STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011381	A. BUILDING: _____ B. WING _____	C 12/27/2022

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
S 000	Initial Comments Complaint Investigation 2279982/IL154373	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Based on interview and record review the facility failed to assess, evaluate, and treat a surgical hip wound for a newly admitted resident. This applies to 1 of 4 residents (R2) reviewed for surgical wounds. This failure resulted in resident (R2) being hospitalized for surgical intervention to surgical site and intravenous antibiotic therapy for infection.	S9999		

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S9999	Continued From page 2 The findings include: R2 was admitted to the facility November 11, 2022, per the admission face sheet. R2 was discharged from the facility December 14, 2022 and was reviewed as a closed record. The physician orders dated December 1, 2022, showed that R2 had diagnoses of fractured right hip, orthopedic after care, history of falls, difficulty walking and lack of coordination. The MDS (Minimum Data Set) dated November 16, 2022, showed that R2 is not cognitively impaired. The electronic healthcare record for R2 showed that on November 11, 2022, V8 RN (Registered Nurse) admitted R2 to the facility. The admission assessment skin documentation dated November 11, 2022, showed R2 had a surgical wound to the right hip. There was no documentation of sutures or staples. There was no description of the wound itself. A second note written on November 12, 2022, by V4 (LPN/Wound care nurse) showed a second assessment of the skin was free of injury at this time. Throughout all progress notes November 12, 2022, until discharge there is no documentation of the surgical wound to R2's right hip. There were no physician orders for care of the surgical wound to R2's right hip. The MAR (Medication Administration Record) showed no treatments or assessments were done to the right hip wound. Wound care was not addressed in the care plan.	S9999		

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S9999	Continued From page 3 R2's hospital discharge papers provided to the facility showed that if a patient had sutures or staples, they need to be removed in 1 to 2 weeks. There were instructions for wound care including showering and dressing changes. On December 20, 2022, at 11:50am V2 (Acting Director of Nursing/Assistant Director of Nursing) stated, "R2 was brought to the facility and stayed a short time. She was a surgical admission. The admitting nurse should document the wound in the admission assessment or progress notes. The physician should be notified and orders for wound care should have been obtained." On December 20, 2022, at 12:15pm V4 stated, "I did not see R2 when she was admitted. I did see her when her room was changed to the villa side. I don't recall seeing any staples to her skin. When we do an admission, we count the staples and document it in the admission assessment. I usually do a head-to-toe assessment and I describe what I see. I do not recall any incision or wound. I would also measure the length of the wound, the color and if there was any drainage." On December 21, 2022, at 9:52am V6 (Orthopedic Surgeon) stated, "R2 was supposed to come back in 1 or 2 weeks to have the staples removed. No one from the facility called us to schedule. When R2 did come in the staples were harder to remove. Now R2 is back in the hospital for an infection of the wound and surrounding tissue. She is on intravenous antibiotics. I have had problems with the facility lately and am thinking of not letting my patients go there anymore." V6's hospital progress note (dated 12/14/22)	S9999		

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S9999	Continued From page 4 showed that V6 removed R2's staples 5 weeks and 2 days following surgery. Clinical note: Suture removal... Number of sutures removed: 31... V6's 12/22/2022 faxed response to surveyor showed, "Patient (R2) was not seen here for 5 weeks and there was no mention of her staples or wound care during her 5 weeks stay at the nursing home. She did come in to see us week 5 with staples still in. She had some irritation staples were removed at that time she subsequently after this at 6 weeks in delayed fashion got a superficial infection that does appear this is spread to the subcuticular tissues." On December 21, 2022, at 4:45pm V7 (Medical Director) stated, "No one ever contacted me for wound care orders for this resident. This should never happen. I looked at R2's chart and she did have staples. The staff are to notify me, and I give them wound care orders. Lack of wound care could cause infection." On December 22, 2022, at 11:20 V8 (Practicing Manager on the orthopedic ward at the community hospital) stated, "R2 is on intravenous antibiotics. The infection is at the suture line. R2 required surgical intervention today to debride the wound. In communication with V6 it is likely the infection is from both lack of dressing changes and wound care and the length of time the staples were left in." On December 23, 2022 at 3:00pm V9 RN (Registered Nurse) stated, "I remember R2. She came to our unit several days after she was admitted. She originally was admitted to the 400 unit I think. I do not recall a wound on her backside. The wound care nurse is V4 LPN. I just mark off the weekly skin checks when I check the	S9999		

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S9999	Continued From page 5 bath sheets." (A)	S9999		