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: C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1701 NORTH BOWMAN ARCADIA CARE DANVILLE** DANVILLE, IL 61832 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation 2161498/IL131533 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1210 d)2) 300.1210 d)3) 300.1210 d)5) Section 300.610 Resident Care Policies 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 Attachment A care and personal care shall be provided to each Statement of Licensure Violations resident to meet the total nursing and personal

Illinois Department of Public Health

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

TITLE

(X6) DATE

URR811

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: C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN ARCADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 care needs of the resident. 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: Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. All treatments and procedures shall be administered as ordered by the physician. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour. seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection. and prevent new pressure sores from developing. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement pressure relieving interventions. assess for pressure ulcer risk, complete weekly skin assessments, administer treatments as ordered, and assess wounds weekly (R1, R2, R3) and implement an antibiotic timely for a surgical wound infection (R2) for three of three residents reviewed for pressure ulcers in the sample list of

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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S9999	seven residents. The developing a Deep and three Stage II purely and three Stage II purely findings include: The facility's Pressure Assessment policy, documents: "Wound and skin assessment by the nurse. Pressure will be completed up Dressings shall include administered the treadministered the treadministration will be The resident's care include skin alteration care." 1.) R3's Minimum Deformer R3 is continent of bowel extensive assistance.	nese failures resulted in R3 Tissue Injury to the right heel pressure ulcers. Tissue Injury and Skin Condition	S9999			
	admitted to the facili ulcers, and R3 uses program. R3's Base Line Care document R3 has si Physician's Orders, documents orders for Assessment on admithree weeks and we medical record does Pressure Ulcer Risk as ordered upon adweeks after admissi	eloping pressure ulcers, ity without any pressure a turning and repositioning elements and repositioning elements. R3's with a start date of 3/5/21, or a Pressure Ulcer Risk hission and then weekly for ekly skin assessments. R3's a not document that a Assessment was completed mission and weekly for three on. There are no documented completed after R3's				

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

URR811

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 IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1701 NORTH BOWMAN** ARCADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 admission on 2/26/21 until 3/6/21. R3's Skilled Charting notes, dated 2/26/21 and 3/6/21, document R3's skin is intact and the section for pressure relieving interventions is not completed. R3's Initial Wound Evaluation & Summary, dated 3/10/21, by V23, Wound Physician, documents R3 has an Unstageable deep tissue injury to the right heel that measured 1.5 cm (centimeters) (long) by 1 cm (wide) by no measurable depth. This summary documents treatment orders to apply a skin protectant daily and heel protectors worn when in bed. R3's Skin Condition Report. dated 3/11/21, documents: "R3 has two shear wounds to the right buttock that measured 8 mm (millimeters) by 2 mm by 1 mm(depth) and 4 mm by 3 mm by 1 mm. R3 has a shear wound to the posterior left thigh that measured 0.5 cm by 4 mm by 1 mm." R3's Physician's Orders document an order dated 3/11/21 for pressure relieving boots to R3's heels when in bed, cleanse and apply a skin protectant to R3's right heel, and cleanse and apply a hydrocolloid dressing three times weekly to the right buttock and posterior thigh wounds. There is no documentation in R3's medical record that a turning and repositioning program was implemented or pressure relieving interventions for R3's bilateral heels were implemented prior to 3/11/21. R3's Nursing Notes document: On 3/11/21 at 12:37 PM shearing areas were noted to the right buttock and posterior left thigh during incontinence care. R3 was turned and repositioned and pillows were used for comfort. R3 had poor appetite documented on 3/2, 3/3, 3/9 and 3/10/21. There is no documentation that the

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facility consulted a registered dietitian since R3's

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	` '):		MPLETED		
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:	admission or when on 3/10/21 and 3/11	R3's wounds were identified				,		
	(RN), V16, and V17 entered R3's room t wound care. R3 was lying directly on the	Certified Nursing Assistants, to provide incontinence and slying in bed with R3's heels mattress. R3's heels were not V14 stated R3 admitted to						
	the facility with a pre and developed two from shearing. V16 brief and V17 turned	essure wound to the right heel more wounds to R3's buttocks removed R3's incontinence of R3 onto R3's left side. There is to R3's right buttock. V17						
N	turned R3 onto R3's open area to R3's le bloody drainage not cleansed the wound	right side there was a small ift posterior thigh. There was ed on R3's brief. V14 s and applied a hydrocolloid						
	delivered pressure r V14 applied a skin p R3's heel had a sma in color. V14, V16, a	e V13, Director of Rehab, elieving boots to R3's room. protectant to R3's right heel. all area that was purple/black and V17, applied R3's boots. V17 stated pressure						
	relieving intervention	ns for R3 include turning and 2 hours and floating R3's						
made.	turning R3 from side but R3 has not had I R3 needs staff assis repositioning and inc	PM, R3 stated staff have been to side throughout the day, R3's heels floated. R3 stated stance with turning and continence care. R3 stated at of bed regularly, and R3 etite.						
	been assisting with repast couple of weeks	PM, V4, RN, stated V4 has monitoring wounds for the s since V21, Former Wound stated Pressure Ulcer Risk						

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
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	CUMMADV CTA	TEMENT OF DEFICIENCIES	1	:		-
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	· ·					
		d be completed on admission				
		onfirmed R3's orders sure Ulcer Risk Assessment to				
	E .	admission and weekly for 3				i
		ed there are no completed				
		Assessments in R3's				
	medical record sinc	e R3 admitted to the facility on				
		f the physician's order				
		ure Ulcer Risk Assessment be				
		or 3 weeks then it should have				
		ed R3 has shear wounds to				
		d left posterior thigh that were I, and V4 stated V4 thought				
		acility with the deep tissue				
		eel. V4 confirmed there is no				
		3's medical record that R3's				
	deep tissue injury w	as present on admission. V4				
		e responsible for completing				
		ments which are documented				
		nent Administration Records)				
		ent in the resident's medical				
		ressure relieving interventions the resident's care plan and				
	R3's interventions in					
		2 hours and as needed. V4				
	confirmed there is n	o documentation in R3's				
		a turning and repositioning				
		mented or pressure relieving				
		mplemented for R3's heels				
	prior to 3/11/21.					
	On 3/16/21 at 9:41 A	AM, V23, Wound Physician,				
		o are at risk for developing				
		risk factors including				
		nould have pressure relieving				
		nented such as turning and				
		2 hours, a pressure relieving				
		tting in the same position for				
		V23 stated not implementing				
	pressure relieving in	terventions can contribute to				

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: C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1701 NORTH BOWMAN** ARCADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 6 S9999 the development of pressure ulcers. V23 stated V23 saw R3's deep tissue injury on 3/10/21, and recommended the use of bilateral heel protectors. On 3/16/21 at 11:20 AM, V2, Director of Nursing (DON), stated the facility's dietitian rounds at the facility monthly and assesses residents who are newly admitted, have weight loss, and wounds. V2 was unsure if the facility had notified V25. Registered Dietitian, of R3's admission, or after R3 developed pressure ulcers. On 3/16/21 at 1:30 PM, V2, Director of Nursing, stated V2 was unable to provide documentation that Pressure Ulcer Risk Assessments were completed, skin assessments were completed between 2/26/21 and 3/6/21, V25 was consulted in regards to R3's wounds, and pressure relieving interventions were implemented for R3 prior to R3 developing pressure ulcers on 3/10/21 and 3/11/21. 2.) R1's Pressure Ulcer Risk Assessment, dated 12/1/20, documents R1 is at high risk for developing pressure ulcers. There are no documented Pressure Ulcer Risk Assessments completed after 12/1/20 in R1's medical record. R1's MDS, dated 12/6/20, documents R1 had Unstageable pressure ulcers that were present upon admission. R1's MDS, dated 3/6/21. documents R1 is cognitively impaired, is always incontinent of bowel and bladder, is dependent on two staff for transfers and bed mobility, uses extensive assistance of one staff person for toileting. This MDS documents R1 has three Stage 1, two Stage III, and two stage IV pressure ulcers that were not present upon admission. R1's Care Plan, revised on 2/24/21, documents R1 has impaired skin integrity with interventions for heel protectors to be worn in bed initiated on

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: _ C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN ARÇADIA ÇARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 7 S9999 12/3/20, pressure reducing mattress, pillows to protect skin, pressure relieving cushion for wheelchair, alternating air mattress initiated on 12/18/20, refer to physician orders and TAR (treatment administration record) for wound treatments, turn and reposition every 2 hours and as needed, and weekly documentation including measurements of skin breakdown, drainage, and any other noted changes. R1's Wound Evaluation & Management Summaries by V23, Wound Physician, document the following: On 10/21/20 R1 had abrasions to R1's left lateral foot 9 cm long by 2.5 cm wide and left lateral heel 1.5 cm by 3 cm. V23 recommended heel protectors to be worn in bed. On 10/28/20 R1 had an abrasion to the left lateral foot 7 cm by 1 cm and left distal medial foot 1 cm by 1 cm. On 11/11/20 R1 had the following abrasion wounds: left lateral foot abrasion measured 3 cm by 0.5 cm, left distal medial foot 1 cm by 1 cm, right medial foot 1.5 cm by 1 cm, right heel 1.2 cm by 0.5 cm, left heel 1 cm by 0.8 cm by 0.1 cm. On 12/2/20 R1 had an Unstageable necrotic (dead tissue) wound with a duration of greater than 76 days duration to the left, proximal, lateral foot that measured 2 cm long by 1.5 cm wide by 0.2 cm deep. R1 had an Unstageable necrotic wound with a duration of greater than 56 days to the left, distal, lateral foot the measured 1.5 cm by 1 cm by no measurable depth. R1 had an Unstageable deep tissue injury to the right distal. lateral foot that measured 9 cm by 2.5 cm by no measurable depth. On 12/9/20 R1 had the following wounds: stage

Illinois Department of Public Health

IV pressure ulcer to the left proximal, lateral foot 2 cm by 1.5 cm by 0.2 cm, Unstageable necrotic left distal, lateral foot pressure ulcer 1.5 cm by 1

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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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S9999	right distal, lateral for tissue injury to the repressure ulcer to the stage III sacral pressure. On 12/16/20 R1 had ulcers: Stage IV left 1.5 cm by 0.2 cm, U foot 1.5 cm by 0.2 cm, U foot 1.5 cm by 0.1 cm, a medial foot 1.5 cm by 0.1 cm, a medial foot 1.5 cm to 0n 2/18/21 R1 had Stage IV left distal, I Stage IV right distal, by 0.1 cm, Stage III 1.3 cm by 0.2 cm, S 2.5 cm by 0.5 cm, S foot 1.5 cm by 0.2 cm proximal lateral foot Stage II left lateral h	ecrotic pressure ulcer to the pot 9 cm by 2.5 cm, deep light hip 3 cm by 2 cm, stage I e left heel 1.5 cm by 1 cm, sture ulcer 0.8 cm by 1 cm by d the following pressure proximal, lateral foot 2 cm by Instageable left distal lateral, Unstageable right distal, 2.5 cm, right hip deep tissue m, Stage III sacrum 4.5 cm by and Unstageable left distal by 1.5 cm. the following pressure ulcers: lateral foot 2.5 cm by 1.5 cm, lateral foot 2.5 cm by 2 cm left distal medial foot 2 cm by tage III left buttock 3.5 cm by tage IV left proximal lateral m by 0.2 cm, Stage IV right 2 cm by 1 cm by 0.2 cm, leel 0.3 cm by 0.2 cm, Stage IV right 2 cm by 1 cm by 0.2 cm, Stage	S9999				
	buttock 2.5 cm by 2 cm, Stage 1 left low cm. On 2/24/21 R1 had to Stage IV left distal lastage IV right distal 0.2 cm, Stage III left 1 cm by 0.2 cm, Stage 1.5 cm by 0.9 cm by proximal lateral foot Stage II left lateral heright ear 1.5 cm by 0 by 3.5 cm, Stage I left lateral heright ear 1.5 cm by 0 by 3.5	by 0.2 cm, Stage II right cm, Stage I left hip 6 cm by 3 er medial thigh 5 cm by 1.5 the following pressure ulcers: ateral foot 1 cm by 2 cm, lateral foot 1 cm by 1 cm by distal medial foot 1.5 cm by ge III left buttock 4 cm by 2 e IV left proximal lateral foot 0.2 cm, Stage IV right 2 cm by 1.2 cm by 0.3 cm, eel 0.5 cm by 1 cm, Stage III 0.8 cm, Stage I left hip 5 cm oft medial thigh 4 cm by 1 cm, al ankle 0.8 cm by 1.5 cm.					

(X2) MULTIPLE CONSTRUCTION

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: C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1701 NORTH BOWMAN ARCADIA CARE DANVILLE** DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 9 S9999 There are no documented measurements of R1's wounds until 3/10/21. On 3/10/21 R1's wounds are documented as: Stage IV right distal lateral foot 0.5 cm by 0.4 cm by 0.2 cm, Stage IV left distal lateral foot 0.4 cm by 0.3 cm by 0.1 cm, Stage III left buttock 3.5 cm by 2 cm by 0.2 cm, Stage IV right proximal lateral foot 1.5 cm by 1 cm by 0.1 cm, Stage III right ear 1.2 cm by 0.5 cm, and Stage I right hip 2 cm by 1 cm. R1's medical record does not document skin assessments were completed weekly as ordered in October 2020, between 11/5 and 11/16, upon readmission on 11/30/20, weekly between 12/1/20 until 12/21/20, and weekly after 2/17/2. R1's Nursing Notes document: On 11/30/20 R1 returned to the facility from the hospital with wounds to bilateral feet and buttocks and R1 will be referred to the wound nurse. There is no documentation that R1's wounds were assessed or measured until R1 was seen by V23 on 12/2/20. R1's Orders Listing Summary, dated 12/1/20 -3/31/21, documents the following treatment orders: Cleanse left buttock wound, apply calcium alginate, and a foam dressing daily. Cleanse right buttock wound, apply calcium alginate and a foam dressing daily. Cleanse left and right distal and proximal lateral foot wounds and apply: petrolatum dressing, one fourth strength bleach soaked gauze, abdominal pad, and gauze wrap twice daily. R1's TARs dated January 2021. February 2021, and March 2021, do not document that R1's treatments were administered as ordered to: R1's left and right buttock wounds on 2/4, 2/9, 2/10/21, and 3/1-3/4/21, and left: distal and lateral foot wounds

Illinois Department of Public Health

and right distal and lateral foot wounds on 2/25

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: C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN ARCADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 10 S9999 and 2/26/21. R1's Weekly Skin Assessments are not documented as being completed in March or on 2/22/21. On 3/11/21 at 12:10 PM, V10, RN, entered R1's room and administered R1's left buttock wound treatment. R1's left buttock wound was red with some yellow tissue. There was a foam dressing to R1's right hip. V10 removed the dressing and there was a small red scabbed area to R1's right hip. R1's right ear wound was red. On 3/11/21 at 3:12 PM, V10 administered R1's treatments to R1's bilateral foot wounds. R1 had one wound to the left lateral and inner foot and two wounds to the right lateral that were small with red wound beds. On 3/15/21 at 2:38 PM, V4, RN, stated: V4 has been assisting with monitoring wounds for the past couple of weeks since V21, Former Wound Nurse, resigned. V23 did not round on 3/3/21 and there wasn't anyone assigned to assess and measure the wounds that day since V21 had resigned that same week. Pressure Ulcer Risk Assessments should be completed on admission and quarterly. The nurses are responsible for completing weekly skin assessments which are documented on the TARs and as an assessment in the resident's medical record. Nurses should sign out the TAR when a treatment is administered. R1 had declined after having COVID-19 (Human Coronavirus Infection) and then developed multiple pressure ulcers while in the facility. R1 used to be up in a wheelchair and

Illinois Department of Public Health

2/17/21.

was more mobile prior to having COVID-19, V4 confirmed R1's last completed Pressure Ulcer Risk Assessment was 12/1/20 and there are no documented weekly skin assessments after

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 C IL6002364 B. WING 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN ARCADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 11 S9999 On 3/16/21 at 9:41 AM, V23, Wound Physician. stated residents who are at risk for developing pressure ulcers with risk factors including impaired mobility, should have pressure relieving interventions implemented such as turning and repositioning every 2 hours, a pressure relieving mattress, and not sitting in the same position for more than 2 hours. V23 stated not implementing pressure relieving interventions can contribute to the development of pressure ulcers. V23 stated V23 would expect V23's recommendations to be implemented within a day or two, and the facility has access to V23's Physician Notes the day after V23 rounds at the facility. On 3/16/21 at 9:00 AM, V2, DON, stated V2 would expect an alternating air mattress to be initiated if a resident has multiple stage II, stage III, or stage IV pressure ulcers. On 3/16/21 at 1:30 PM, V2 stated V2 had no additional skin. assessments that were completed in October 2020, between 11/5 and 11/16, upon readmission on 11/30/20, weekly between 12/1/20 until 12/21/20, and weekly after 2/17/2. V2 was unable to provide documentation that pressure relieving boots were implemented for R1 on 11/11/20 as ordered or that an alternating pressure mattress was implemented prior to 12/18/20. 3.) R2's Admission Record, dated 3/15/21. documents R2 admitted to the facility on 1/14/21 with diagnoses including Chronic Kidney Disease Stage IV, Type 2 Diabetes Mellitus, Morbid Obesity, and Bilateral Above Knee Amoutations. R2's MDS, dated 1/20/21, documents R2 is dependent upon two staff for transfers and bed mobility, dependent upon one staff person for toileting, is frequently incontinent of bladder and always incontinent of bowel.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN ARCADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 12 S9999 S9999 R2's Pressure Ulcer Risk Assessments, dated 1/14/21, documents R2 is at high risk, and 1/21/21 document R2 is at very high risk for developing pressure ulcers. There are no documented Pressure Ulcer Risk Assessments after 1/21/21. R2's Minimum Data Set (MDS), dated 1/20/21, documents R2 is cognitively intact. R2's Care Plan, revised on 2/5/21, documents R2 has impaired skin integrity and admitted with shearing to the lower sacrum. R2's Care Plan documents interventions including dietitian consult, encourage R2 to shift weight, monitor for moisture and apply barrier product as needed, and administered treatments as ordered by the physician. This Care Plan also documents R2 has impaired skin integrity and is at risk for infection with a post surgical incision to the left forearm and documents interventions to administer antibiotics as ordered, evaluate the surgical incision and monitor for signs or symptoms of infection. R2's Physician Orders, dated 3/15/21, documents an order for Pressure Ulcer Risk Assessment upon admission and then weekly for three weeks and wash sacral wound and apply barrier cream once per shift until healed. R2's Order Listing Report, dated 1/1/21 - 3/31/21, documents an order to cleanse R2's sacral wounds, apply a calcium alginate dressing and foam dressing every shift from 1/14/21-1/20/21; Apply Betadine twice daily to the left forearm surgical wound from 2/4/21 until 2/16/21. Apply Gentamicin Sulfate 0.1 % ointment, gauze soaked in one fourth strength bleach solution, abdominal pad and wrap with gauze wrap twice daily to the left forearm surgical wound beginning on 2/19/21. Complete skin

Illinois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: _ C B. WING __ IL6002364 03/16/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA CARE DANVILLE

1701 NORTH BOWMAN DANVILLE II 61832

	DANVILL	E, IL 61832		
(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
\$9999	Continued From page 13 assessments weekly beginning on 1/14/21. Doxycycline Hyclate (antibiotic) 100 mg (milligrams) by mouth twice daily for 10 days for left arm wound infection beginning on 2/15/21. R2's TARs, dated January, February, and March 2021, do not document R2's sacral wound treatments were administered on 8 shifts in January, 12 shifts in February, and 11 shifts in	\$9999		
e de la companya de l	March. R2's Treatment Administration Records, dated February and March 2021, do not document that R2's surgical incision treatments were administered on 11 shifts in February, and 10 shifts in March. R2's Skin - Pressure/Diabetic/Venous/Arterial Wound Report, dated 1/14/21, documents R2's: stage II left medial sacral pressure ulcer			
	measured 3.5 by 1 by 0.1 cm, Stage II left lower sacral pressure ulcer measured 3 by 1 by 0.1 cm, and Stage II left upper distal sacral pressure ulcer measured 1.5 by 1.5 cm. R2's Skin Condition Report dated 2/10/21 documents R2's shear wound to the left lower sacrum measured 1 cm			
	by 0.3 cm by 0.1 cm. There are no documented skin assessments or wound assessments until 2/24/21. R2's Skin Condition Report, dated 2/24/21, documents R2's shear wound measured 0.4 cm by 0.3 cm by 0.1 cm. There are no documented skin assessments or wound assessments after 2/24/21.			
	R2's Wound Evaluation & Management Summary, dated 2/10/21 by V23, Wound Physician, documents R2's post surgical wound to the left forearm measured 0.5 cm (centimeters) long by 5 cm wide by 0.1 cm and the wound had necrotic (dead) tissue and periwound cellulitis (skin infection.) V23 documented orders for			

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: __ C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN **ARCADIA CARE DANVILLE** DANVILLE, IL 61832 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 CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 i Continued From page 14 S9999 Doxycycline 100 mg by mouth twice daily for 10 days. There is no documentation that R2's wound was assessed and measured after 2/10/21 until 2/24/21, and none after 2/24/21. R2's Medication Administration Record, dated February 2021, documents R2 received the first dose of Doxycycline on 2/15/21 at 9:00 AM, five days after ordered by V23 on 2/10/21. On 3/11/21 at 10:20 AM. R2 was lying in bed and R2's dressing to the left forearm was dated 3/9/21. R2 stated the nurses administer a wet to dry dressing daily to R2's left forearm. R2 stated R2 had a dialysis shunt in the left forearm, but now R2 has a port in R2's chest. On 3/11/21 at 11:46 AM, V19 and V20, CNAs, provided incontinence care for R2. R2 had a small pink, superficial open wound to R2's coccyx. V19 confirmed R2's wound is open and stated R2 admitted to the facility with the wound. On 3/15/21 at 9:00 AM, V2, DON, stated, "V23 did not round at the facility on 3/3/21 and that was the same week that V21 had resigned." V2 stated V2 was not sure who would have been responsible for wound assessments and measurements in V23's absence. V21 was responsible for assessing and measuring wounds. V2 stated V2 could not provide R2's Pressure Ulcer Risk Assessments completed

after 1/21/21 and skin assessments or wound measurements on 2/17/21 or after 2/24/21.

On 3/15/21 at 2:38 PM, V4, RN, stated: V4 has been assisting with monitoring wounds for the past couple of weeks since V21 Former Wound Nurse resigned. V23 did not round on 3/3/21 and there wasn't anyone assigned to assess and

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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 C IL6002364 B. WING 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN ARÇADIA CARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 15 S9999 measure the wounds that day since V21 had resigned that same week. Pressure Ulcer Risk Assessments should be completed on admission. and quarterly. If the physician's order specifies the Pressure Ulcer Risk Assessment be completed weekly for 3 weeks then it should have been done as ordered. V21 was responsible for completing weekly wound assessments and measurements. The nurses are responsible for completing weekly skin assessments which are documented on the TARs and as an assessment in the resident's medical record. Nurses should sign out the TAR when a treatment is administered. V4 confirmed there are no documented skin assessments after 2/24/21 for R2. V4 stated: R2 was not seen by V23 on 2/17/21 and I (V4) don't see a skin assessment or wound assessment completed on 2/17/21, R2 may have been out for dialysis at the time V23 rounded at the facility. V4 confirmed V23 ordered Doxycycline on 2/10/21, and the antibiotic was not initiated as ordered until 2/15/21, V4 stated R2 has a surgical wound to the left forearm with an order for wet to dry dressing changes twice daily on the dayshift and evening shift. R2 was at dialysis on 3/10/21. R2's left forearm dressing changed before R2 left for dialysis and again when R2 returned to the facility. V4 confirmed there are no documented wound assessments and measurements for R2's left surgical wound on 2/17/21 or after 2/24/21. On 3/16/21 at 9:00 AM, V2, Director of Nursing, stated the facility has a convenience medication box provided by the pharmacy that is kept in the medication room that the nurses can access to initiate antibiotic orders. V1 Administrator provided an undated list of the medications in the convenience box that documents the box contains Doxycycline 50 mg capsules.

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: _ C B. WING IL6002364 03/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN **ARCADIA CARE DANVILLE DANVILLE, IL 61832** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 16 S9999 On 3/16/21 at 9:41 AM, V23 stated V23 rounds weekly at the facility with the nurses and gives verbal orders for antibiotics to the nurses. V23 stated the facility has access to V23's Physician Notes the day after V23 rounds at the facility. V23 stated waiting five days is a little late to be initiating an antibiotic. (B)