

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  10/03/2024
NAME OF PROVIDER OR SUPPLIER  Arthur Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50993</b></p> <p>Based on observation, interview, and record review the facility failed to assist with residents' transfer out of bed for three (R236, R28, and R25) of 16 residents reviewed for activities of daily living (ADLs) on the sample list of 23.</p> <p>Finding Include:</p> <p>1.) On 10/01/24 at 10:45 AM, R236 was lying in bed covered with a sheet. R236 was wearing an incontinence brief with no shirt or pants. Upon entering R236's room, R236 stated are you here to get me up? R236 stated he usually gets dressed in the morning and goes to the dining room for breakfast, but no one has assisted him out of bed yet.</p> <p>On 10/02/24 at 9:15 AM, R236 was lying in bed covered with a sheet. R236 was wearing an incontinence brief with no shirt or pants. R236 stated he had breakfast in bed again this morning. R236 stated he would rather get out of bed for breakfast in the morning.</p> <p>On 10/02/24 at 9:17 AM, V5 CNA (Certified Nurse's Assistant) stated V5 doesn't know if R236 usually gets up for breakfast or not, V5 is new to the facility and is not familiar with the residents.</p> <p>On 10/02/24 at 11:10 AM, V8 CNA states R236 usually stays in his room for breakfast and comes out for lunch. V8 states I don't know what his preference is I need to ask him.</p> <p>R236's Admission assessment dated [DATE] at 10:34 AM, documents R236 is a one person assistance for transfers, ambulation, and dressing.</p> <p>2.) On 10/01/24 at 10:35 AM, R28 was sitting up in a wheelchair with a finished breakfast tray in front of R28. V10 (R28's spouse) stated he arrived to the facility at 9:30 AM and R28 was still in bed and had not had breakfast. V10 stated he had to call the CNA's to assist R28 to get out of bed and get R28's breakfast. R28 stated she would like to get out of bed earlier but no one was available to help R28 this morning.</p> <p>The facility's Daily Lifestyle, Habit, and Routine Questionnaire dated 04/28/23 documents R28 prefers to wake up/get up between 7:00 AM and 8:00 AM.</p> <p>R28's Care Plan updated on 06/21/24 documents R28 needs assistance at this time and is dependent on staff in ADL areas for toileting, transfers, bathing, and dressing.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3.) On 10/03/24 at 9:04 AM, R25 was lying in bed in her pajamas. R25's breakfast was sitting on R25's bedside table by R25's recliner across the room from the bed and out of R25's reach. R25 stated that her breakfast has been sitting there for an hour and she is waiting on someone to help her out of bed. R25 states that she prefers to get up and get dressed between 7:00 am and 7:30 am.</p> <p>On 10/03/24 at 9:19 AM, V7 LPN (Licensed Practical Nurse) states she would expect the CNA's to assist R25 out of bed when the breakfast tray is delivered.</p> <p>The facility's Daily Lifestyle, Habit, and Routine Questionnaire dated 08/22/23 documents R25 prefers to wake up/get up at 6:00 AM.</p> <p>R25's Care Plan updated on 08/15/24 documents R25 needs assistance in all ADL areas except for eating.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>20892</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview and record review the facility failed to follow their oxygen policy by not dating residents' oxygen tubing, nebulizer tubing, and humidification bottles for two (R14 and R23) of three residents reviewed for oxygen in a total sample of 23.</p> <p>Findings include:</p> <p>The Facility's Oxygen Administration policy with a revision date of 10/2/24 documents a protocol to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. This policy documents a protocol to label the oxygen tubing and mask/cannula, if in use, with tape and date and initials.)</p> <p>During the facility tour on 10/1/24 at 10:00 AM, R14 was sitting in her wheelchair beside her bed. R14 was wearing a nasal cannula and was receiving oxygen from an oxygen concentrator. The humidifier bottle attached to the oxygen concentrator was labeled with a date of 9/19/24. R14's oxygen tubing was not labeled. At that time, R14 stated she did not know when her oxygen tubing was last changed.</p> <p>On 10/2/24 at 11:30 AM, V4 Registered Nurse stated oxygen tubing is to be changed weekly on Tuesday's on night shift.</p> <p>On 10/2/24 at 10:30 AM, R23 was sitting in his wheelchair watching television. Oxygen tubing was draped across an oxygen concentrator connected to a humidification bottle. The oxygen tubing and the humidifier bottle was not dated. A nebulizer machine was sitting on top of a bedside table. The nebulizer tubing was connected to a medication mouth piece and was spread out over the top of the nebulizer machine. The nebulizer tubing and medication mouth piece was not dated. At that time, R23 stated no one had changed any of his tubing except his IV (intravenous) tubing.</p> <p>On 10/2/24 at 2:30 PM, V2 Director of Nursing stated all the oxygen, nebulizer, and CPAP(continuous positive airway pressure - machine) is supposed to be changed weekly on Tuesday nights on the night shift.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>50993</p> <p>Based on observation, interview, and record review the facility failed to provide palatable hot food to two (R25, R28) of 16 residents reviewed for food in the sample list of 23.</p> <p>Findings Include:</p> <p>1.) On 10/01/24 at 1:30 PM, R25's lunch tray was sitting on bedside table, R25 states lunch was delivered at 1:15 PM and was cold when it was delivered.</p> <p>On 10/02/24 at 9:00 AM, R25's breakfast was on bedside table containing biscuits and white gravy. R25 consumed 50% of the breakfast. R25 stated breakfast was cold when she received it in her room.</p> <p>On 10/03/24 at 9:04 AM, R25 was lying in bed. R25's breakfast was sitting on R25's bedside table. R25 states that her breakfast has been sitting there for about an hour. R25's breakfast consisted of a biscuit covered with white gravy, sausage, and eggs. The biscuit covered with white gravy had a temperature of 74 degrees Fahrenheit. The crumbled sausage had a temperature of 80 degrees Fahrenheit. The scrambled eggs temperature was 79.4 degrees Fahrenheit.</p> <p>On 10/03/24 at 11:25 AM, V11 Dietary Manager stated the dietary aides pass the hall trays to residents that eat in their rooms. V11 states this morning R25's tray was delivered at 8:05 AM. V11 stated R25's breakfast would be cold if it sat for an hour before being eaten.</p> <p>The facility's Policy Record of Food Temperatures dated 2024 documents hot foods will be held at 135 degrees Fahrenheit or greater.</p> <p>2.) On 10/01/24 at 10:35 AM, R28 was sitting up in a wheelchair with finished breakfast tray in front of R28. R28 states the breakfast was cold when delivered to her room this morning.</p> <p>The facility's Policy Record of Food Temperatures dated 2024 documents hot foods will be held at 135 degrees Fahrenheit or greater.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50993</p> <p>Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions for one (R238) of two residents reviewed for catheters in the Sample List of 23.</p> <p>Findings include:</p> <p>The facility's policy Enhanced Barrier Precautions dated 2024, documents an order for Enhanced Barrier Precautions will be obtained for residents with an indwelling medical device including urinary catheters. This policy states that make gown and gloves available near or outside of the resident's room.</p> <p>R238's Care Plan updated on 04/10/24 documents R238 requires an indwelling urinary catheter. R238's October 2024 Face Sheet documents R238 has a history of Urinary Tract Infections.</p> <p>On 10/01/2023 at 11:27 AM, R238 was lying in bed. R238 had an indwelling urinary catheter draining cloudy urine. The entrance to R238's room did not indicate that R238 was on Enhanced Barrier Precautions and PPE (Personal Protective Equipment) was not available outside of R238's room.</p> <p>On 10/02/24 at 11:05 AM, V8 CNA (Certified Nurse's Assistant) performed catheter care for R238. V8 was not wearing a gown or mask. The entrance to R238's room did not indicate that R238 was on Enhanced Barrier Precautions and PPE (Personal Protective Equipment) was not available outside of R238's room.</p> <p>On 10/03/24 at 10:30 AM, V2 Director of Nurses states that any resident with a urinary catheter needs to be placed in Enhanced Barrier Precautions.</p>		