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: B. WING IL6002364 12/08/2021 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 (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S 000 Initial Comments S 000 Annual Licensure and Certification survey S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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. 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

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

d) Pursuant to subsection (a), general nursing

care needs of the resident.

care and personal care shall be provided to each resident to meet the total nursing and personal

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
186			D MAINO			
IL6002364		B. WING		12/08/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
ARCADIA CARE DANVILLE 1701 NORTH BOWMAN						
DANVILLE, 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	,	EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE	
S9999	Continued From page 1		S9999			
X	•	at a minimum, the following ed on a 24-hour,				i
		nd procedures shall be dered by the physician.				vii
	These requirements by:	s were not met as evidenced	III			
	review, the facility for treatments as order (R78) reviewed for sample list of 68. The	ion, interview and record ailed to provided skin red for one of four residents non-pressure wounds on the his failure resulted in R78 I itching and discomfort.		3.		8
	Findings Include:				-40	
		um Data Set), dated 10/11/21, 8 is alert and oriented.				
	has Impaired Skin I multiple areas of the immobility, weakness failure to thrive, and condition that cause This Care Plan doc due to excessive so back scratcher ever with interventions to hydration, and to se Administration Recontreatment and performance of the second	ord) for orders for wound orm as ordered.				
	yelling out that R78	I AM, R78 was lying in bed 's leg is hurting. V16 Care Plan Coordinator entered				

PRINTED: 01/07/2022 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: _ B. WING IL6002364 12/08/2021 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) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 2 S9999 R78's room at this time. V16 went to get an unidentified nurse, who entered R78's room and administered liquid Morphine (Narcotic) for R78's pain. R78 had open sores/skin lesions covering all R78's visible skin other than R78's face; arms, chest, and feet. R78 stated R78 has a skin condition causing the sores and is being seen by a physician for it. R78 stated they {staff} are to put cream on R78 but that it doesn't get applied twice a day like it is supposed to. R78 stated the sores itch, causing discomfort, and make R78 "miserable", therefore R78 "don't want to be bothered." On 12/6/21 at 10:15 am, R78 was lying in bed and stated staff has not completed the skin treatment yet and R78 "is itching bad" and uncomfortable. "I (R78) just want to sleep so I (R78) don't itch so bad." On 12/7/21 at 12:16 pm, R78 was asleep in bed with R78's lunch tray untouched on the overbed table. On 12/7/21 at 1:53 pm, R78 was lying in bed awake but stated R78 just wanted to rest and not talk. R78's December Physician Orders document an order for Triamcinolone Acetonide Cream {Corticosteroid to reduce itching} 0.1 %, with directions to apply all over body topically every day and evening shift related to Bullous Pemphigoid - apply to neck, chest, abdomen, back, hand, armpits. These orders also document

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(as needed) for pain.

an order for Morphine 100 mg (milligrams) per 5 ml (milliliters) - give 0.25 ml/5 mg every hour PRN

R78's November 2021 TAR (Treatment

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 12/08/2021 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 **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 Administration Record) does not document that R78's cream was applied on 11/10, 11/11, 11/12, 11/13, 11/23, 11/24, 11/29 and 11/30 on day shift, at all on 11/14 and 11/19, and 11/25 evening shift. R78's December 2021 TAR does not document R78's cream was applied on 12/1 or 12/3 day shift. On 12/8/21 at 10:00 AM, V2 DON (Director of Nursing) confirmed R78's treatments are not signed off, on the above dates, and stated when a treatment is completed, it needs to be signed out on the TAR. On 12/08/21 at 10:06 AM, V27 RN (Registered Nurse) stated R78 is supposed to get cream to R78's entire body twice a day, and it should be signed off in TAR when completed. V27 stated R78 goes through a lot of it at a time, so it might not have been signed out due to not having any cream to apply. V27 checked both treatment carts and could not find any of R78's cream in either one. The facility Medication Administration Policy, dated 1/1/2015, documents only a licensed nurse (RN, LPN (Licensed Practical Nurse)) may prepare, administer and/or record the administration of medications (prescription ointments are considered medications), and that the time, date and initials of the licensed nurse who administered the medications should document the administration, once administered on the MAR (Medication Administration Record) or TAR. Medications must be administered in accordance with a physician's order, including the right resident, right medication, right dosage, right route, and right time.

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(B)

FORM APPROVED 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: _ B. WING IL6002364 12/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN **ARCADIA CARE DANVILLE** DANVILLE, IL 61832 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**)

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