

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/05/2025
NAME OF PROVIDER OR SUPPLIER  Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  555 West Carpenter Springfield, IL 62702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32874</p> <p>Based on interview and record review the facility failed to provide supervision for 1 of 1 residents (R3) reviewed for supervision in the sample of 7. This failure resulted in R3 leaving the facility going to liquor store obtaining alcohol and being sent by ambulance to the hospital for evaluation.</p> <p>Findings include:</p> <p>1. On 4/23/2025 at 3:52PM V1, Administrator stated R3 is alert and orientated. V1 stated R3 knows he is supposed to sign out. V1 stated R3 took his wonder guard off. V1 stated the police found R3 at 3:00PM and took him to the hospital. V1 stated R3's family or family friend will sign R3 out and take R3 out in community. V1 stated he was last seen in the building around 1 PM. V1 stated R3 had been drinking. V1 stated the facility did not know R3 was gone.</p> <p>On 4/23/2025 at 4:20PM R3 stated he got an attitude yesterday and left. R3 stated, all my folks have passed away and I am only one left. R3 stated he walked about 13 miles. R3 stated he walked over by Clear Lake and was sitting on a bench when police found him. R3 stated he bought vodka at the grocery store.</p> <p>On 4/23/2025 at 4:34PM V1 stated there is a delay in the doors closing at the entrance and R3 got out between the doors. V1 stated R3 does not go out on his own, someone comes in and signs him out. V1 stated rounds are made every 2 hour and staff were just rounding when they got the call. V1 stated they did not know R3 was gone from the facility.</p> <p>On 4/28/2025 1:34PM V8, Certified Nursing Assistant (CNA) stated he was working the day R3 left the facility. V8 stated he worked the day shift came in at 6 and left at 2:00PM. V8 stated he gets to facility at 5:30 am. V8 stated he was CNA for R3 on 4/22/2025. V8 stated when he came on shift R3 was in bed with covers on. V8 stated the last time he saw R3 on his shift was when he took his lunch in around 1:15PM. V8 stated R3 is always wandering around. V8 stated when R3 wants to go somewhere, he goes. V8 stated he has done 2-3 times before. V8 stated he does not think wander guard is appropriate because R3 knows what he is doing. V8 stated R3 needs to be somewhere where his needs can be met. V8 stated R3 is very slick and knows what is going on.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/29/2025 at 2:29PM V7, Licensed Practical Nurse (LPN) stated she was on duty on 4/22/2025 when R3 went out of building. V7 stated it was around 3:00PM when police called, and officer asked if R3 lived at the facility and was informed the R3 was with the police. V7 stated the officer reported he was found sitting down by the liquor store 709 East Clear Lake. V7 stated the officer stated R3 would be going to the hospital to be checked out. V7 stated R3 did not have a wander guard in place. V7 stated R3 told her he cut his wander guard off. V7 stated she had not seen R3 leave the facility but R3 always wanting to go smoke.</p> <p>4/29/2025 at 10:45AM V12, Activities stated she works the front desk at times to relieve staff. V12 stated she has not seen R3 exit out the front door. V12 stated she has seen R3 hanging around the front door.</p> <p>On 4/29/2025 at 11:00AM V13, Activities stated she has not witnessed R3 walk out the front door. V13 stated she has observed R3 standing in area by front door watching people enter and exit.</p> <p>On 4/29/2025 at 11:30am V1 stated R3 did not return to the facility until around 7:30pm with a family friend. V1 stated she was at the facility when R3 returned.</p> <p>On 4/29/2025 at 2:02 PM City police department dispatch stated a call came in at 3:46pm of elderly gentlemen on bench on Clear Lake and [NAME] City Avenue.</p> <p>On 4/30/2025 at 12:15PM V10, receptionist stated if R3 is downstairs in reception area he will wander around. V10 stated has never seen R3 attempt to exit.</p> <p>On 5/1/2025 at 1:41PM V14, physician stated R3 is cognitively intact and should be able to go out in the community. V14 stated R3 will get drunk.</p> <p>R3's progress notes dated 4/22/2025 at 16:30PM documents R3 left the facility without following facility protocol, he returned to the facility approx. 19:30 with friend.</p> <p>R3's Emergency Department (ED) record documents dated 4/22/2025 documents service date/time 4/22/2025 at 17:13pm and discharge service date and time as 4/22/2025 at 19:10PM. R3's ED record documents R3 was brought to the emergency department by Emergency Medical Services (EMS) after they found R3 wandering around in public. Record documents R3 reportedly eloped from his nursing facility and went to the liquor store and got himself a pint of 40 proof vodka. The report documents R3 reported he drank about half of the pint and was out on a walk looking for something to eat when the ambulance found him and brought him to the hospital. R3's report document alert and orientated to person, place time and situation. No focal neurological deficits observed. Report documents medical decision making rationale: presentation concerning for elderly gentleman who has eloped from his nursing home to drink. Report documents 4/22/2025 at 18:58PM patient facility has been contacted and willing to take R3 back. Report documents R3 has a friend with him in the department who is comfortable transporting him. Report documents R3 is able to ambulate appropriately and is eating occult tray without difficulty, and is alert orientated and answering questions appropriately. Will discharge back to the facility. Report document stable and R3 given educational materials on alcohol abuse.</p> <p>R3's progress notes dated 4/22/2025 at 19:15 documents R3 is on q 15 minutes checks.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Management of Missing Resident, Elopement, and Risk Reduction Strategies dated last revised 04/2023 documents policy guidelines: The facility strives to promote resident safety and protect the rights and dignity of the residents. The policy documents the facility maintains a process to assess all residents for risk for elopement, implement risk reeducation strategies for those identified as an elopement risk, and institute measure for resident identification at time of admission. The policy defines elopement- is the ability of a cognitively impaired resident, who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way. The policy defines wandering as refers to a cognitively impaired resident's ability to move about inside the facility aimlessly, but often without clear purpose and without regard to ones personal safety. The policy fails to define elopement/ wandering for a cognitively intact person.</p> <p>The policy documents the preadmission evaluation process includes a wandering and elopement history and whether the resident can safely be cared for at the facility. The policy documents an Elopement Risk Assessment is completed on all residents at time of admissions, quarterly and with any increase in exit seeking or wandering behaviors. The policy documents a facility approved risk evaluation tool or scoring system is utilized and the evaluation is based on various risk factors that may precipitated and elopement event, the risk tool includes a defined parameter which, when reached, indicates and increased risk and prompts strategies, as described below. The policy documents the risk evaluation and new resident observation addresses the resident's mobility and psychologically, behavioral, physical and cognitive functions. specific risk factors may include: a history of wandering prior to admission or finding the resident lost in the facility after admission. Details of the wandering history may include when the wandering occurs, if more common during daytime or night time hours, the usual traffic pattern, if purposeful (e.g. need for food, toileting, exercise), if exit seeking and other triggers such as pain, noise or odors.</p> <p>Problems noted in the resident's adjustment to the facility such as stating a desire to go home, looking for children, attempting to attend functions that are based on past schedule. Interference with risk reduction strategies, including an expressed displeasure with wander bracelet or an attempt to remove it. Behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive. The policy documents actual wandering behavior, including exit seeking (the resident is intent on leaving the unit or facility, looking for exits, and hovering exits waiting for the opportunity to leave with someone, or pushing on a door)</p> <p>The policy documents risk reduction measures as interventions that may be used for residents identified as high risk for elopement include:</p> <ol style="list-style-type: none"> <li>a. frequent monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g. every 15 minute checks 1:1 monitoring)</li> <li>b. room placement close to common areas such as the nurse's station and away from exits.</li> <li>c. promoting activities that are in full view of staff members</li> <li>d. alternative activities to maintain the interest level of the wanderer</li> <li>e. implementation of wander bracelet or other electronic alert systems</li> </ol> <p>(continued on next page)</p>		

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