STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000285	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE ON THE HILL	555 WEST CARPENTER , SPRINGFIELD, Illinois, 62702

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Health Survey Complaint Investigations 2613836/2548681	S0000		09/24/2025
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)1) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999		09/24/2025

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

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S9999	Continued from page 1 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 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure competency of the Professional Nursing staff when that staff failed to provide a resident in a crisis condition the correct medication for 1 of 6 residents (R5) reviewed for medication errors in the sample of 50. This failure resulted in the R5 not receiving his Glucagon when needed resulting in his blood sugar dropping to a critical low and being transferred to the hospital and subsequently admitted to the Intensive Care Unit (ICU). The Findings Include: R5's Admission Record, dated 9/11/25, documents R5 was admitted to the facility on 7/7/25 with diagnosis of: Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Hypoxemia, Type 2 Diabetes Mellitus (DM), End Stage Renal Disease (ESRD), Dependent on Dialysis, Hypertension (HTN), anxiety disorder, and schizoaffective disorder.	S9999		

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S9999	Continued from page 2 R5's Care Plan, dated 4/1/25, documents R5 has Diabetes Mellitus and Diabetic Neuropathy. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, Monitor/document/report PRN any s/sx (signs/symptoms) of hypoglycemia: Sweating, tremor, increased heart rate (Tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait, Monitor/document/report PRN (as needed) any s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, or coma. R5's Minimum Data Set (MDS), dated 7/28/25, documents R5 is cognitively intact and is dependent on staff for most ADLs. R5's Physician Order, dated 7/23/25, documents, "Baqsimi one pack nasal powder 3 MG (milligram)/dose (Glucagon) 1 pump in nostril as needed for low blood sugar. May repeat in 15-minutes." R5's Medication Administration Record (MAR)-Treatment Administration Record (TAR), dated September 2025, does not document Baqsimi One Pack Nasal Powder 3 MG/Dose (Glucagon) was given to R5. There is no documentation of R5 receiving Narcan or Epinephrine (Epi). R5's SBAR (situation, background, assessment, and recommendation) Note, dated 9/10/25 at 8:08 AM, documents in part, Situation: The Change in Condition (CIC)/s reported on this CIC Evaluation are/were: Altered mental status. At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 120/70 - 9/10/25 at 8:09 AM, - Pulse: P 70 - 9/10/25 at 8:09 AM, Pulse Type: Regular - RR (respiratory rate): R 18 - 9/10/25 - Temp: T 97 - 9/10/25 - Pulse Oximetry: O2 97.0 % - 9/10/25 Method: Oxygen via Nasal Cannula - Blood Glucose: BS 49.0 - 9/10/25 at 7:50 AM. Relevant medical history is: COPD Diabetes. Code Status: Full Code. Resident/Patient is on: Hypoglycemic	S9999		

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S9999	Continued from page 3 medication(s)/Insulin. Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) - Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Nursing observations, evaluation, and recommendations are: Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: send for eval. On 9/11/25 at 11:05 AM, V6, Registered Nurse (RN), stated, “I went in to see (R5) yesterday morning to check his blood sugar and he was lethargic, would only respond by opening his eyes when his name was called. His blood sugar was 49 at that time so I gave him some Ensure to drink, then got him some Glucagon spray from the E-Kit (Emergency Kit) and gave that to him. I then rechecked (R5’s) blood sugar and it had dropped and was now reading 33. I called 911 to transport (R5) to the hospital. I do not recall giving (R5) anything else, including any injections. (V27, Licensed Practical Nurse (LPN) was the other nurse helping me with (R5).” On 9/11/25 at 11:55 AM, V27, LPN, stated, "(V6) asked me to come help her with (R5) and that she needed the E-Kit. I went and got the E-Kit and handed her a long tube-looking thing and a nasal spray. I saw her take out the long tube looking thing, then put the top from the nasal spray on the long tube thing and she gave it to (R5) in his nose. I did not give any drugs. If that was an Epi Pen, then yes, I handed it to her and that was my fault. I did an incident report, reported it to the NP (Nurse Practitioner) and the DON (Director of Nursing)." On 9/11/25 at 12:00 PM, V26, NP, stated, "I was just getting to the facility when EMS was taking (R5) out. (R5) had his eyes open when he left here. V27 then came and told me that (V6) gave (R5) Epi by accident. I do not see how they could have given the Epi with a Glucagon Nasal Spray cap on it. (R5) probably did not even get it, which is why his blood sugar never went up for them. It was a med error and a mistake."	S9999		

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S9999	Continued from page 4 On 9/11/25 at 1:41 PM, V28, Emergency Medical Technician Paramedic (EMTP), stated, “When we arrived at the facility, we had a male unresponsive with a blood sugar of 42. We started an IV (intravenous catheter) and administered D10. When we were moving him from his bed to our stretcher, we found an Epi Pen with a Narcan nasal spray cap on top of it. When I asked the nurse about it, she said she gave him Glucagon. I had two other firefighters look at it and they both verified that it was an Epi Pen. Again, the nurse stated that she knew she gave Glucagon. We put the resident on the stretcher and left the facility and took him to the ER (emergency room). Upon our arrival to the ER, the resident was slightly more alert to verbal stimuli, and his glucose was up to 136. I told the ER and my EMS director about the Epi Pen, and they were going to report it.” R5's Emergency Medical Service (EMS) Report, dated 9/10/25, documents in part: "Arrived on scene, made entry into the facility and into pt (patient) room to find male pt lying in bed unresponsive. Nurse states pt is diabetic and his blood sugar was low. Nurse states she gave pt internasal glucagon and placed him on a non-rebreather mask with 15 LPM (liters per minute) of O2 (oxygen). No staff is bedside with pt upon arrival. ALS (advanced life support) had arrived first on scene. Obtained blood glucose level via finger prick method. Value of 42. Started 18g (gauge) angiocath in pt left hand and flushed with saline before locking and securing with Tegaderm. Pt skin is warm and clammy at this time. Started 250 ML (milliliter) bag of D10% (glucose solution) using macro drip tubing. While D10 is infusing, pt is moved to the stretcher from his bed using bed sheet and assistance from FD (fire department). While moving pt, an Epi Auto Injector pen is found in pt. bed. Placed on top was the nasal piece used for internasal Narcan. When staff nurse was asked why the Epi pen was in the bed, she stated that it was Glucagon, and she had administered it in an attempt to raise pt glucose level. Pen was handed to FD for confirmation. FD also confirmed that pen is an Epi pen and not Glucagon. Nurse continues to argue that it is Glucagon, and it must have been placed in the wrong spot, and she did not confirm before administration." On 9/11/25 at 9:50 AM, V24, Master Social Work (MSW)/Licensed Social Worker (LSW), stated, “I was working yesterday when (R5) arrived in the ER. The EMS guys gave us an Epi Pen that had a Narcan Cap from a intranasal administration unit on top of it and was told that the nurse at the facility gave this to (R5). The EMS told the ER staff that (R5) was unresponsive	S9999		

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S9999	Continued from page 5 upon their arrival to the facility, they gave some D10 solution to raise his glucose and upon arrival to the ER, (R5) was awake, alert but still groggy. (R5) was admitted to the ICU for observation." On 9/11/25 at 12:05 PM, V6, RN, stated, "I have to tell you what happened. I lied to you earlier. (V27) handed me the Epi Pen and Glucagon Nasal Spray and I did not even look at them to see what they were. I put the cap on the pen and tried to give it to (R5). Honestly, I don't even know if he got any of it. So much was going on at that time and the next thing I know, EMS was here and took over. I did give the EMS guys the Epi Pen and Nasal Spray. I'm not that familiar with these types of drugs. This was my first med error, and I feel horrible, especially about lying about it." On 9/11/25 at 2:40 PM, V2, DON, stated, "There are tackle boxes with emergency medications in it, including Epi Pens, Narcan, and Baqsimi Nasal Powder. The nurses would grab this for emergency situations." On 9/15/25 at 10:25 AM, V3, LPN, stated, "If I found a resident who was unresponsive, I would check their blood sugar, look for orders, and grab the medication that you put up their nose. I can't think of the name of it right now, but if I see it, I will know what it is. It is kept in the tackle box E-Kit. I would not give Epi because it is not an allergic reaction, nor would I give Narcan because it is not an overdose." On 9/15/25 at 10:30 AM, V11, LPN, stated, "If I found one of my residents unresponsive, I would check their vital signs and blood sugar. If the blood sugar is low and they are not able to take something by mouth, I would go to the E-Kit and get the Glucagon nasal spray and administer it to them to get their blood sugar up. I would not give Epi for something like this because it is not an allergic reaction." On 9/15/25 at 10:50 AM, V2, DON, brought in an Epi Pen and a Narcan Nasal Spray and attempted to demonstrate how V6 was administering R5's medication. V2 stated, "I doubt that he got any of the medication the way she put this together. I feel this is simply incompetent nursing." On 9/15/25 at 2:13 PM, V29, Physician/Medical Director, stated, "I was only notified of (R5's) hypoglycemic episode and that he was sent to the hospital. No one mentioned to me that he was not given his glucose and was given something else. I have standing orders for Glucagon to be given and that should have been given." When told of V6 giving R5 an Epi Pen with the Narcan	S9999		

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S9999	Continued from page 6 top and spraying up R5's nose, V29 stated, "Oh my God, that is unbelievable. I have never heard of such a thing. This could have been detrimental to (R5) and could have been fatal to him. He didn't get his Glucagon that was ordered, and his glucose could have continued to drop. This is truly unbelievable; the lack of competency could have subsequently determined (R5's) outcome, which could have been death in this case. I would expect the Nurse to administer medications as per my orders, and per appropriate route." On 9/11/25 at 2:10 PM, V2, DON, stated, "I would expect the nurses to use the five rights of medication administration and to follow physician orders." V2's Investigation, dated 9/11/25, documents, "Nursing Description: Nurse called into room and found resident's blood sugar to be 39. Blood sugar was retaken and decreased to 33. Nurse then went to medication room to obtain Glucagon nasal spray and Narcan nasal spray was given in error. Immediate action taken: NP was made aware of the Epi spray being given. VS-120/70, 70, 18, 97.0. Nursing stayed with resident and 911 called to transport resident to ER via stretcher. Resident was alert leaving the unit." V2 stated she is not finished with the investigation and will be in-servicing the nurses. The Facility's "Registered Nurse Job Description", dated 10/2024, documents in part "The Registered Nurse is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is always maintained. Essential Duties and Responsibilities: Prepare and Administer medications as ordered by the physician. Qualifications: Must be able to make independent decisions when circumstances warrant such action. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities." According to the NIH – National Library of Medicine; SCOPE OF PRACTICE - Nursing Fundamentals - NCBI Bookshelf at https://www.ncbi.nlm.nih.gov/books/NBK610819. The Scope of Practice refers to services a trained health professional is deemed competent to perform and permitted to undertake according to the terms of their professional nursing license. Nursing scope of practice	S9999		

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S9999	Continued from page 7 provides a legal framework and structured guidance for activities that practical nurses and registered nurses can perform based on their nursing license. Nurses must also follow standards when providing nursing care. Standards are set by several organizations, including your state's Nurse Practice Act, the American Nurses Association (ANA), agency policies and procedures, and federal regulators. These standards help guide nursing actions with the intent that safe, competent care is provided to the public. Nursing Process: The nursing process is a critical thinking model based on a systematic approach to client-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing client care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses (RNs), regardless of role, population, specialty, and setting, are expected to perform competently. Education: The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking. Quality of Practice: The registered nurse contributes to quality nursing practice. Resource Stewardship: The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and judiciously used. According to the NIH – National Library of Medicine; Nursing Rights of Medication Administration - Stat Pearls - NCBI Bookshelf at https://www.ncbi.nlm.nih.gov/book/NBK/560654/ documents in part "Nursing Rights of Medication Administration. Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. The five traditional rights in the traditional sequence include: Right Patient, Right Drug, Right Route, Right Time, and Right Dose." The Facility's "Medication Administration" Policy, dated 10/2024, documents in part "Administration of Medications: Medications must be administered in accordance with a Physician's order, e.g., the Right Medication, Right Dosage, Right Route, and Right Time." (A)	S9999		