FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6011381 B. WING 05/12/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1095 TWILIGHT DRIVE ARCADIA CARE MORRIS MORRIS, IL 60450 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 First Probationary Licensure Survey S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.696b) 300.696d)1) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.696 Infection Prevention and Control Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Affachment A Statement of Licensure Violations Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	Department of Public				FUK	MAPPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER STREET AD		DRESS, CITY	, STATE, ZIP CODE	05/12/2022			
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S9999	Continued From page 1		S9999		<u> </u>		
	Respiratory Protection and procedures must include the requirem Communicable Disection of Sexually Transmit d) Each facility guidelines and toolki Control and Prevent Health Service, Depisorvices, Agency for Quality, and Occupa Administration (see \$1) Guideline for	on Program Toolkit, and the and Health Administration's on Guidance. The policies st be consistent with and nents of the Control of eases Code, and the Control ssible Infections Code. shall adhere to the following its of the Centers for Disease ion, United States Public artment of Health and Human Healthcare Research and tional Safety and Health Section 300.340): r Prevention of Urinary Tract Infections					
	b) The facility share and services to practicable physical, well-being of the resident's complan. Adequate and pare and personal caresident to meet the transport of the resident to meet the transport of the resident and personal care needs of the resident to meet the transport of the resident to the resident to the transport of the resident to the resident to the resident	nall provide the necessary attain or maintain the highest mental, and psychological dent, in accordance with rehensive resident care roperly supervised nursing re shall be provided to each otal nursing and personal ident.					
*	Based on observation review, 1) the facility storage of respiratory	NOT met as evidenced by: n, interview, and record failed to ensure sanitary equipment. 2) the facility tion a resident's indwelling			6		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011381		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED 05/12/2022	
			B. WING	05/			
NAMEOF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, 8	STATE, ZIP CODE			
ARCADI	A CARE MORRIS		LIGHT DRIVE	E			
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S9999	Continued From pa	ge 2	S9999				
	R11) reviewed for u a sample of 11.	residents (R8, R9, R10 & se of respiratory equipment in of 2 residents (R4) reviewed ters in sample of 11.					
	observed in her room uncovered. R10's E Record) showed dia obstructive pulmona	21am R10's BiPAP was m and the mask was HR (Electronic Health gnoses including, chronic try disease, type 2 diabetes, nea, heart failure, and					
	in his room with the R9's EHR (Electronic diagnoses including	am R9's CPAP was observed mask uncovered. c Health Record) showed type 2 diabetes, coronary uctive and sleep apnea.			8	54.0	
	his room with the ma R8's EHR (Electronic diagnoses including c	Health Record) showed					
i c	R11's EHR (Electroni diagnoses including t	with the mask uncovered. ic Health Record) showed ype 2 diabetes, asthma, ctive sleep appea, and		£: 0[
ir C re	hat the residents res n a plastic bag for the ontrol. V5 said if not	pnal Nurse Consultant) said piratory mask should be put a purpose of infection contained it could cause or a surface infection.					

PRINTED: 06/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011381		(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING			05/12/2022	
NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE			
ARCADIA CARE MORRIS	1095 TW MORRIS,	ILIGHT DRIV IL 60450				
PREFIX (EACH DEFICIENCY I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)			
S9999 Continued From pag	e 3	S9999			 	
1/2019, showed under minimize the risk of in procedure to see a cl	n and Respiratory Equipment policy with revision date of er purpose number three to infection transmission. Under lean plastic bag will be cannula when not in use.	19				
2) On 5/10/22 at 11:1 wheelchair by the from area. R4's walker was wheelchair with his in hooked on top of the	0 AM R4 was observed in nt door by the reception desk s positioned in front of his					
was positioned in fron was again hanging on	R4 was observed in sing station. R4's walker t of him; R4's catheter bag top of his walker. R4's ng were above the level of				9	
R4's face sheet showed metabolic encephalop reflux uropathy.	ed his diagnoses include athy and obstructive and					
On 5/11/22 at 2:18 PM Nurse-LPN) said, indw below the bladder for f blockage and infection	, V8 (Licensed Practical relling catheters should be low and to prevent		3			
below the bladder level	elling catheters should be to prevent urine from der. V5 said if not properly cause irritation to the					
In the facility's Urinary (Catheter Care (revised	9.5				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ JL6011381 05/12/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1095 TWILIGHT DRIVE ARCADIA CARE MORRIS MORRIS, IL 60450** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 9/2020 and using Resource: CDC Guidelines for Prevention of Catheter Associated Urinary Tract Infections 2009) policy, under guidelines it showed, "6. Catheters shall be positioned to maintain a downhill flow of urine to prevent a back flow of urine into the bladder or tubing...." (C)

linois Department of Public Health