

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057224		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/02/2026	
NAME OF PROVIDER OR SUPPLIER ARCADIA CARE AUBURN				STREET ADDRESS, CITY, STATE, ZIP CODE 304 MAPLE AVENUE , AUBURN, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments	S0000				04/03/2026	
	Annual Licensure and Certification						
S9999	Final Observations	S9999				04/03/2026	
	Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)5) 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 300.1210 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. 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:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on interviews, observations, and record review the facility failed to follow wound care orders and prevent a pressure injury from developing in 1 of 2 residents (R51) reviewed for Quality of Care in the sample of 37. This failure resulted in R51 developing a stage two pressure injury to his left heel. Findings include: R51's Facesheet documented he was admitted to the facility on 1/9/25 with diagnoses of, in part, congestive heart failure, hypertension, major depressive disorder, and lymphedema. R51's Minimum Data Set (MDS) dated 2/15/26 documented he was cognitively intact, required substantial/maximal assistance from staff to roll left and right, and dependent on staff for toileting hygiene and lower body dressing. R51's Care Plan revised on 2/14/25 documented R51 has an ADL (activities of daily living) self-care performance deficit with interventions of, in part, that R51 requires assistance of 2 staff with bed mobility. R51's Care Plan revised on 3/4/25 documented that he had an actual skin impairment of pressure to coccyx with interventions of, in part, encourage/assist R51 to reposition every 2 hours (revised 2/25/25), minimize pressure over boney prominences (revised 1/13/25), and treatment as ordered (revised 1/9/25). R51's Care Plan revised on 1/13/25 documented he was at risk for skin impairment with interventions of, in part, assess/record changes in skin status, provide/monitor effectiveness of pressure relieving or reducing devices, and weekly treatment			S9999			04/03/2026

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S9999	Continued from page 2 documentation to include measurement of each area of skin (all created on 1/13/25). R51's Regenerative Wound Care Visit Report dated 3/2/26 documented the initial exam of his stage 2 pressure injury to left heel 3/2/26 and measured to be 2.5 cm (centimeters) in length by 2 cm in width by 0.1 cm in depth. The report continued to document R51's left heel pressure injury required debridement and was a stage 3 post debridement. R51's Braden Scores (level of risk for acquiring pressure wounds over the past 10 assessments) dated 1/23/25 to 2/26 documented he remained at high risk. R51's Orders started on 3/27/26 and ended on 3/31/26 documented "coccyx: cleanse area to coccyx with wound cleaner or NS (normal saline) and pat dry. Apply wet to dry and cover with dry dressing daily. On 3/31/26 at 10:15 AM, R51 stated his coccyx wound hasn't been getting cared for so it might be closed up and his heel gets changed daily. R51 stated he got his heel wound from his foot rubbing but heard it's improving. On 3/31/26 at 10:17 AM, V13 license practical nurse (LPN) stated the orders for R51's wound care is to be completed daily for his coccyx on midnights and his left heel to be done daily. On 3/31/26 at 10:33 AM, V13 assisted R51 in rolling over to see his back and no dressing was in place to his coccyx and smears of stool were noted on the pad he was lying on. V13 stated there are two wounds while pointing out R51's anal opening and his actual wound directly above that. V13 stated they look to be pressure. R51's left heel dressing was intact and dated 3/31/26. V13 stated she wasn't sure how long R51 has had the wounds on his buttocks, would have to speak with the V4 assistant director of nursing (ADON) to find out details on treatment and will have to complete wound care on him. On 3/31/26 at 11:00 AM, V13 went to provide wound care for R51's coccyx. V13 completed hand hygiene and donned gloves but did not apply a gown prior to providing wound care to R51. V13 stated R51's orders are to cleanse with wound cleanser, put a wet to dry dressing on and cover with a foam dressing daily. V13 applied wound cleanser to gauze pads then wiped R51's anus followed by using the same gauze and wiping R51's coccyx ulcer. When asked			S9999			04/03/2026

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S9999	Continued from page 3 where R51's anal entryway was located V13 looked and pointed it out then sprayed cleanser again in his ulcer and re-cleansed it. V13 stated the wound orders are to be wet to dry with normal saline and foam pad. V13 proceeded to pack R51's coccyx wound with normal saline soaked gauze, folded up dry gauze and then an island dressing on top without changing gloves or hand hygiene. On 3/31/26 at 11:08 AM, V13 stated to R51 you don't like heel protectors right and R51 responded stating he doesn't mind heel protectors, but they haven't been putting them on him. V13 stated we can put those on. V13 left R51's heels lying flat on the mattress, did not offer to float them and did not apply heel protectors. On 3/31/26 at 12:37 PM, R51's heels were flat on the mattress, not floated and no heel protectors in place. On 3/31/26 at 12:43 PM, V4 (ADON) stated she is taking over as the wound nurse but just started last week. V3 (MDS nurse) stated she would be able to answer care questions. V3 stated the wound doctor (V30 family nurse practitioner-FNP) saw R51 on Friday and stated we could do a wet to dry dressing with saline on his coccyx. V3 stated R51 came in on 1/9/25 with his coccyx wound and it has improved a lot since then. V3 stated R51's wound care is daily for his coccyx, and he developed his left heel wound here. V4 stated they expect for wound care to be done according to orders. V3 stated R51's left heel wound was facility acquired, his legs hurt a lot, and we used to prop his heels up but was not sure if they got orders for heel protectors. V3 and V4 stated they expect R51's heels to be kept floated somehow. On 3/31/26 at 1:13 PM, V2 (Regional Nurse Consultant/Acting DON) stated her expectations are for wound dressing to remain in place intact. On 4/1/26 at 10:19 AM, R51's heels were not floated in bed. On 4/1/26 at 10:47 AM, R51 stated he wouldn't mind having his heels floated off the bed, he doesn't feel them and sleeps most of the day. R51 stated he couldn't remember if they have tried to lift them today, he's just been sleeping. On 4/1/26 at 12:00 PM, V4 (ADON) stated she couldn't get in to see R51's weekly wound measurements. V3 stated she doesn't know why V4 doesn't have access to it and said she would try on her account. V3 stated she expects nurses to be			S9999			04/03/2026

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S9999	Continued from page 4 encouraging R51 to float his heels, we should probably put an order in for it so the nurses can't say they didn't know. V3 stated R51 has been non-compliant with care in other areas, and we have that care planned but don't see anything for pressure relief measures. On 4/1/26 at 12:21 PM, V30 (Wound FNP) stated he has been treating R51 for his wounds and he has been at high risk for pressure injuries. V30 stated his expectations for those at high risk of pressure injuries are to be repositioned every two hours and to have bony prominences relieved of pressure such as lifting/elevating/floating heels. V30 stated if someone at high risk for pressure injuries is not provided with pressure relief measures that would increase their risk of developing a pressure injury. The facility's Pressure Ulcer Prevention Policy dated 2/2025 documented to turn dependent residents approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated; use positioning devices or pillows, rolled blankets, to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated. (B) .			S9999			04/03/2026