STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145753	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCADIA CARE DANVILLE	**1701 NORTH BOWMAN DANVILLE, IL 61832**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0573 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** Based on interview and record review, the facility failed to honor a resident's right to obtain a copy of their medical records upon request. This failure affects 1 resident (R1) out of seven reviewed for medical records copy request. Findings include: On 7/29/20 at 12:50 pm, V3, Psychiatric Rehabilitation Services Director, stated, I do remember (R1) saying (R1) was going to request a copy of (R1's) medical records. (R1) was unhappy about being denied admission to another facility, then (R1) said (R1) was going to request a copy of (R1's) records. On 7/29/20 at 6:05 pm, R1 stated, I asked the social worker (V22), the medical records person (V23), and the New Focus Director (V3) for a copy of my medical records. I also submitted the request in writing twice to (V3), and even offered to pay a reasonable fee for the copying. R1 stated at this time that R1 never received the requested records. On 7/30/20 at 9:13 am, V22, Social Services Director, confirmed, (R1) did make a verbal request to me for a copy of (R1's) medical records, but that is not something I do, so I referred (R1) to (V23, Medical Records Designee). I talked to (V23) and (V23) told me those requests now go to corporate because there is such an involved process in copying the records. V23, Medical Records Designee, was not available for interview throughout the survey. The facility's Contract Between Resident and Facility, Attachment F: Statement of Resident Rights, (undated) documents, No resident shall be deprived of any rights, benefits, or privileges, guaranteed by law, nor shall a resident forfeit any of the following rights: 21. The right to access, and the right to review and copy, the resident's personal files maintained by the Community (facility), during normal business hours or at a time agreed upon by the resident and the Community. The facility's Medical Record Policy (undated) documents, The resident, or legal representative, may receive a copy of the medical record within a reasonable time after the resident request and at the resident's expense. Resident may purchase photo copies of all resident's records pertaining to his or her care upon written request for a nominal fee.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the residents Power of Attorney was notified in a timely manner of addition and changes to medications, fall with head injury, change of condition, and assessment and treatment at emergency room for one resident (R4) of one resident reviewed for notification of change of condition. Findings include: R4's Undated Face Sheet documents R4 was admitted [DATE]. This same Face Sheet documents [DIAGNOSES REDACTED]. R4's Psychiatric physician progress notes [REDACTED]. R4's Psychiatric physician progress notes [REDACTED]. This same Psychiatric physician progress notes [REDACTED]. Resident Transfer Sheet from previous long-term care facility that R4 transferred from, dated 11/19/19, documents name and phone number of V30 as contact person for R4. Illinois Statutory Short Form Power of Attorney for Healthcare, dated 12/11/17, documents V30 as R4's legal Power of Attorney for Healthcare and lists V30's address and telephone number. This same document was given to facility at the time of R4's admission. R4's Brief Interview for Mental Status (BIMS), dated 11/20/19, documents a score of 5 (severely cognitively impaired). R4's BIMS dated 2/24/20 documents a score of 0 (severely cognitively impaired). Hospital emergency room visit records, dated 1/6/20, documents clinical impression for R4 was a fall and head contusion that occurred at facility. R4's Minimum Data Set (MDS), dated [DATE] and 4/19/20, were both completed due to R4's significant change in health status. On 7/30/20 at 9:25 AM, V1, Administrator, stated upon R4's admission the Power of Attorney for Healthcare and the Power of Attorney for Property was entered in the electronic medical record under the wrong tab. V1 stated the facility did have the necessary information to contact R4's Power of Attorney but stated, no one dug through the records to find that information. V1 stated this was an unfortunate mistake on the facility's end for not having contacted R4's Power of Attorney for any change of condition, medicine changes/additions, trips to the emergency room or fall with head injury. On 7/31/20 at 9:55 AM, V4, Assistant Director of Nursing (ADON), stated staff should notify the physician and Power of Attorney for any resident change of condition, fall, medication changes, room changes, and trips to emergency room or physician appointments. V4 stated R4 was sent to hospital, had changes in R4's medication regimen, did have a fall, and changes of condition that R4's Power of Attorney was not made aware of. V4 stated any resident that is severely cognitively impaired and does not have a Power of Attorney, should be assisted in finding a Power of Attorney, or the facility should help the resident obtain a legal guardian. V4, Assistant Director of Nursing, stated that V4 requested V25, Social Service Director (SSD), to investigate whether R4 had a Power of Attorney on several occasions. V4, ADON, stated V25, SSD, response was that V25 could not find any information regarding R4's Power of Attorney. On 7/31/20 at 10:30 AM, V25, Social Service Director (SSD), stated if a resident who is severely cognitively impaired did not have a Power of Attorney or guardian, V25 would attempt to assist resident with obtaining a legal guardian. V25 stated R4 did not have a Power of Attorney or legal guardian, and did not inquire about obtaining a guardian for R4. V25 stated aware that R4 was cognitively impaired. On 7/31/20 at 1:30 PM, V29, Care Plan Coordinator (CPC), stated V29 requested V25, Social Service Director (SSD), to investigate if R4 had a Power of Attorney. V29 (CPC) stated V25 (SSD) response was that V25 could not find a Power of Attorney for R4. Facility Policy titled Physician-Family Notification-Change in Condition, revised 11-13-18, documents the following: Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. Guidelines: The facility will inform the resident; consult with the resident's physiician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an intereted family member whne there is: (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial statue (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to distontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); *A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g. an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that haS not been used on that resident before). (D) A decision to transfer or discharge the resident from the facility.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to acquire and provide routine physician ordered medications. This failure affects two residents (R5 and R20) out of seven reviewed for medication administration. Findings include: 1. R5's Census, Medication Administration Record, [REDACTED]. R5's Nursing Notes, dated 4/15/20 at 3:21 PM, documents the facility had electronically transcribed R5's medication orders and the computer system had identified a possible drug allergy for [MEDICATION NAME] ([MEDICATION NAME]). Nursing Notes, dated 4/15/20, at 5:04 PM and 5:46 PM, document R5's admission to the facility. R5's Hospital Discharge Orders (facility admission orders [REDACTED].O.) at every bedtime, [MEDICATION NAME] (Insulin [MEDICATION NAME]) 68 units injected subcutaneously at every bedtime, and Trazadone 200 mg by mouth at every bedtime. R5's Medication Administration Record [REDACTED]. This same MAR indicated [REDACTED]. R5's Nurses Note, Medication Administration Note, for 4/15/20 at 10:19 PM documents, On order. R5's Location of Administration Report also does not document any location for a [MEDICATION NAME] injection on 4/15/20. R5's MAR, dated for 4/16/20 at 8:00 PM, documents R5 did not receive the medication Ziprasidone, being marked with a code 9- other see nurses notes. R5's Nurses Note, Medication Administration Note, dated 4/16/20 at 7:58 PM, documents, Not available. The facility's Medication Administration Policy (undated) documents, Medications must be administered in accordance with a physician's orders [REDACTED]. On 7/29/20 at 1:03 PM, R5 stated, The first few days I was here, they didn't have my meds (medications). They skipped my insulin too. On 7/30/20 at 9:33 AM, V4, Assistant Director of Nursing, stated, I don't know why (R5) didn't get (R5's) medications when (R5) first got here. We try to have the hospital give them their evening medications before they come here so residents don't miss any doses, and we do keep 2 different kinds of fast acting insulin and 2 different kinds of slow acting insulin in stock. As long as we get the orders to the pharmacy before 5:00 PM, they should deliver that night and the medications would be available for the morning doses the next day. We do have a back-up pharmacy and we should be able to get any medication here in about 2 hours. 2. R20's electronic medical record documents R20 was admitted to the facility 4/29/19 with medical [DIAGNOSES REDACTED]. R20's Physician order [REDACTED]. On 7/30/20 at 8:49 AM, R20's [MEDICATION NAME] was not administered to R20. On 7/31/20 at 9:03 AM, V21, Licensed Practical Nurse, stated, As far as I know, we don't have a supply for R20's [MEDICATION NAME]. We give (R20's) iron out of the stock bottle on the cart. This is what I gave yesterday when you were watching. The bottle shown by V21 contained [MEDICATION NAME]. V21 then searched both medication carts for a supply of the [MEDICATION NAME] and stated, No we don't have any. The facility's Medication Administration Policy (undated) documents, Medications must be administered in accordance with a physician's orders [REDACTED].
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure resident care responses were completed in a timely manner due to the resident call light system not displaying activated call lights in a timely manner for four (R16, R23, R24 and R25) of four residents reviewed for quality of care. Findings include: 1. R16's undated Face Sheet documents [DIAGNOSES REDACTED]. Care Plan intervention, dated 3/16/20, documents R16 needing prompt response to all requests for assistance. On 7/29/20 at 12:50 PM, R16 pressed call light button to activate call light at 12:52 PM. Digital marquee sign at end of R16's hall displayed the words, Assist room (R16) at 12:54 PM for a few seconds and then scrolled to another message. The digital marquee display repeated Assist room (R16) every 8-9 minutes for a few seconds each, totaling three separate evenly spaced times within a 26 minute time frame. Staff did not answer R16's call light during that time. Staff was asked to answer R16's call light after 26 minutes of waiting with no staff response. There were no staff that came to the television style monitor during that time to see which room numbers were in need of assistance. This monitor at the nurses station is not clearly visible to staff members on the resident halls. On 7/29/20 at 12:51 PM, R16 stated R16 frequently waits long periods for call light to be answered. R16 stated sometimes R16 waits hours before anyone comes to help. R16 stated, If I really need something quick, then I yell out as loud as I can. Even then sometimes it takes hours for them to answer the light. R16 demonstrated use of call light. R16 states R16 relies on staff to assist with cares such as turning, positioning, using the bedpan, and bathing. On 7/31/20 at 9:55 AM, V4, Assistant Director of Nursing, stated call lights should be answered promptly. V4 stated 26 minutes is too long for a resident to wait to have their call light answered. V4 stated this is a known problem and is currently working with the owner of the facility to obtain a new call light system. 2. R23's undated Face Sheet documents [DIAGNOSES REDACTED]. R23's Care Plan intervention, dated 7/29/20, documents for staff to assist resident as needed. R23's Admit/Readmit assessment, dated 7/29/20, documents R23 as requiring total dependence with toileting. On 7/30/20, R23 activated R23's call light at 10:19 AM. R23's call light was not answered until 11:28 AM, when staff were requested to attend to R23's needs. During that time, the digital marquee sign displayed R23's room number one time for a few seconds. At no other time was R23's room number displayed on the digital marquee sign. The television style monitor at the central nurses station did display R23's room number as needing assistance. There were no staff that came to the television style monitor during that time to see which room numbers were in need of assistance. This monitor at the nurses station is not clearly visible to staff members on the resident halls. On 7/29/20 at 12:40 PM, V5, Certified Nurse Aide (CNA), stated there are too many residents for staff to care for properly. V5 stated many times residents have to wait to be assisted due to staff are busy helping others since there is not enough staff. On 7/31/20 at 9:55 AM, V4, Assistant Director of Nursing, stated call lights should be answered promptly. V4 stated 1 hour eleven minutes is too long for a resident to wait to have their call light answered. V4 stated this is a known problem and is currently working with the owner of the facility to obtain a new call light system. 3. R24's undated Face Sheet documents [DIAGNOSES REDACTED]. R24's Care Plan, dated 6/3/20, documents R24 as requiring a mechanical lift with two staff to assist for transfers. This same Care Plan documents R24 as needing prompt response to all requests for assistance. R24's Minimum Data Set (MDS), dated [DATE], documents R24 as requiring total assistance from two staff members for toileting, hygiene, and bed mobility. On 7/30/20, R24 activated R24's call light at 11:07 AM. R24's call light was not answered until 11:26 AM. During that time, the digital marquee sign displayed R24's room number one time for a few seconds. At no other time was R24's room number displayed on the digital marquee sign. The television style monitor at the central nurses station did display R24's room number as needing assistance. There were no staff that came to the television style monitor during that time to see which room numbers were in need of assistance. This monitor at the nurses station is not clearly visible to staff members on the resident halls. On 7/31/20 at 9:55 AM, V4, Assistant Director of Nursing, stated call lights should be answered promptly. V4 stated 19 minutes is too long for a resident to wait to have their call light answered. V4 stated this is a known problem and is currently working with the owner of the facility to obtain a new call light system. 4. R25's undated Face Sheet documents [DIAGNOSES REDACTED]. R25's Care Plan, dated 6/21/19, documents R25 as requiring one staff assist for cares. On 7/30/20, R25 activated R25's call light at 10:56 AM. R25's call light was not answered until 11:28 AM. During that time, the digital marquee sign displayed R25's room number one time for a few seconds. At no other time was R25's room number displayed on the digital marquee sign. The television style monitor at the central nurses station did display R25's room number as needing assistance. There were no staff that came to the television style monitor during that on the resident halls. On 7/29/20 at 1:20 PM, V17, Certified Nurse Aide/Scheduler, stated V27, Maintenance Director, is in charge of the call light system. V17 stated once a resident presses their call button, the signal is sent through the system and the resident room number and bed number are displayed on the digital marquee sign hanging at the end of each hall. V17 stated Certified Nurse Aides (CNA's) watch the digital marquee sign to know when a resident is in need of assistance. On 7/30/20 at 11:45 AM, V1, Administrator, stated there is no back up system in place in case of failure of current call light system. V1 stated 19 minutes, 26 minutes, 29 minutes, and 1 hour eleven minutes is too long for a resident to wait to have their call light answered. On 7/31/20 at 9:55 AM, V4, Assistant Director of Nursing, stated call lights should beanswered promptly. V4 stated this is a known problem and is currently working with the owner of the facility to obtain a new call light system. On 7/30/20 at 11:10 AM, V27, Maintenance Director, stated when a resident depresses button on call light in resident room or bathroom, it sends a signal to the television like monitor at the central nurses station. The monitor at the nurses station then displays the room number and bed number on the monitor screen. This same monitor then relays the signal to the digital marquee signs hanging from the ceiling at the end of each resident hallway. V27 stated it does take a couple of minutes from the time the resident depresses the call light button until the resident room number and bed number show up on the marquee sign. V27 stated the digital marquee sign scrolls through the activated call lights in order. V27

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) stated if a call light is cancelled, that 'request' is then bumped to the top of the list and sent directly to the digital marquee sign without allowing the other call light requests to be displayed until the cancelled call light is cleared. V27 stated the digital marquee sign displays only one call light request at a time. V27 stated it is possible for the time for a call light to be displayed on the digital marquee sign to be delayed if there were other 'higher priority' messages, such as a new call light or a cancelled call light. V27 stated staff would have to leave their assigned hallways due to the staff would not be able to read the monitor at the nurses station from resident hallways. Facility Policy titled Call Light revised 2/2/18 documents the following: Purpose: To respond to to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. Procedure: 1. Answer call light (signal) promptly.