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S 000	Initial Comments Complaint Investigations: 2444116/IL173597 2444204/IL173708	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)1)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999		

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S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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. 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:	S9999		

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1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

3) 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.

These Regulations are not met as evidenced by:

Based on interviews and record review the facility failed to notify the Physician or Psychiatry Nurse Practitioner, accurately assess, monitor, implement interventions, provide services, for R2's Mental and Psychosocial wellbeing and to prevent overdose of medication due to R2 recently sustaining physical abuse, and having major depressive disorder and anxiety. This resulted in R2 overdosing on Xanax and Tylenol that facility was aware R2 had in her purse. Then being admitted to hospital and subsequently expiring.

Findings include:

R2 admit date to facility on 4/18/2024, with diagnoses of Parkinson's Disease, Encounter for Mental Health Services for Victim of Spousal or Partner abuse, Depression, unspecified, and Generalized Anxiety Disorder.

Hospital discharge prior to admit to facility, dated 4/12/2024, documents, Chief Complaint R2 Reportedly being battered by her husband, states, she was struck in the head multiple times,

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she also fell and hit her right ribs. The patient presents after an altercation with her husband. He has been aggressive and has had history of abusing her physically in the past. She states that he became angry earlier today and "threw several things at me". She was struck to the face, possibly with an ashtray. Patient sustained some lacerations and abrasions.

R2's trauma informed care document, dated 4/22/2024 documents, physical assault-yes, how much are you bothered by the problem-extremely, comment section documents-husband has beaten her, broke her neck with a case of soda and broke her leg with walker.

R2's PHQ-9 assessment dated 4/22/2024 documents, little interest, or pleasure in doing things-yes, 7-11 days, feeling down, depressed, or hopeless-yes, 12-14 days, trouble falling asleep-yes, 12-14 days, feeling tired-yes, 12-14 days, poor appetite-yes, 12-14 days, total score of 16 -moderately severe depression.

R2's abuse/neglect screening dated 4/22/2024 documents, history of abuse-yes, diagnosis of depression-yes- total score of 3 indicating moderate risk.

R2's behavior charting dated, 5/23/2024 documents, disruptive sounds, anxious, delusions, agitated hallucinations on dayshift and second shift.

R2's Nurses Notes documents, on 5/05/2024, at 9:52pm, R2 reported that V4, (her sister), brought her pills from local Pharmacy today and that they were in her drawer. V5, (Licensed Practical Nurse), explained that medications would be put in nurses' cart, because it is a liability to keep

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medications for others to access in room. R2 was upset that medications could not be kept in her room.

R2's Medication Administration Record, (MAR), dated 5/2204 documents, Xanax 0.5mg, twice a day with dates of 5/04/2024 at hs, (nighttime), dose not given, 5/05/2024 am, dose not given, 5/05/2024 hs dose not given, 5/06/2024 am, dose not given, 5/06/2024 hs, dose not given, 5/07/2024 am dose not given, 5/07/2024 hs, dose not given.

V11, Psychiatry Nurse Practitioner notes dated 5/14/2024 documents, Chief Complaint Psychiatric Evaluation, related to Depressive symptoms. R2 has a history of major Depressive Disorder and generalized Anxiety Disorder. Staff reports, R2 is anxious, restlessness, paranoid regarding her abusive husband finding her here. R2 denies feeling sad, depressed, or hopeless. R2 stated, her mood was "alright".

V11 (Nurse Practitioner), Progress Note dated 5/11/2024, documents, R2 has an order of protection against her husband. She is now discharged to skilled rehab facility. During exam patient is lying in bed, in no acute distress, Psych: cooperative, anxious during exam.

R2's Progress Note dated 5/23/2024, at 8:52pm documents, V6, CNA, (Certified Nursing Assistant), came to V5, (LPN), with an empty bottle of Alprazolam, (Xanax), 0.25mg tab. The bottle showed it was filled on 5/06/24 and that there were 60 tablets in the bottle. V6 questioned R2 upon finding bottle and R2 stated, "I took the rest of my medication, so I should be gone by the end of the night." V6, (CNA), notified V7, (ADON), (Assistant Director of Nursing).

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R2's Progress Note dated 5/23/2024, at 9:02pm, documents, V6, (CNA), questioned R2 and R2 reported taking approximately 15 Alprazolam and 25 Tylenol.

On 5/28/2024, at 1:35pm, V4, (R2's sister), stated, that she brought medications in to R2 around the first week of May, because R2 had called, V4 and asked her to bring the medication to her. V4 stated, that the facility did not have her medications. V4 stated, that she brought two bottles of medications into R2 and put them in R2's drawer. V4 stated, it was a bottle of Ropinirole and something else. V4 stated, she picked these medications up from the Pharmacy. V4 stated, that she did not tell anyone, that she brought in the medications, but that R2 had called her later and stated, that one of the nurses had found the medications in her drawer and took them away from her.

On 5/28/2024 at 2:05pm, V5, (LPN), stated, that on the evening of 5/23/2024, R2 had been yelling and hallucinating earlier in the evening and that V6, (CNA), came to her and said that she had found an empty bottle of prescription medication on R2's bed and that R2 stated, "I should be gone by the end of the night". V5, (LPN), stated, the empty bottle was labeled Alprazolam with a fill date of 5/06/2024, and it said 60 tabs on it. V5 stated, that V6 also, found an empty bottle of Tylenol on the floor next to R2's bed. V5 stated, that both bottles were empty. V5 stated, that R2 stated, she had taken 15 tabs of the Alprazolam and 25 tabs of the Tylenol. V5 stated, that she was not aware, prior to this occurrence that R2 had any medications on her. V5 stated, that R2 did not have any signs of Depression. V5 stated, that V4 brought the medications into R2. V5

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stated, that R2 did go several days without her Alprazolam, earlier in May, due to having difficulty getting a new a script.

On 5/28/2024, at 2:35pm, V6, CNA stated, that a few days prior to this event, (5/23/2024), R2 had been Hallucinating and stated, that a black boy was stealing her stuff and she had dumped all her stuff from her purse on her lap. V6, CNA stated, that she reassured her that no one was stealing her stuff and that she saw prescription bottle of medication and Tylenol bottle in her lap and put these medications back into R2's purse. V6 stated, she did not tell anyone about the medications in R2's purse. V6 stated, that on the evening of 5/23/2024, R2 was yelling so much and so loud that other residents were complaining about R2's yelling. V6 stated, that R2 was making comments about wanting to be home with her husband and that she missed her family and that she didn't want to be here. V6 stated, that R2 was having hallucinations on 5/23/2024, that R2 was making comments, that people were beating her up. V6 stated, that she told V5 about it and V5 gave R2 her bedtime medications to calm her down.
V6 stated, around 8:45pm-9pm, she went to do bed check and R2 was talking very calmly and stated, "you should be glad, I took all my meds." V6 stated, she told R2 that she was glad, she took her meds from the Nurse. V6 stated, that R2 then said, "no I took more, I took about 15 Xanax, (alprazolam), and 25 Tylenol." V6 stated, she looked in R2's purse for the Prescription bottles, she had seen a few days earlier and she found it empty. V6 stated, she then saw the Tylenol bottle on the floor, and it was empty. V6 stated, took the prescription bottle to V5. Then told V5, what R2 had said about taking the pills.

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On 5/28/2024, at 2:50pm, V5, LPN stated, that on 5/05/2024, V5 had found two bottles of medications in R2's drawer and that she took the medications to the med room and educated R2, on not having medications in her room or her purse. V5 stated, she searched R2's room and R2 did not have any other meds in the room at this time. V5 stated, that the two bottles of medications were R2's Ropinirole, (requip), and Fluoxetine, (Prozac), and the fill date for these medications were 5/05/2024.

On 5/29/2024, at 9:00am, V3, (Social Service Director), stated, that R2 was her own decision maker, that R2 was completely with it when she first admitted to facility. V3 stated, that R2 was admitted after being in the Hospital for being beaten by her husband. V3 stated, R2 had an Order of Protection, against her husband and her husband was to not have any kind of communication with R2. V3 stated, on 5/02/2024 the Activity Aide delivered a letter, to R2 from her husband and R2 read the letter. V3 stated, that R2 started, to have Delusions and Hallucinations after receiving the letter from her husband. V3, SSD, stated, that R2 was feeling down and seemed sad, about not seeing her family/kids but, not to the extent of harming herself. V3 stated, that she did ask R2 if she felt like harming herself and R2 would say, NO. V3 stated, that Adult Protective Services, would call and check on R2. V3 stated, that R2 scored a 16 on her PHQ assessment and that is a Moderately Severe Depression score. V3 stated, that the facility does not provide any Psychosocial Programs, small groups, or any Counseling Services for any of the residents. V3 stated that they don't do anything different for the residents who score high or low. V3 stated, she believes that more services should be provided for residents with Psych needs and

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that she herself has requested more training on this. V3 stated, she was not aware of R2 having medications at her bedside, prior to R2's Hospitalization and that it was not safe for any resident to have medication at the bedside. V3, SSD, stated, after this situation, she went room to room and collected any medications/ointments that residents had in their rooms. V3 stated, that R2 is currently on a Ventilator at the Hospital.

On 5/29/2024, at 11:50am, V3, SSD, stated, that the staff attempt to redirect and divert a resident if they are having behaviors, but they do not have any Psychosocial Programs available or any community counselling services available for the residents. V3 stated, she has been trying for the last year to get some kind of counseling services for the residents but, there have been issues with getting one.

On 5/29/2024, at 1:15pm, V8, CNA, stated, that at the end of R2's stay, R2 cried a lot, said she missed her husband, that she stopped eating and was more incontinent of urine, that R2 stopped calling for help to the bathroom and just wet on herself instead. V8 stated, that R2 made comments, about her husband hitting her with a case of pop in the back of the head and that was why R2 had pain in her neck and back. V8 stated, that R2 did not make comments, about taking her life, she just cried a lot. V8 stated, she had not seen any medications in R2's room.

On 5/29/2024, at 1:45pm, V9 CNA, stated, that in the beginning of R2 would talk about her husband a lot, and at the end of her stay she was angry a lot, that she threw her tray one time, because she was mad at the phone.

On 5/29/2024, at 1:50pm, V10, CNA, stated, that

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R2 was one assist with cares when R2 was first admitted but, then R2 started getting more confused and was seeing people in her closet. V10 stated, that R2 became more fearful during her stay, saying she was afraid her husband was coming back to get her, that R2 even began asking for the light to be left on and wanted V10 to check the closet and make sure no one was in the closet. V10 stated, that R2 was afraid and tearful a lot, before she went to the hospital. V10 stated, that R2 was tearful and scared about things in her past. V10 stated, that R2 stopped going to the dining room, for meals and isolated herself in her room. V10 stated, R2 was very quiet, when she was first admitted but, towards the end of her stay, R2 became very scared, just seemed very afraid. V10 stated, she was not aware of R2 having any meds in her room.

On 5/29/2024, at 3:00pm, V11, Nurse Practitioner, stated, that she expected Psych evaluation, for R2 and that would provide recommendations to the facility, for R2's Psych needs. V11 stated, that the last time she saw R2, she was very Anxious and tearful but, V11 was not aware that R2 had received a letter from her husband. V11 also, stated, she was not aware that R2 had missed, 7 consecutive doses of her Xanax in the month of May. V11 stated, that R2 would benefit from Psychosocial Therapy if that was available. V11, Nurse Practitioner, stated, that she did not feel that it was safe for R2 to have medications at the bedside, and V11 did not trust, R2 to take it appropriately.

On 5/29/2024, at 3:25pm, V12, Medical Director, stated, that R2 was admitted to facility for Physical Therapy, and that if the facility had Psych services, R2 could have used some but, the facility does not have those services. V11,

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Nurse Practitioner, stated, that V4 should not have brought in the medication, for R2 because, R2 had Psych issues.

On 5/30/2024, at 10:15am, V3, SSD, stated, that she was not aware of the incident on 5/05/2024, when a Nurse, removed medications from R2's room. V3 stated, that she was not aware that a staff member knew that R2 had prescription meds in her purse either. V3 stated, she would expect staff to remove the meds. V3 stated, that someone like her, with a history of abuse and depression, would be referred to Psych Nurse Practitioner. V3 stated, that Psych Nurse Practitioner, is the one who would decide if R2 needed any other services. V3 stated, that R2 had expressed, that she would like to transfer to a different facility and V3 was assisting with that. V3 stated, that she would have reached out to the Doctor, if she had known, of R2 having behaviors of crying, angry, scared, tearful, afraid, missing her family and hallucinating.

On 5/30/2024, at 10:15am, V2, DON, stated, that she was not aware of R2 having meds in her room on 5/05/2024. V2, DON, stated, she doesn't know what she would have done if she knew about it. V2 stated, that she was not aware that a staff member knew, that R2 had prescription meds in her purse. V2 stated, she expected staff to remove the meds from her purse, if they knew that R2 had them or at the least notify someone of it. V2 stated, the facility does have an assessment, they can do, to let a resident have meds at the bedside, if they feel like the resident is safe to do so. V2 stated, they did not do an assessment for R2. V2 stated, she was not aware of R2 having behaviors of crying, angry, scared, tearful, afraid, missing her family and hallucinating.

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On 5/30/2024, at 10:25am, V1, Administrator, stated, that she was not aware of R2 having meds in her room, prior to the 5/23/2024 incident. V1 stated, that she was not aware of R2 having prescription meds in her purse. V1 stated, she would expect her staff to keep a better watch on R2, if she had known these things were going on. V1 Admin, stated, that they would have put interventions in place. V1 stated, that if she was aware of R2 having behaviors of crying, angry, scared, tearful, afraid, missing her family and hallucinating that the Doctor, would have been contacted and if it was bad enough, they would have sent R2 to the Hospital for an evaluation.

On 5/30/2024 at 11:30am V16, Certified Occupational Therapist Assistance, (COTA), stated, that R2 was Paranoid, that she stated, one time, R2 thought this place was safe, that she had visitors come in over the weekend but, no one came in to see her over the weekend. V16 stated, R2's cognition had gotten worse during her stay, that in the beginning, R2 was good but, near the end she didn't want to do much.

On 5/30/2024, at 1:30pm, V15, Psych Nurse Practitioner, stated, that R2 was struggling with Intermittent Depression and Anxiety, on V15's visit on 5/14/2024, R2 was in a decent mindset, that spousal abuse is absolutely considered trauma/PTSD, that her services are available 24-hours a day but, V15 did not receive any update on R2's behaviors. V15, stated that R2 having behaviors of crying, angry, scared, tearful, afraid, missing her family and hallucinating are all clues of worsening depression and someone should have been talking/seeing R2, that someone should have called V15, and she could have come to see R2 more frequently or

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	IL6007181	A. BUILDING: _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE AUBURN	304 MAPLE AVENUE AUBURN, IL 62615

(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 12	S9999		

medications could have been adjusted. V15 stated, that with R2 exhibiting those behaviors the facility should have been monitoring/tracking her behaviors and checking on her more frequently as in every 15-30 minutes. V15 stated, that she is not involved in the Care Plan Process, that she rarely makes recommendations to a facility for interventions. V15 stated, she was not aware of R2 received a letter from her husband on 5/02/2024, but it was her understanding that R2's husband was not to have any contact. V15 stated, that this could have been prevented, if facility had made V15 aware of R2's behaviors. V15 stated, that she has a Clinical Team that is available and even have specially trained, Trauma Counseling Services, available if needed. V15 stated, "I can't do anything if I am not aware of anything."

Based on resident's Care Plan, dated 04/2024, the facility noted the following: Administer medications and observe for adverse side effects, if noted, document and report to MD (medical doctor). Contact Social Services, prn, (as needed). Discuss with resident ways to utilize present coping skills to deal with situations that arise. Encourage and allow open expression of feelings and reinforce appropriate expression of feelings. Encourage frequent contact with family and friends, per resident's request/approval. Ensure ADL, (Activities of Daily Living), needs are met. Investigate the need for psychological support. Observe for signs and symptoms of depression, document, if noted, and report to improvise emotional support. Report, assess and record any changes in mood. Report to MD changes in mood. However, the facility failed to provide any of the above-mentioned interventions or cares for R2 as nothing was identified within residents Care Plan or within the Nursing Notes provided by the facility.

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S9999	Continued From page 13 (A)	S9999		