

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 06/24/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision to prevent falls in 1 of 3 residents (R2) reviewed for falls in the sample of 6.</p> <p>Findings include:</p> <p>1-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, lack of coordination, and reduced mobility.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively intact, ambulated with wheelchair, and was dependent for toileting.</p> <p>R2's Undated Care Plan documents R2 is at risk for falls and is dependent for toileting.</p> <p>R2's Fall Risk assessment dated [DATE] documented R2 was at risk for falls.</p> <p>R2's 5/9/25 Progress Note by V25, Licensed Practical Nurse (LPN), documents, Writer entered room and noted resident lying on the bathroom floor next to toilet. Resident had BM (bowel movement) on the toilet and floor. Resident was assessed for injuries, vs (vital signs) taken, cleaned up dressed and continues visiting with family. Resident denies pain or hitting head. Family was sitting in room at the time of the fall. Family alerted writer to room to assist resident off floor.</p> <p>R2's Fall Investigation by V25, on 5/9/25 documents, Writer was alerted to residents room by family after resident had fallen off toilet.</p> <p>On 6/20/25 at 9:50 AM, V25 stated V17, Certified Nursing Assistant (CNA), stepped out of R2's room while she was on the toilet.</p> <p>On 6/20/25 at 10:14 AM, V17 was not available by phone.</p> <p>On 6/13/25 at 1:03 PM, V2, Director of Nursing (DON) stated V17 stepped out of R2's room while she was toileting to give her privacy, and she fell with family in the room.</p> <p>On 6/20/25 at 9:04 AM, V1, Administrator, stated R2 had family visiting on 5/9/25. V17 told R2's family to let her know when R2 was finished toileting. V17 then stepped out of R2's room, and R2 fell.</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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(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>The Facility's Fall Prevention Program Policy revised 5/2022 documents, Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet.</p>		