STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145623	A. BUILDING _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE MORRIS	1095 TWILIGHT DRIVE MORRIS, IL 60450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigations: 2276820/IL150567- no findings 2276825/IL150572- no findings 2276927/IL150695- no findings 2277000/IL150782- F689G 2277087/IL150899- no findings 2277093/IL150897- F684D Incident Report Investigation to Incident of 9/4/2022/IL151072- no findings	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to monitor and obtain orders for new surgical wounds and provide medication and treatments per physician orders for an infected wound. This applies to 2 of 3 residents (R8, R27) revived for wounds in a sample of 27. Findings include: 1. On 9/7/2022 at 10:22 AM, R8 had a light red circular shaped healed wound to her forearm, which she states was from an infected boil that	F 684	**Attachment A** **Statement of Licensure Violations**	9/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 684	Continued From page 1 was treated. R8's Physician Wound Evaluation and Summary Report, completed by V32 (Wound Physician), dated 8/19/2022, documents R8 with an infected wound to her right forearm. Recommendations include to apply an antibiotic ointment topically to the wound and cover with a dressing every day, and start Bactrim (antibiotic) 800 milligrams (mg) twice daily by mouth. R8's August 2022 Medication Administration Record documents R8 did not start receiving oral Bactrim or the antibiotic ointment until the evening of 8/21/2022 as recommended on 8/19/2022. On 9/8/2022 11:05 AM V4 (Wound Nurse) confirmed R8's antibiotics and treatment should have started on 8/19/2022 as ordered. R8's Brief Interview of Mental Status dated 7/1/2022 documents R8 as cognitively intact. 2. On 9/7/2022 at 12:10 PM R27 and V31 (R27's Wife) stated the facility has not changed his dressing to his surgical incisions at all since he was admitted. R27 stated V31 brought in dressing supplies, pointing to dressings on the bedside table, and V31 has been changing the dressings. R27 lifted up his shirt exposing two non-stick bandages (undated), one on each side of his spine in the lower lumbar (back) area. A Progress Note dated 8/19/2022 shows R27 admitted to the facility after surgery to fuse vertebrae in his lumbar spine. This note documents R27 with two incisions with staples	F 684		

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F 684	Continued From page 2 intact. R27's Progress Note dated 8/22/2022 documents a skin assessment was completed which identifies R27 with two incisions to his lumbar spine. These incisions show the left sided incision measuring 6.0 centimeters (cm) with fourteen staples and the right sided incision measuring 7.0 cm with 16 staples. On 9/8/2022 at 11:05 AM, V4 (Wound Nurse) stated R27 has a surgical wounds and his care to the incision sites is being directed by the surgeon who completed the surgery. V4 stated R27's incision sites should have been monitored at least daily with documentation of this monitoring on the Treatment Administration Record (TAR). V4 stated she thought orders had been obtained for the care of R27's surgical incisions from the surgeon. At 1:38 PM, V4 confirmed there were no orders obtained for the care of R27's wound and there should have been. R27's August 1-September 30, 2022 Medication Administration Record, TAR and Physician Order Summary do not document any orders for the care of R27's incision. R27's TAR documents a weekly skin assessment but no daily monitoring or any specific orders for monitoring the surgical incisions. R27's Care Plan for skin impairment dated 8/22/2022 documents R27 with 2 surgical incisions to his lumbar spine with interventions to include keep clean and dry and monitor the site for signs of infection. R27's BIMS dated 8/26/2022 documents R27 as	F 684		

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F 684	Continued From page 3 cognitively intact.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide safe wheelchair transport. This failure resulted in R4 incurring a left prosthetic knee dislocation, a forehead laceration, a left knee tibial plateaus fracture, and right knee distal femur peri-prostetic fracture. This applies to 1 of 3 residents (R4) reviewed for injuries in a sample of 24. Findings include: R4's Admission Record dated 9/1/2022 documents R4 with diagnoses including Covid-19 (5/31/2022), lymphedema (fluid build up causing swelling), hemiplegia and hemipariesis affecting the right side following a stroke. The facility's incident report dated 6/24/2022, completed by V10 (Nurse), documents R4 was being propelled in her wheelchair by staff when she leaned forward, causing her to fall to the floor in the hallway, hitting her forehead and nose. R4 was bleeding from the nostril and forehead and	F 689		9/16/22

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F 689	Continued From page 4 she was transported to the hospital. V17's (Occupational Therapist) Treatment Encounter Note dated 6/24/2022 documents upon transporting R4 back to room in a wheelchair, R4's foot/feet became caught under the wheelchair and as result, R4 fell forward out of the wheelchair and onto the floor. On 9/1/2022 at 12:10 V10 stated, V17 (Occupational Therapist) was pushing R4 in her wheelchair without footrests present and R4's feet got caught underneath the wheelchair, causing her to fall forward and hit her head. V10 stated R4 did not have the strength to break her fall and R4 usually had footrests on her chair because she was not able to hold up her legs when she was propelled. V10 also stated R4 required a mechanical lift to get out bed and had gross edema to her entire body. On 9/2/2022 at 9:57 AM V17 (Occupational Therapist) stated R4 did not have the footrests on her wheelchair when she was brought into therapy after bingo on 6/24/2022. V17 stated she was pushing R4 to her room and R4 had items on her lap, which included supplies to work on oral hygiene and bingo prizes. V17 stated the accident happened quickly and she is unsure of the cause, but thinks R4 may have leaned forward to prevent things from her lap falling and her feet got caught underneath the chair, causing the fall. On 9/1/2022 12:20 V14 (Director of Rehabilitation/Physical Therapy Assistant) stated, "...I suspect she (R4) was being pushed too fast and unable to keep up..." V14 further stated, R4	F 689		

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F 689	Continued From page 5 was leaving therapy and the distance between therapy and her room was quite a ways to hold up her feet in the wheelchair without footrests. On 9/1/2022 at 9:33 AM, V7 (Nursing Assistant) stated that before R4 fell, she was total assist for ADLs (Activities of Daily Living) and used a mechanical lift for transfers between the bed and wheelchair. V7 said R4 had declined significantly prior to the fall to the point that she was requiring two people for assistance for her ADL's. V7 further stated, R4 would not even lift her legs and required staff to lift her legs to put on her pants and dress her. V7 stated R4 needed assistance to and from therapy and her wheelchair footrests were being kept on at all times, even in her room where she spent most of the time, because she was no longer using her feet to move her wheelchair. On 9/2/2022 at V19 (Nurse Practitioner) stated, R4 was an extensive assist for her ADLs. V19 stated, R4 should have had the footrests on the wheelchair when being transported. V19 further stated, "I think all residents should have footrests on when being transported for safety purposes to prevent falls." R4's Occupational Evaluation and Treatment Plan dated 6/15/2022 documents an initial referral being completed due to a decline in function after COVID 19 which caused R4 to have increased complications with mobility for ADLs and ADLs performed. This assessment also documents R4 requiring the use of a mechanical lift for transfers. R4's Minimum Data Set dated 5/4/2022	F 689		

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F 689	Continued From page 6 documents R4 as requiring the extensive assistance of one person for movement while in a wheelchair, requiring the extensive assistance of one person for dressing, the extensive assist of 2 staff and with bilateral lower extremity impairments. R4 is documented in this assessment as cognitively intact. R4's Hospital Emergency Room record dated 6/24/2022 documents R4 reporting she got her legs caught in the wheelchair and she fell forward onto her knees and head. Her Final Diagnosis is documented as left prosthetic knee posterior dislocation, a forehead laceration (stitches applied), left knee tibial plateaus fracture, right knee distal femur peri-prosthetic fracture. This note documents R4 was transferred to higher level hospital for further treatment after 4 failed attempts to correct the dislocated left knee failed.	F 689		