could have been injured worse without having been assessed prior to moving a Dementia resident after an unwitnessed fall. V31 stated V31 would expect the facility to immediately call 911 emergency services and then call V31. V31 stated In these extreme cases, it is always best to notify emergency services first and then call the Physician, family and anyone else. It is most important to get the resident the emergency medical attention that they need. Even if they hadn't called 911, I would have absolutely sent (R8) to the emergency room due to being exposed to frigid temperatures and the chemical. Those chemicals should have been stored properly to avoid accidents just like this one. V31 stated R8 could have had Hypothermia, Low Blood Pressure causing a change in her Level of Consciousness (LOC) or died from an internal injury, the exposure to the cold or falling on a concrete floor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled Elopements and Wandering Resident Policy revised [DATE] documents the facility will provide a safe and secure environment for all residents. The facility will properly assess residents and plan their care to control wandering behavior and prevent elopement. Wandering is random or repetitive locomotion that may be goal-directed or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. An elopement assessment will be completed on admission, quarterly and after a significant change in condition. The careplan will be modified as necessary. Notify the appropriate State Agency of any incident or accident which has, or is likely to have a significant effect on the health of a resident or any incident or accident requiring the services of a physician, hospital, police department, coroner or other service provided on an emergency basis. This notification of the appropriate State Agency by telephone or fax must be made within twenty-four hours of the serious incident/accident with a narrative summary forwarded to the appropriate State Agency within five days. Observe for aimless wandering, fear or anxiety about the surroundings. Review physical plant to be sure door alarms are working and that unauthorized areas are properly locked to prevent resident entry. The Immediate Jeopardy that began on [DATE] and was removed on [DATE] when the facility took the following actions to remove the immediacy. 1. R8 was placed on 15 minute visual checks, increased sensory alarm checks, and a (departure alert band) was placed on R8's wheelchair, and the staff assignment sheet and careplan were updated on [DATE] by V2 DON. 2. V3 Minimum Data Set (MDS) Coordinator/MDS Careplan Coordinator(CPC)/Licensed Practical Nurse (LPN) updated R8's elopement risk assessment on [DATE]. 3. All current residents' elopement risks were reviewed by V2 and V3 on [DATE]. Any resident identified to be at risk has interventions in place to keep residents safe and unable to wander away without staff knowledge. 4. V3 reviewed and updated all resident care plans of residents identified as at risk for elopement on [DATE]. 5. V38 Licensed Social Worker contractor was contacted by V1 Administrator to schedule Dementia training on [DATE] at 9:00 PM. 6. V3 updated the elopement book on [DATE]. A check off list was placed in the staff/new staff/agency binder to address steps to be taken during an elopement. Implemented on [DATE] by V2. 7. V2 reviewed the facility's last quarter of falls to ensure interventions were appropriate and careplans updated with each fall on [DATE]. V2 will review falls with the Interdisciplinary Team (IDT) to ensure fall interventions are implemented, and careplans are reviewed and updated as needed by V3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. The facility fire doors at the North end of skilled unit were alarmed, a keyed lock was placed on the mechanical room door, an alarm audible to staff was placed on the employee dietary east entrance/exit door, a lock was placed on the door separating the kitchen from the dining rooms, with all resident areas remaining open. Completed on [DATE]. 9. All new admissions/readmissions or those residents with a change in condition, will have an elopement assessment completed and residents at risk of elopement will be added to the elopement book and 15 minute checks will be initiated. Initiated on [DATE] and will be ongoing per V2. 10. All staff were educated on the elopement policy by V1 Administrator and V2. Completed on [DATE]. 11. Random elopement drills will be conducted by V1 Administrator or designee, to assess staff understanding of the policy including the codes/locks for doors and new doors/alarms. The first elopement drill was completed on [DATE]. 12. V2 and V26 Assistant Director of Nurses educated staff on the Fall Prevention Program Policy to include assessment of the resident by a Licensed Nurse and the alarm policy on [DATE]. 13. A Performance Improvement Tool was initiated on [DATE] by V2 to review residents that are at risk of elopement. 14. A Performance Improvement Tool was initiated on [DATE] to review fall reports, appropriate interventions and follow through on interventions by V2. Audits will continue five times weekly for two weeks, three times weekly for two weeks, weekly for two weeks, monthly for three months and then quarterly for three quarters. 15. A Performance Tool was initiated by V2 and V26 on [DATE] to randomly review door locks/alarms. The audits will take place seven times per week for four weeks, five times per week for four weeks, three times per week for four weeks, weekly for four weeks, monthly for four months and then quarterly for four quarters. 16. The facility Quality Assurance Committee will review the Performance Improvement Tools and make additional recommendations based on the outcome of the tools. The facility presented an abatement plan to remove the immediacy on [DATE]. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility two separate times on [DATE] for revisions. The facility presented a third revised abatement plan on [DATE] and the survey team accepted the third revision of the abatement plan on [DATE]. B. Based on interview and record review the facility failed to provide supervision during toileting resulting in a fall for one of six residents (R10) reviewed for accidents in a sample list of twelve residents. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b.) R10's Electronic Medical Record (EMR) documents medical diagnoses as Cerebral infarction due to unspecified occlusion or Stenosis of right cerebellar artery, Chronic Atrial Fibrillation, Dementia without behavioral disturbance, Anxiety, Systolic (Congestive) Heart Failure, Type 2 Diabetes Mellitus, Pain, Coagulation Defect, Essential (primary) hypertension and history of Traumatic Subarachnoid Hemorrhage with loss of Consciousness of unspecified duration. R10's Minimum Data Set (MDS) dated [DATE] documents R10 as moderately cognitively impaired. This same MDS documents R10 as dependent on staff for toileting, bathing, dressing and bed mobility. This same MDS documents R10 requires moderate assistance with transfers and walking up to 10 feet. R10's Careplan fall goal dated [DATE] documents R10 is at risk for falls due to assist needed for transfers from staff. R10's Careplan intervention dated [DATE] documents R10 was placed on personal alarms. R10's careplan intervention dated [DATE] documents R10's grip alarm should be placed on (R10's) innermost clothing. R10's careplan intervention dated [DATE] documents staff education was completed for R10's [DATE] fall. R10's Fall Risk assessment dated [DATE] documents R10 as a fall risk. R10's Fall Investigation dated [DATE] documents R10 had an unwitnessed fall in her bathroom at 9:00 PM at night. This same investigation documents (R10) was assisted to the bathroom, verbalized understanding of using call light for assistance. However, (R10) did not use the call light for assistance, stood up on her own, pulled her pants up and fell backwards which bumped her occipital area of her head off the wall and landed her in a seated position. (R10) had two small skin tears on bilateral lower arms, first aid applied. This same investigation documents R10's usual ambulatory status as assist of one with/without device and R10 was not wearing any socks/shoes. On [DATE] at 1:30 PM V2 Director of Nurses (DON) stated R10 fell on [DATE] due to V36 Agency Registered Nurse (RN) assisted R10 to the bathroom and left R10 unattended. V2 stated R10 fell with minor injuries of skin tears because of the fall. V2 stated R10 was already careplanned to use a personal alarm and was a high fall risk prior to her fall on [DATE]. V2 stated Nurses should know better than to leave a high fall risk resident (R10) alone in the bathroom. (V36) could have gotten a Certified Nurse Aide (CNA) to stand with (R10) if (V36) was busy. (R10) fell because (V36) was not supervising (R10). The facility policy titled Fall Prevention Program dated [DATE] documents a fall is an event in which an individual unintentionally comes to rest on the ground floor, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is noted on the floor or ground and can occur anywhere. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to employ a Certified Dietary Manager (CDM) full time. This failure has the potential to affect all 33 residents residing in the facility. Findings include: The facility daily midnight roster dated 11/27/24 documents 33 residents residing in facility. The Facility assessment dated [DATE] documents the facility will employ a Dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services. On 11/27/24-12/9/24 at various times each day of the survey process there was no Certified Dietary Manager (CDM) onsite. On 11/27/24 at 9:01 AM V7 [NAME] Assistant stated the facility has not had a Dietary Manager since the middle of October, 2024. On 11/27/24 at 9:04 AM V8 [NAME] stated the facilities previous Dietary Manager left in the middle of October 2024. V8 stated there is an interim Dietary Manager who is not certified. V8 [NAME] stated We (staff) never see (V20) Interim Dietary Manager. (V20) is an office lady that got thrown into trying to help the kitchen. So (V20) isn't around the kitchen because she also has her regular full time job to do up front. We (staff) are really struggling back here (kitchen). On 11/28/24 at 10:00 AM V1 Administrator confirmed the facility does not have a Certified Dietary Manager (CDM). V1 Administrator stated V1 has been conducting interviews for the position but has not hired anyone at this time. V1 stated V1 is aware of some of the problems in the kitchen and hopes that a CDM will be able to provide some oversight and guidance for the kitchen staff.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 41970 Based on observation, interview and record review the facility failed to ensure all dietary staff have completed the required Food Handlers training. This failure has the potential to affect all 33 residents residing in the facility. Findings include: The facility daily midnight roster dated 11/27/24 documents 33 residents residing in facility. On 11/27/24 at 9:45 AM V8 [NAME] was giving instruction to Dietary Aides on serving and assisting in the dietary department. On 11/27/24 at 12:00 PM V9, V10, V12, V39 Dietary Aides were serving resident meals, providing drinks, and assisting residents in the dining room as necessary. On 12/4/24 at 11:05 AM V20 Interim Dietary Manager stated V20 was not aware that anyone other than the cooks needed any kind of training. V20 stated V20 has never been a Dietary Manager in a long term care facility and does not know 'all the rules'. V20 stated V20 is currently making a list of all the dietary employees to get them all enrolled in a Safe Food Handlers course. On 12/4/24 at 3:05 PM V1 Administrator stated the facility is aware that the dietary employees need to complete the Safe Food Handlers course and are currently getting the employees registered for this training.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41970 Based on observation, interview and record review the facility failed to document temperature logs for the facility kitchen coolers, freezers and temperatures of foods being served and/or kept on the warmer and failed to prevent cross contamination in the facility walk in cooler. These failures have the potential to affect all 33 residents residing in the facility. Findings include: The facility daily midnight roster dated 11/27/24 documents 33 residents residing in facility. The local County Health Department Food Establishment Inspection Report dated 11/12/24 documents 'poor' for the facility kitchen non-food contact surfaces being cleaned and physical facilities installed, maintained and cleaned. This same report documents The following areas are soiled: kitchen cookline floor under/behind equipment, floor inside the walk-in cooler and floor under kitchen counters and tables next to the floor mixer. This report documents all violations should be corrected within the time frames of this report (11/19/24). Dated 11/19/24 documents all violations corrected except violation #55. Violation #55-Clean floor under tables and mixer area across from walk in cooler-remains. Correct as soon as possible. No reinspection necessary. The facility Freezer Temperature Log dated November 2024 does not document any entries for the day shift for the entire month of November. This same log does not document any entries for 16 days (11/1-11/3, 11/6, 11/8, 11/11, 11/15-11/17, 11/22, 11/25-11/30) on evening shift. The facility Milk Machine Temperature Log dated November 2024 does not document any entries for the day shift for the entire month of November. This same log does not document any entries for 16 days (11/1-11/3, 11/6, 11/8, 11/11, 11/15-11/17, 11/22, 11/26-11/30) on evening shift. The facility reach in freezer Temperature Log dated November 2024 does not document any entries for the day shift for the entire month of November. This same log does not document any entries for 16 days (11/1-11/3, 11/6, 11/8, 11/11, 11/15-11/17, 11/22, 11/25-11/30) on evening shift. The facility walk in Freezer Temperature Log dated November 2024 does not document any entries for the day shift for the entire month of November. This same log does not document any entries for 16 days (11/1-11/3, 11/6, 11/8, 11/11, 11/15-11/17, 11/22, 11/25-11/30) on evening shift. The facility walk in Cooler Temperature Log dated November 2024 does not document any entries for the day shift for the entire month of November. This same log does not document any entries for 16 days (11/1-11/3, 11/6, 11/8, 11/11, 11/15-11/17, 11/22, 11/25-11/30) on evening shift. The facility Food Temperature Sheet date the weeks October and November 2024 documents: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Arthur Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Eberhardt Drive Arthur, IL 61911	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10/6/24-10/12/24 does not document food temperatures obtained for the entire meals for breakfast and lunch on 10/8/24, supper on 10/9, lunch and supper on 10/10, breakfast and lunch on 10/11 and supper on 10/12/24. -10/13-10/19 does not documents food temperatures obtained for the entire meal for supper on 10/13, 10/15, 10/18 and breakfast, lunch and supper on 10/19/24. -10/20-10/26 does not document food temperature obtained for the entire meals for breakfast, lunch and supper on 10/20, 10/21, 10/24 and 10/26. This same log does not document temperatures obtained for the entire meal for lunch and supper on 10/23 and breakfast and lunch on 10/24. -10/27-11/2 does not document food temperatures obtained for the entire meal for breakfast, lunch and supper for 10/27-11/1 and supper on 11/2/24. -11/3-11/9 does not document food temperatures obtained for the entire meal for supper on 11/3, 11/4, 11/9 and breakfast, lunch and supper on 11/5-11/8/24. -11/10-11/16 does not document food temperature obtained for the entire meal for supper on 11/10, 11/11, 11/16 and breakfast, lunch and supper on 11/12-11/15. -11/17-11/23 does not document food temperatures obtained for the entire meal for supper on 11/17, 11/18, 11/23 and breakfast, lunch and supper on 11/19-11/22/24. -11/24-11/30 does not document food temperatures obtained for the entire meal for supper on 11/24, 11/27 and breakfast, lunch and supper on 11/25 and 11/26. On 11/27/24 at 9:22 AM facility walk in cooler outer door had a loose seal. As the facility walk in cooler door opened there was no vacuum/suction or resistance as the door opened. The thermometer was placed at the back of the cooler and read 42 degrees Fahrenheit (F). There were large empty trays positioned on the top shelves inside the cooler with clear fluid sitting in them. The facility walk in cooler fan was dripping water over the foods, walls and puddled on the floor under the foods. On 11/27/24 at 9:25 AM V8 [NAME] stated the walk-in cooler fan/condenser has been leaking water for a long time. V8 [NAME] stated I put the trays on the top shelf to try to help catch some of the water. It gets some of it but not all. You can see the water travels along the ceiling, down the walls and makes a puddle on the floor. It also drips from the ceiling onto the foods that the trays don't cover. That is not sanitary at all. On 12/4/24 at 11:10 AM V20 Interim Dietary Manager stated the staff in the kitchen have not been properly trained on how to prevent cross contamination. V20 stated the dietary staff have not been obtaining and/or documenting the temperatures for the facility coolers, freezers and meal temperature logs every meal/day as they should have been. V20 stated the dietary staff are all being in-serviced on all of these things. V20 stated not obtaining the temperatures of foods served, not maintaining proper temperatures in the walk in cooler and having the leak in the condenser in the walk in cooler are all ways to cross contaminate resident foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Sanitation Inspection revised 7/22/2024 documents all food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. Sanitation inspections will be conducted daily for refrigerators/coolers, freezers, storage area temperatures, dishwasher temperatures and weekly for all food service areas to ensure the areas are clean and comply with sanitation and food service regulations. The Dietary Manager will obtain an inspection score based on an in-depth analysis of the data obtained during the inspection utilizing the following: Numerator (the number of positives) divided by the denominator (the number of total opportunities) to equal an inspection score. Inspection scores will be formulated on each area being evaluated. Food Safety Requirements Policy dated 1/29/19 documents practices to maintain safe refrigerated storage include monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation. Foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed. Staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed. Foods and beverages shall be delivered to residents in a manner to prevent contamination. Strategies include covering all foods with lids or plate covers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41970 Based on observation, interview and record review the facility failed to prevent cross contamination of the dishwashing area with human feces and failed to maintain the facility dishwashing system in a sanitary manner. These failures have the potential to affect all 33 residents residing in the facility. Findings include: The facility daily midnight census dated 11/27/24 documents 33 residents residing in the facility. 1.) The facility Incident Report dated 10/15/24 documents (V6) employed as a dishwasher, was terminated following an allegation of defecating into the kitchen drain. Upon (V1) arrival at the kitchen, (V1) was greeted by an overpowering and noxious odor reminiscent of fecal matter, which as an Administrator with nursing experience, identified with certainty. (V5) Dietary Manager promptly instructed (V6) to leave the premises pending (V1) further communication. This incident reportedly occurred approximately one -two hours prior to (V1) arrival, and despite best efforts to sanitize the area by (V19) Maintenance Director and (V18) Head of Housekeeping, the malodorous stench persisted profoundly. V5 previous Dietary Manager's written employee report dated 10/15/24 at 7:15 AM documents (V5) walked back into the kitchen after running to the store to a very fowl smell. The smell was coming out of the dishroom. (V6) stated at one point that it smelled like a (animal) farm. I then stated 'that's far from that'. I went to the office to see if someone else could come and smell what I was smelling which was human feces smell. (V20) Interim Dietary Manager did a walk through. I went with (V20) to (V2) Director of Nursing (DON) asking if I could send (V6) home for hygiene purposes, (V2) stated I could. After (V6) left, I went in the dishroom to continue to look for the source only to discover what appeared to be human feces on the floor under the dishwasher. I immediately started sanitizing and sterilizing the area and removing what appeared to be feces that appeared to be sprayed towards drain but never went to the drain. On 11/27/24 at 9:00 AM V7 [NAME] Assistant stated V7 was present on the day V6 previous dishwasher 'had an accident' in the kitchen. V7 stated V6 defecated in his pants and over the drain under the counter by the dishwasher and garbage disposal. V7 stated the smell from V6's incident was overpowering the entire kitchen area. V7 stated V5 previous Dietary Manager (DM) was out doing an errand and when V5 returned to the facility V6 had already had his incident. V7 [NAME] Assistant stated V5 previous DM told V6 to go to her office and the rest of the employees had to stay out of the dishwashing area. V7 stated she saw V5 attempting to clean up the mess by using the extension hose from the dish rinsing area to spray the feces into the facility floor drain. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/27/24 at 9:05 AM V8 [NAME] stated (V6) previous dishwasher s*** (expletive) under the dishwasher. The way that mess looked you could tell that (V6) turned his back to the counter at the dishwasher and took a s*** (expletive). It looked like then (V6) took the sprayer and tried to spray it down the floor drain underneath the garbage disposal which is right next to the dishwashing machine. (V6's) s*** (expletive) was sprayed everywhere under the counter, on the pipes, all over the walls and floor, underneath the garbage disposal and dishwasher. I saw chunks of s*** (expletive) on the wall and on the floor drain. It stunk up the whole kitchen for a long time. This all happened during breakfast and before lunch. I didn't feel right serving breakfast when the kitchen was in such a mess. Everybody (V5, V18, V19) plus the dietary aides and cooks were working out of the this s*** (expletive) filled kitchen to serve the residents breakfast. Lunch was already on the stove, the staff were prepping foods for lunch at the same time all the management staff were walking in and out of the kitchen trying to clean up all the s*** (expletive). We (facility) should have shut down the entire kitchen and got carry out for our residents. On 11/27/24 at 10:30 AM V1 Administrator stated on 10/15/24 V1 received a phone call from V20 Interim Dietary Manager. V1 stated V20 reported to V1 that (V6) S*** (expletive) in the drain. V1 stated V1 instructed V20 to keep all the other staff away from the area and V1 was en route to the facility. V1 stated when V1 arrived the smell was foul. V1 stated I could smell the smell of feces as soon as I walked into the kitchen. It was horrible. (V18) Housekeeping Supervisor and (V19) Maintenance Director had both already been in there and had the mess cleaned up by then. I terminated (V6) over this incident. On 11/27/24 at 11:05 AM V18 Housekeeping Supervisor stated V18 and V19 Maintenance Director cleaned up the feces in the kitchen on 10/15/24 after V6 had defecated in the dishwashing area. V18 stated (V19) and I both got it cleaned up. (V5) previous Dietary Manager had started but we (V18, V19) got in there and got the whole area cleaned up. We (V18, V19) cleaned the dishwasher, dishwasher piping underneath the counter, the garbage disposal, the counter, walls, floor, drain and everything else we could reach or thought it might have even had the chance of getting dirty. On 12/3/24 at 2:50 PM V2 Director of Nurses (DON) stated the entire kitchen should have been closed for a deep cleaning after V6 defecated in the kitchen area. V2 DON stated the smell was horrible and lingered for hours. V2 DON stated the facility should have obtained breakfast and lunch from another source that day (10/15/24) in order to maintain a sanitary environment for the residents. 2.) The local County Health Department Food Establishment Inspection Report dated 11/12/24 documents 'poor' for the facility kitchen non-food contact surfaces being cleaned and physical facilities installed, maintained and cleaned. This same report documents Food contact surfaces cleaned and sanitized were out of compliance. The facility Dish Machine Part Per Million (PPM) Record Log dated November 2024 documents 100 PPM for every entry on AM and PM shift from 11/1/24-11/26/24. On 11/27/24 at 9:15 AM V9 Dishwasher obtained a temperature from the dishwashing machine sanitize cycle of 115 degrees Fahrenheit (F). V9 stated there are not any litmus strips to check the sanitizer level with. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/3/24 at 11:55 AM V9 Dishwasher obtained a temperature from the dishwashing machine sanitize cycle of 100 degrees F. V9 stated the facility just got the litmus strips on 12/3/24. V9 applied the litmus paper to the clear liquid in the overflow container of the dishwasher with a less than 10 parts per million (PPM) reading. On 12/3/24 at 12:10 PM V19 Maintenance Director obtained a temperature from the dishwashing cycle after the cycle was completed of 115 degrees F. V19 then ran the same load of facility cooking pans through the dishwashing cycle, used a new litmus strip each time to obtain a reading of less than 10 PPM. V19 Maintenance Director removed the hose from the one fourth filled container of sanitizing solution sitting under the dishwasher which showed the end of the hose was wet. On 12/3/24 at 1:05 PM V19 Maintenance Director stated the dishwashing machine has not been sanitizing the dishes due to the hose that runs through the machine was 'weak' and not pulling the sanitizer through the hose up into the dishwasher. V19 Maintenance Director stated the facility dishwashing machine has not being running as it should but not aware of how long due to the dietary staff not monitoring the sanitization level correctly. V19 Maintenance Director stated The facility PPM log has the same reading for ever entry. We (facility) have not had litmus strips for months so there is no way anyone could have tested the dishwasher for the right amount of sanitizer when the strips you need to check it with aren't there. V19 stated V19 has never ordered litmus strips as it was V5 previous Dietary Manager's duty. V19 stated the facility dishwashing machine is considered a low temperature style dishwasher. V19 stated the temperature should be above at least 120 degrees Fahrenheit (F) to get the dishes cleaned. On 12/3/24 at 2:15 PM V40 Service Technician stated V40 is the service provider for the facility dishwashing machine. V40 stated V40 has been in this facility previously to provide maintenance on the facility dishwasher. V40 stated V40 was aware the facility was out of litmus strips. V40 stated V40 offered V5 previous Dietary Manager extra litmus strips in September and October 2024 and was told the facility would need to buy them. V40 stated the facility dishwasher is a low temperature style. V40 stated if the dishwasher does not maintain a temperature of at least 120 degrees Fahrenheit(F) then the sanitizer should control any level of bacteria and/or organisms but if the sanitizer is not added to the dishwashing cycle then the dishwashing temperature has to be at least 180 degrees F. V40 stated the residents could be at risk of any potential bacteria that could be on the utensils, dishware and/or cookware if the dishwasher was either not at temperature and/or the sanitizer was not added to the dishwashing load. V40 stated the facility parts per million (PPM)log could not be correct due to the facility did not have litmus strips which are required to obtain the PPM readings. The facility policy titled Dishwasher Temperature revised 6/1/24 documents all items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items. For low temperature dishwashers (chemical sanitization), the wash temperature shall be 120 degrees Fahrenheit (F). The sanitizing solution shall be 50 parts per million (PPM) hypochlorite (chlorine) on dish surface in final rinse. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to provide Dementia training for all staff. This failure has the potential to affect all 33 residents residing in facility. Findings include: The facility policy titled Behavior Health Services revised 4/25/23 documents the facility will have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, determined by resident assessments and individual plans of care and considering the number , acuity and diagnosis of the facility's resident populations. These competencies include but are not limited to knowledge of and appropriate training and supervisor for caring for residents with mental and psychosocial disorders identified in the facility assessment and implementing non-pharmacological interventions. The facility daily midnight census report dated 11/27/24 documents 33 residents residing the facility. The Facility assessment dated [DATE] documents the facility will include Dementia management training and address the care of the cognitively impaired. The facility Staff Education logs dated 2024 document Dementia training for the following: -V28 Certified Nurse Aide (CNA) was hired on 6/17/24 and has zero hours of Dementia training documented. -V29 CNA was hired on 7/17/24 and has zero hours of Dementia training documented. -V32 CNA was hired on 10/14/24 and has zero hours of Dementia training documented. -V41 Social Service Director (SSD) was hired on 8/5/24 and has one hour of Dementia training documented. -V12 Dietary Aide was hired on 5/4/24 and has had zero hour of Dementia training documented. On 12/3/24 at 1:50 PM V1 Administrator stated the facility has not kept their staff current with Dementia training. V1 stated Dementia training has not been completed since April of 2023. V1 stated any staff who have been hired post April 2023 have not received any Dementia training. V1 stated V1 reached out to a person to come to the facility and provide Dementia training to get all staff trained on 12/10/24. On 12/4/24 at 3:50 PM V2 Director of Nurses (DON) the facility houses many residents with Dementia who could benefit from staff being trained on Dementia. V2 stated the facility need the training and would be able to provide more comprehensive care with Dementia training. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/10/24 at 9:00 AM V41 Social Service Director stated the facility proved a two day online training that included one hour of Dementia training. V41 stated having the staff trained on how to approach residents or how to deescalate behaviors before they become a problem will be very beneficial to the residents and the staff.