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	IL6011381	A. BUILDING: _____ B. WING _____	02/17/2023

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S 000	Initial Comments Annual Recertification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services	S9999		
	b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.			

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure supervision to prevent falls with injury for 1 resident (R45), failed to provide ambulation assistance for 1 resident (R61), and failed to implement updated fall prevention measures for a resident following a fall with a fracture for 1 resident (R2). These failures apply to 3 of 4 residents reviewed for safety and supervision. These failures resulted in R45 having 15 unwitnessed falls with 3 of those falls resulting in major injury and R2 sustaining a hip fracture. The findings include: 1. R45's face sheet showed she was admitted to the facility on 9/21/22 with diagnoses to include traumatic subarachnoid hemorrhage without loss of consciousness, vascular dementia, cerebral infarction, hypertension, repeated falls, difficulty in walking, lack of coordination, and conversion disorder with seizures or convulsions. R45's facility assessment dated 1/24/23 showed she has severe cognitive impairment and requires physical assistance of one staff member for most cares. R45's medical record showed 15 unwitnessed falls occurring as follows: 9/22/22, 9/26/22, 9/29/22 (Sustained Major Injury), 10/19/22 (Sustained Major Injury), 10/20/22, 10/28/22, 10/29/22, 10/31/22, 11/1/22 (Sustained Major Injury), 11/13/22, 11/26/22, 12/9/22 (Sustained Major Injury), 12/28/22, 1/30/23, and 2/15/23. R45's record showed 2 witnessed falls occurring as follows: 10/11/22 and 1/9/23.	S9999		

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S9999	Continued From page 3 R45's 9/22/22 fall report showed an unwitnessed fall in the resident's room which resulted in her being sent to the acute care hospital for evaluation. R45's 9/22/22 fall resulted in a small abrasion to her forehead. R45's 9/26/22 nursing note showed, "Resident observed on the floor in bathroom in sitting position. Resident stated, 'I lost my balance as I was going to sit on the toilet.' Physical assessment reveals no apparent injury..." R45's 9/29/22 fall report showed an unwitnessed fall in the resident's room with no injuries sustained. R45's nursing note dated 9/30/22 showed, "IDT (Interdisciplinary Team) met to discuss resident's fall on 9/29/22. Root cause determined to be resident trying to sit herself on the side of the bed...new intervention is placing 'Call don't fall' signs on either side of the bed." R45's 9/30/22 nursing note entered at 2:51 PM showed, "Resident admitted [to acute care hospital], diagnoses 4 left chest rib fractures." R45's acute care hospital discharge documents dated 10/1/22 showed, "Reason for visit: Rib fractures, fall, history of frequent falls... Chief Complaint: ...left sided chest pain. The patient has a history of dementia and CVA (Cerebral Vascular Accident)... history of frequent falls and has been seen numerous times for the same this month. Patient now resides at a local nursing home where she suffered a fall on Monday and again last night injuring the left rib area... She has bruises to her face in different stages of healing... Notes: ... Patient's daughter present and stated that [R45] had fallen in the bathroom on Monday night and again last night. ...X-ray shows fractures of 4	S9999		

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S9999	Continued From page 4 ribs..." R45's 10/11/22 fall report showed a witnessed fall in the resident's bathroom. The report showed, "This nurse was sitting at the nurse's station getting report and heard a loud noise and the CNA yell for assistance. Per CNA she was in the bathroom with the resident when the resident stood up to get off the toilet and the resident fell to the left side. Resident states, 'I was just trying to pull up my pants.'..." R45's 10/19/22 fall report showed an unwitnessed fall in R45's room. The fall report showed, "Writer called to room by CNA, per CNA resident is lying on the floor under the table, writer went to room, noted resident lying on the floor under bed, with laceration to back of the right side of head...laceration to back of head on the right side 0.5 cm deep and 4.5 cm length... Paramedics called..." R45's 10/19/22 nursing note showed, "... at 5:40 AM: Resident returned from [acute care hospital]... resident noted with 2 staples..."	S9999		
	R45's 10/20/22 nursing note showed (unwitnessed fall in R45's bathroom), "Resident observed on the floor in bathroom in sitting position. Resident stated, 'I was trying to get up off the toilet and fell.' Physical assessment reveals no apparent injury..." R45's 10/26/22 Nurse Practitioner note showed, "...Frequent falls - no changes to current medications. Patient was made a priority return to bed after meals to help avoid recurrent falls. Close monitoring and fall precautions..." R45's 10/28/22 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "Resident observed on the floor at bedside...			

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S9999	Continued From page 5 Resident stated, 'I'm not sure what happened, I woke up sitting up on the floor.'...No injuries observed at the time of incident..." R45's 10/29/22 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "...Resident is observed sitting on the floor next to the bed. Resident had just finished eating lunch and propelled herself to her room... On assessment, no apparent injury noted..." (Three days after the intervention regarding making R45 a priority return to bed after meals.) R45's 10/31/22 nursing note showed an unwitnessed fall in her room. This note showed, "Resident observed on floor at bedside in sitting position... Resident stated, 'I was getting up to use the bathroom and forgot to use the call light..." R45's nursing note dated 10/31/22 showed, "Spoke with resident regarding falls... Reports that she thinks she is going to the bathroom when she gets up but doesn't really know. Resident says she knows she needs to ask for help but is used to doing it alone..." R45's 11/1/22 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "...Resident was found sitting on the floor by the door of her bathroom by staff member. A laceration 3-5 cm was noted on the right side of her forehead... Pressure on the laceration with sterile gauze..." R45's nursing note dated 11/2/22 showed, "Resident returned to facility, laceration with sutures: 2 anterior sutures and 8 exterior sutures." R45's acute care hospital documentation dated 11/1/22 showed, "...Patient comes into the emergency room via emergency medical services with complaint of falling. Patient has a 3 cm laceration to the forehead. She also has a small skin tear to the left arm... Patient is	S9999		

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S9999	Continued From page 6 able to state her name, date of birth, and the fact that she fell. She states she hit her head on the door frame..." R45's 11/13/22 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "...Resident observed on the floor in sitting position in front of the wheelchair... Resident stated, 'I was getting up to go to the bathroom and fell on the floor.'...Physical assessment reveals no apparent injury..." R45's 11/26/22 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "...Resident observed on the floor at bedside laying on her right side... Resident stated, 'I was getting up to go to the bathroom and fell on the floor... Physical assessment reveals no apparent injury..." R45's 12/9/22 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "...Resident observed on the floor in sitting position... Resident stated 'I was getting up to go to the bathroom and fell and hit the bedside dresser, I forgot to use the call light... Physical assessment reveals a 2 inch laceration to mid-forehead, dark red blood noted on the resident's face/hands and on the floor near the resident...received order to send resident to [acute care hospital] for evaluation..." R45's acute care hospital documentation dated 12/9/22 showed, "...Diagnoses: Primary: Fall, Additional closed head injury, forehead laceration...presents with head injury... Per nursing home staff she was found on the ground this morning. It is unclear how long she was down for but it had been about 30 minutes since she was last checked on. She has a laceration to the right forehead and complains of pain there... Laceration - Single	S9999		

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S9999	Continued From page 7 Repair... 10 sutures..." R45's 12/28/22 fall report showed an unwitnessed fall in the resident's bathroom. The fall report showed, "...The CNA was making rounds and observed the resident sitting on the floor in her bathroom. Resident description: 'I walked to the bathroom and fell.'...Resident was assessed and bruise noted to the right hand..." R45's 1/9/23 fall report showed a witnessed fall in the resident's room. The fall report showed, "...CNA stated she witnessed resident sliding out of bed onto mat and sitting on buttocks... Resident told CNA she was looking for a brownie... No injuries noted at this time..." R45's 1/30/23 fall report showed an unwitnessed fall in the resident's room. The fall report showed, "Resident was last observed during routine medication administration by the nurse on duty. Nurse on duty was called to resident's room by facility staff around 7:50 PM. Resident was sitting upright on the floor. Resident with laceration to back of head... Resident was unable to give description of incident... Nurse on duty placed pressure dressing on resident head with assistance of peer nurse... Nurse on duty placed call to 911 emergency medical services..." R45's 1/30/23 acute care hospital documentation showed, "...Diagnosis: Primary: closed head injury, Additional, scalp laceration...history of frequent falls, vascular dementia who presents to the emergency department with complaints of fall. Patient state she stood up and fell...she states she hit her head... The patient states that she loses her balance frequently and this is what happened this time..." R45's 2/15/23 fall report showed an unwitnessed	S9999		

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S9999	Continued From page 8 fall in the resident's room. The fall report showed, "...The resident was sitting next to the wheelchair by her dresser in her room... Resident unable to give description... The resident was assisted to her feet after assessment, no signs or symptoms of pain..," On 2/17/23 at 12:56 PM, V7 (Assistant Director of Nursing/ADON) said she does the fall investigations. V7 said R45 is a frequent faller at the facility. V7 said, "We discuss as a team either that day or next morning and talk to the resident and put an intervention into place. Changes to the interventions are put into the care plan and also into the tasks section for the CNAs. She uses her call light when she wants to, there are times when she has said she forgot to use it, that is why we are trying to make it as visible as possible. Reeducate family and resident on non-compliance and the risks involved. I think she can be reeducated, she is very much with it, slow to respond but very with it, she is on the dementia unit to keep a better eye on her. We reevaluate the interventions on the care plan by literally continuing to follow up with her and see if they are working. If that isn't working, we would figure out something else." 2. R2's electronic face sheet printed on 2/14/23 showed R2 has diagnoses including but not limited to fracture of left femur, spondylosis, Alzheimer's disease, and history of falls. R2's facility assessment dated 2/4/23 showed R2 has severe cognitive impairment and is a 2 person assist for transfers. R2's fall occurrence report dated 1/27/23 showed, "12:30 AM resident observed on floor near dresser in supine position, appropriate footwear	S9999		

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in use walker near resident. Resident stated 'I was going towards my dresser and lost my balance.' Physical assessment reveals left leg shorter than the right leg and left foot inverted inward. Sent to ER and left hip fracture noted."

R2's fall risk assessment dated 1/27/23 showed R2 is not at risk for falls. (Immediately following R2's fall resulting in a left hip fracture.)

R2's fall occurrence report dated 2/9/23 showed, "1500 [3:00 PM] Resident observed on floor on bedside safety mat on right side. Appropriate footwear noted on resident at time of incident, call light within reach and functioning properly. Physical assessment reveals no apparent injury. Staples intact to 3 separate surgical areas left hip. Resident offers no complaints of pain or discomfort at time of incident."

R2's care plan updated 1/19/23 showed, "The resident is at risk for falls related to confusion, gait/balance problems, debility, history of falls and vision/hearing problems." No interventions or increased monitoring were added to R2's fall care plan following her fall resulting in a left hip fracture on 1/27/23.

On 2/14/23 at 10:57 AM, R2's room was observed towards the far end of the hallway. R2 was sitting up in her wheelchair with the right foot pedal pushed to the right side of her wheelchair. R2's left foot pedal was placed in a neutral position under her left leg and foot. R2 was sleeping with her head on her bedside table. R2's call light was secured on her bed rail on the other side of the room and out of reach for R2 to utilize. R2's fall mat was placed in front of her bed so she was unable to get her wheelchair over to the bed. R2 had a sign in her room across from the

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S9999	Continued From page 10 bed on that stated, "Yell for help don't stand alone." On 2/17/23 at 2:05 PM, V7 (Assistant Director of Nursing) stated, "When (R2) fell it was thought to be a result of a medication, so we changed the medication to attempt to decrease fall risk. I don't see any documentation in her chart about it, but we did do it. I'm sure we did. Anytime we change a medication or attempt a new intervention related to falls it should be documented in the progress notes or on the care plan, ideally it would be put in both places but that doesn't always happen. I know R2 doesn't always use her call light so that's why she has the sign in her room to yell for help; however, she should always have her call light available to her for her to utilize if she remembers to use it." 3. R61's electronic face sheet printed on 2/17/23 showed R61 has diagnoses including but not limited to fracture of T7-T8 vertebra, hypertensive heart disease, insomnia, anxiety disorder, lack of coordination, and repeated falls. R61's facility assessment dated 1/7/23 showed R61 has no cognitive impairment and requires 2 staff assist for transfers. R61's care plan dated 1/4/23 showed, "The resident is at risk for falls related to gait/balance problems, history of falls, and psychoactive drug use." R61's nursing notes dated 1/29/23 showed, "At 3:25 AM, Certified Nursing Assistant (CNA) answered resident's call light. Resident was walking in her room and asked the CNA to ask the nurse for a pain pill because she was in pain and could not get comfortable or rest. As CNA	S9999		

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S9999	Continued From page 11 was walking down the hallway to get Registered Nurse (RN), a loud noise was observed and the resident was found by the CNA on the floor of her room. The CNA got the RN and the RN walked into the room with resident on the floor in a fetal position with her right arm back, left arm forward, as resident stated she braced herself from falling and hitting their head...the resident stated she was trying to sit down in her wheelchair while waiting for her pain medication and forgot to lock the brakes on her wheelchair...no injuries noted from fall." On 2/17/23 at 12:13 PM, V17 (Physical Therapy Assistant) stated, "[R61] transfers now with supervision and a walker. When she first came here our initial evaluation on 1/4/23 showed she was unable to stand due to fatigue, on 1/27/23 she was a contact guard, hands on assist for all transfers. We never deemed her appropriate to be independent in her room and she still isn't independent. If staff observe her up on her own they are to assist her with hands on assistance with a gait belt. If the CNA saw her walking in her room, she should have assisted her immediately and could have prevented this fall." On 2/17/23 at 12:09 PM, R61 stated, "It was about 3:00 AM and I wasn't able to sleep so I thought I would get up in the chair. I was standing up and the CNA had just been in the room with me. She left and I went to sit down in my wheelchair to wait for my pain medication and one brake was locked and the other one wasn't. I didn't have injuries. It's nobody's fault but my own. I shouldn't have been standing up on my own." On 2/17/23 at 2:05 PM, V7 (Assistant Director of Nursing) stated, "[R61] needs assistance with ambulation. If a staff member saw her ambulating	S9999		

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S9999	Continued From page 12 on her own, they should have immediately provided assistance to her. This fall could have been prevented if the CNA would have assisted her to sit down in her wheelchair." The facility's policy titled, "Fall Prevention Program" revised on 05/2022 showed, "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary...Standards:...Safety interventions will be implemented for each resident identified at risk...all assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained ...Fall/safety interventions may include but are not limited to...The nurse call device will be placed within the resident's reach at all times...residents will be observed approximately every 2 hours to ensure the resident is safely positioned in the bed or a chair...nursing personnel will be informed of resident who are at risk of falling. The fall risk interventions will be identified on the care plan..." (A) (Violation 2 of 3) Statement of Licensure Findings 300.610a) 300.1210b) 300.1210d)1)	S9999		

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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) COMPLETE DATE
S9999	Continued From page 13 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These requirements were not met as evidenced	S9999		

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S9999	Continued From page 14 by: Based on interview and record review the facility failed to ensure pain medications were available to a resident for 1 of 1 resident (R39) reviewed for pain in the sample of 22. This failure resulted in R39 experiencing sleeplessness and narcotic medication withdrawal symptoms. The findings include: R39's face sheet showed he was admitted to the facility on 1/19/19 with diagnoses to include secondary malignant neoplasm of bone, malignant neoplasm of brain, panlobular emphysema, neoplasm related acute and chronic pain, and major depressive disorder. R39's facility assessment dated 12/3/22 showed he has no cognitive impairment. On 2/15/23 at 10:05 AM, R39 said, "They ran out of my narcotic a couple months ago and it took 3-4 days for them to get it back in. I have a lot of pain. I have a pain patch and I take the other medication twice a day. I was going through withdrawals, and I couldn't sleep because of the pain." R39 said he has cancer and they weren't going to operate because the cancer was so bad. R39 said after he had some chemotherapy treatments the doctors decided they could go ahead and do a surgery to remove a large tumor out of his back. R39 said he now has a lot of pain due to the cancer and the surgery. R39 said he has a steel rod in his back and the cancer had eroded part of his spine and ribs. R39 said if he has his pain medications on time his pain is controlled. R39's care plan revised 10/4/21 showed, "[R39] is on pain medication therapy related to palliative	S9999		

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S9999	Continued From page 15 care for mediastinum Cancer with metastatic disease to bone and brain, neoplasm related chronic pain, and spinal stenosis... Interventions: Administer analgesic medications as ordered by physician..." R39's December 2022 MAR (Medication Administration Record) showed an order started 8/2/22 for "Methadone Hcl 5 mg, Give 5 mg by mouth two times a day for pain." R39's MAR showed R39 missed 7 consecutive doses of his Methadone from 12/18/22 at 8:00 PM through 12/21/22 at 8:00 PM. R39 resumed his Methadone pain treatment on 12/22/22 at 8:00 AM. R39's 12/19/22 nursing note showed his Methadone was not administered because it had not arrived from the pharmacy. R39's 12/20/22 nursing note documents, "Writer spoke with pharmacy in regards to methadone prescription...that was faxed to them on 12/13. Pharmacy stated it was a 'refill too soon' and they were not able to fill it at that time and it needed to be resent. Writer refaxed methadone prescription... Pharmacy received methadone script and will be sending it out." R39's 12/20/22 and 12/21/22 Medication Administration notes showed the methadone was not administered because it had not been delivered from the pharmacy. On 2/17/23 at 1:05 PM, V2 (Director of Nursing) stated, "We tried to get [R39's] pain medication from our pharmacy but they said it was a 'refill too soon'. Then when he ran out, we called the pharmacy again and they told us they never got the script, so we sent it again. I personally sent the prescription to the pharmacy and told the floor	S9999		

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S9999	Continued From page 16 nurse I sent it in. It didn't come until a couple days later and I'm not sure why. We have a convenience box, but it doesn't have his particular medication in it. We can either get orders STAT [immediately] from our pharmacy or they will contact a local pharmacy to have the medication delivered to us. I guess we thought maybe the palliative care nurse would be handling the medication refills, but they weren't able to get it here either. We dropped the ball on getting his medications and we should have been following it more closely and being more persistent with the pharmacy so he wouldn't run out." The facility's Pain Assessment policy and procedure with effective date of 10/2022, showed, "Purpose: To establish guidelines for appropriate assessment and intervention to manage pain. To respect and support the resident's right to optimal pain management..." (B)	S9999		
	(Violation 3 of 3) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction			

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S9999	Continued From page 17 Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to submit background checks, check the Illinois Department of Corrections (IDOC) website, and check the Illinois State (ISP) website within 24 hours of admission. This applies to 3 of 10 residents (R386, R137, R75) and has the potential to affect all 84 residents who reside at the facility. The findings include: The CMS-672 Resident Census and Conditions Report dated 2/14/2023 shows a facility census of 84. 1. On 2/14/23 the Admission Record showed the admission date for R386 as 2/3/23. The criminal background check, Illinois State Police (ISP) check, and the Illinois Department of Corrections (IDOC) check was submitted on 2/14/23.	S9999		

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S9999	Continued From page 18 2. On 2/14/23 the Admission Record showed the admission date for R137 as 1/28/23. The criminal background check was submitted on 1/30/2023. 3. On 2/14/23 the Admission Record showed the admission date for R75 as 1/21/23. The criminal background check was submitted on 1/23/23. On 2/15/23 at 11:26 AM, V4 (Business Office Manager) said R386's background check was not done initially because the resident's name was spelled incorrectly. V4 said criminal background checks for residents should be completed within 24 hours of admission. The facility's Abuse Prevention and Reporting - Illinois, copyright 2023, states " ...request a Criminal History Background Check within 24 hours after admission of a new resident..." (C)	S9999		