Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
74.01.04			A. BUILDING:		OOMI LETED		
		IL6011381	B. WING		12/08/2023		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
ARCADI	A CARE MORRIS	1095 TWII MORRIS,	JGHT DRIVE IL 60450				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
S 000	Initial Comments		S 000				
	Annual Licensure S	Survey					
S99 9 9	Final Observations		S9999				
	Statement of Licen	sure Violations:					
	300.610a) 300.1010h)						
	300.1210b) 300.1210d)2)						
	300.1210d)3)						
	Section 300.610 R	tesident Care Policies					
	a) The facility shall have written policies and procedures governing all services provided by the						
	facility. The writter	policies and procedures shall					
	Committee consist	Resident Care Policy ing of at least the					
		advisory physician or the ommittee, and representatives					
	of nursing and other	er services in the facility. The					
		ly with the Act and this Part. s shall be followed in operating					
	the facility and sha	Il be reviewed at least annually					
	by this committee, and dated minutes	documented by written, signed of the meeting.					
	Section 300.1010	Medical Care Policies					
		shall notify the resident's					
		cident, injury, or significant nt's condition that threatens the					
]	health, safety or w	elfare of a resident, including,					
		he presence of incipient or ulcers or a weight loss or gain		Attachment A			
	of five percent or n	nore within a period of 30 days.		Statement of Licensure Vio	lations		
	The facility shall ob	otain and record the physician's					
Illinois Depa	rtment of Public Health		1				

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

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING_ IL6011381 12/08/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA CARE MORRIO

1095 TWILIGHT DRIVE

ARCADIA	A CARE MORRIS	iorris, il 60450		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIO	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	59999		
	plan of care for the care or treatment of su accident, injury or change in condition at th of notification.			
	Section 300.1210 General Requirements Nursing and Personal Care	for		
	b) The facility shall provide the necessare and services to attain or maintain the practicable physical, mental, and psycholowell-being of the resident, in accordance weach resident's comprehensive resident caplan. Adequate and properly supervised nucare and personal care shall be provided to resident to meet the total nursing and personal care needs of the resident.	highest gical vith are ursing o each		×
	d) Pursuant to subsection (a), general nursing care shall include, at a minimum, to following and shall be practiced on a 24-hoseven-day-a-week basis:	he		
	2) All treatments and procedures sha administered as ordered by the physician.	ll be		
	3) Objective observations of changes resident's condition, including mental and emotional changes, as a means for analyz determining care required and the need fo further medical evaluation and treatment s made by nursing staff and recorded in the resident's medical record.	ing and r		
	These requirements are not met as eviden	nced by:		
	Based on observation, interview, and recorreview, the facility failed to monitor residentisk for weight loss, offer nutritional supple as ordered by the physician in order to preadditional weight loss, and offer food subs	nts at ments vent		

Illinois Department of Public Health

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		F7 35 50	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6011381	B. WING 12/08/		8/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ARCADI	A CARE MORRIS	1095 TWII MORRIS,	LIGHT DRIVE IL 60450			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999		***	
	unplanned weight k nutritional status. The experiencing a 29.2 months of admission	nat were refused to prevent oss and maintain resident his failure resulted in R40 29% weight loss within 4 on. This applies to 2 residents ewed for weight loss in a				
	The findings include	e :				
	1. R40's MDS (Minimum Data Set) dated 11/14/23 shows her cognition is intact. On 12/5/23 at 12:18 PM, R40 said, "I have lost about 60 pounds since August." R40 said the facility was giving her mighty shake supplements, but she had not received one in almost a week. R40's lunch tray was then delivered in the presence of surveyor, and it did not have any supplement on it. On 12/6/23 at 12:30 PM, V22 (R40's spouse) said R40 lost 20 pounds in the last month.					
	8/8/23. The facility's Summary' report si measured 4 times I and 12/7/23. R40's was 198 pounds. R 9/6/23 was 184.6 p weight loss in 1 morecorded in the moveight measured o showing a 13.65% next weight measure pounds, showing a R40 lost 58.2 pounmonths earlier, sho loss.	shows an admission date of a "Weights and Vitals hows R40's weight has been between the dates of 8/8/23 Admission weight on 8/8/23 Admission weight recorded on ounds, showing a 6.77% onth. R40's weight was not onth of October. R40's next on 11/3/23 was 159.4 pounds, weight loss in 2 months. R40's red on 12/4/23 was 139.8 12.3% weight loss in 1 month. ds since her admission four wing a 29.39% total weight lian Order Sheet) shows an 23 for weekly weight to be				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING		COMPLETED	
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		IL6011381	B. WING 12/08/202		8/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		1095 TWII	LIGHT DRIVE	2 2		
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	CUMMADVCTA		1		ON.	
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S9999	Continued From pa	ge 3	59999			
S9999	REGULATORY OR LSC IDENTIFYING INFORMATION)					
	Dietary Manager by	email and then it is the				
		lity to notify the physician. On				
		, V10 (R40's physician) said a	1			
		ss in 4 months is a lot. V10				
		rsonally notified of R40's				
	weight loss.					
INV	dinant of Dublic Hoolth				_	

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IL6011381 B. WING B. PODVIDERS HAN OF CORRECTION B. PROVIDERS HAN OF	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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ARCADIA CARE MORRIS O(4) D	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
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criteria: 1 month interval-significant loss 5%-severe loss greater than 5%, 3 month interval-significant loss 7.5%-severe loss greater	333	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 R40's Care Plan dated 11/20/23 shows R40 is at increased nutritional risk related to Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension. Interventions include monitor monthly weights or per facility protocol and report significant changes to the physician and power of attorney. An additional Care Plan focus (initiated during this survey on 12/5/23) states R40 has an unplanned/unexpected significant weight loss and interventions include monitor weights per facility protocol. The facility's undated policy titled, "Weight Assessment and Intervention" states, "Guideline: Weights are monitored monthly or more often as recommended by the interdisciplinary care team. The goal is to ensure adequate parameters of nutritional status are maintained by preventing unintentional weight lossProcedure: 1. Nursing staff will record the resident weight upon admission and once a week for four weeks thereafter to establish a base weight and stability of weights. If no weight concerns are noted, the resident's weight will be recorded monthly thereafter or as indicated by the interdisciplinary care team4. Any weight change of 5% or more since the previous weight assessment shall be re-taken to confirm. If the weight is verified, nursing will notify the appropriate designated individuals such as the physician, registered dietician, dining services manager, or other members of the interdisciplinary team6. The threshold for significant unplanned and undesired weight loss shall be based on the following criteria: 1 month interval-significant loss 5%-severe loss greater than 5%, 3 month					

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B. WING IL6011381 12/08/2023 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 (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 5 S9999 Assessment information will be analyzed by the interdisciplinary team and conclusions shall be made ...2. The physician along with the interdisciplinary team will identify conditions and medications that may be causing anorexia. weight loss, or an increased risk of weight loss ..." 2. On 12/05/23 at 11:18 AM R43 stated he does not like the food the facility offers. On 12/07/23 at 10:20 AM R43's breakfast tray was observed. R43 consumed 25% of scrambled eggs and 100% of nonfat yogurt. R43 said, "the meals are not good here and I have lost weight since being here because of the food". R43 said he does not receive any nutritional supplement drinks from the facility. R43 said he asked for Ensure Plus nutritional drink because he likes the taste of it but was told the facility does not carry that in stock. R43 said they offered him the house stock nutritional drink, R43 said he does not like the house stock and does not drink it. R43 said the nurses offer the house stock nutritional drink to him once a week and he refuses it. R43 said no other alternatives for nutritional supplements were offered to him. R43's face sheet showed R43 was admitted to the facility on 05/15/23 with diagnoses of Guillain-Barre Syndrome, essential hypertension. hypothyroidism, gastro-esophageal reflux disease without esophagitis, chronic obstructive pulmonary disease, atrial fibrillation, vitamin deficiency, constipation, major depressive disorder, abdominal aortic aneurysm without rupture, and diseases of the nervous system and sense organs. R43's MDS dated 11/17/23 showed R43 was cognitively intact. The same MDS showed R43's most current weight was 171 pounds. R43's care plan dated 05/24/23 showed R3 is at increased nutritional risk and to offer

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PRINTED: 01/24/2024 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:** COMPLETED A. BUILDING: IL6011381 B. WING 12/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1095 TWILIGHT DRIVE ARCADIA CARE MORRIS MORRIS, IL 60450** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) S9999 Continued From page 6 S9999 afternatives at mealtimes when appropriate, monthly weights, and to report significant weight changes to the MD (Medical Doctor) and POA (Power of Attorney). Per the weight summary, R43's admission weight on 05/15/23 was 183.9 pounds. No recorded weight for the month of June. On 07/10/23 R43's weight was 185.3, on 08/08/23 R43's weight was 175.0 (-5.56%), on 09/07/23 R43's weight was 170.6 (-2.51%), no recorded weights for October and November, and on 12/04/23 R43's was 170.4. The dietary assessment dated 11/22/23 showed R43 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The same assessment stated R43 was not on a prescribed weight loss program. R43's weight change progress note dated 09/15/23 showed R43 was triggered for significant weight loss for two months and weight continues to trend down. The same note stated "resident reports not liking food very much at the facility. Resident with additional Ensure supplement in place three times per day, however, resident states he has not been receiving supplements". On 12/07/23 at 2:10 PM V2 said she was aware of R43's insidious weight loss. V2 said she was not aware of R43 not liking the house stock nutritional drink, V2 said no alternative supplement was offered to R43 since he does not like the house stock nutritional drink. V2 said it is expected that when residents refuse supplements, the dietitian is notified for alternatives. V2 said the dietitian was not notified for any alternative supplements. (B)

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