

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 11/26/2025
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review, the facility failed to maintain resident safety, to document resident fall risk assessments before and after falls occur, and to follow interventions in place to prevent falls for 3 of 4 residents (R1, R3, R12) reviewed for resident safety in the sample of 13. The findings include: 1. R1's admission Record, dated 11/25/25, documents R1 was admitted to the facility on [DATE] with diagnosis of Encephalopathy, Type 2 Diabetes Mellitus (DM), uropathy, disorder of kidney/ureter, morbid obesity, malnutrition, benign prostatic hyperplasia (BPH), Urinary Tract Infections (UTI), major depressive disorder, anemia, atrial fibrillation (A-Fib), hypertension (HTN), legal blindness, adult failure to thrive, anxiety disorder, hallucinations, and schizoaffective disorder. R1's Care Plan, dated 11/17/25, documents R1 is at risk for falls related to impaired mobility due to morbid obesity. Interventions: 1/7/25: Bolsters added to bed as he is visually impaired so that he can know when he is close to the edge of the bed, 12/10/22: non-skid socks, 7/31/22: Educate to seek assistance with transfers/utilize the call light, 7/30/24: offered a body pillow to assist with positioning in bed, 7/29/22: non-skid strips beside bed, 8/17/22: Utilize appropriate Bari shower chair. R1's Minimum Data Set (MDS), dated [DATE], documents R1 has a moderate cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs) and transfers. R1 has a urine catheter in place and is always incontinent of bowel. On 11/24/25 at 10:20 AM, R1 seen lying in bed with air mattress and bolsters on mattress, small side rails up, bed appears to be in a high position, R1's call light was clipped to itself and hanging down the wall and not within reach of R1, who is blind and not able to see where the call light is placed. There is no body pillow seen in R1's room, no non-skid strips seen on his floor by the side of his bed, and his call light was out of reach. On 11/25/25 at 11:00 AM, R1 was seen lying in bed with an air mattress and bolsters on the side of the mattress, small side rails up on each side with the bed appearing to be in a mid-position. R1's call light was clipped to itself and hanging down the wall and not within reach of R1, who is blind and not able to see where the call light is placed. When asked how R1 gets help when needed, R1 stated, I just start yelling and they will eventually come, sometimes it may take a while, but they do come. When asked if he has had staff offer or give him a body pillow, R1 stated, A body pillow, no one has ever given me a body pillow and I'm not even sure what that is. On 11/25/25 at 11:45 AM, V1, Administrator, stated, (R1) has only had one fall that I can see and that was in June 2025. There is no fall risk assessment dated [DATE]. There are no updated interventions documented in R1's Care Plan after his fall on 6/1/25. R1's Comprehensive Incident Fall Assessment, dated 11/5/24, documents R1 was a High Fall Risk. There is no other fall risk assessment documented after 11/5/24 and before 1/7/25. This was completed after R1 experienced a fall on 11/5/25. There was no fall interventions placed in R1's Care Plan after this fall. R1's Comprehensive Incident Fall Assessment, dated 1/7/25, documents R1 as being a High Fall Risk. This was completed after R1 experienced a fall on 1/7/25. R1's Incident Note, dated 1/7/25 at 10:55 AM, documents, Resident sustained a fall on 1/7/25 8:30 AM. The incident occurred in the resident's room. Resident is alert and disoriented per usual baseline. No changes in range of motion from normal baseline. Physician notified on: 1/7/25 8:30 AM. Resident (continued on next page)		

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	denies pain. No new skin concern or change in skin condition noted.R1's Nursing Note, dated 1/7/25 at 7:04 PM, documents, Staff informed the writer that the res (resident) was sliding out of the bed and almost on the floor. The writer assessed the res, no injuries noted, VS (vital signs) WNL (within normal limit), pain 2 on a faces scale. The writer called 911 per PCP (primary care provider). EMS (Emergency Medical Services) and SFD (local fire department) arrived and assisted res onto the stretcher. Res sent out to ER (Emergency Room) for eval/ treatment. Administrator, DON (Director of Nursing), and POA (Power of Attorney) aware.R1's IDT (interdisciplinary team) Note, dated 1/8/25 at 3:57 PM, documents, Attendees present: IDT. Summary of IDT meeting: resident having agitation and screaming and slid himself to the floor before staff could intervene. Intervention: Bolsters added to resident's bed as he is visually impaired so that he can know when he is close to the edge of the bed.The facility's fall investigation, dated 1/7/25, documents, in part When the writer entered the room, the res was sitting on the floor with his legs bent against the wall and holding onto the bed rail. Resident unable to give description.R1's Nursing Note, dated 6/1/25 at 7:21 PM, documents, Aide found res on floor, v/s (vital signs) taken, ambulance called, DON & MD (Medical Doctor) aware. Res transferred to (local hospital) via ambulance.R1's IDT Note, dated 6/2/25 at 2:58 PM, documents, Late Entry: Attendees present: IDT. Summary of IDT meeting: Per staff resident threw himself on the floor onto his fall mat. Intervention: resident sent to ED (Emergency Department) to have urine checked, as this is the behavior he exhibits with UTI.The facility's fall investigation, dated 6/1/25, documents in part, Incident description: Aide went into res room and found on floor. Resident unable to give description. Mental Status: Disoriented, but WNL for this resident.There was no Fall Assessment or new interventions put in place completed after R1's fall on 6/1/25. R1's Call Light was consistently out of R1's reach and awareness of the location due to his blindness. R1's only option was to yell out loud when he needed assistance.2. R3's admission Record, dated 11/25/25, documents R3 was admitted to the facility on [DATE] and discharged on 11/7/25 with diagnosis of Congestive Heart Failure (CHF), A-Fib, falls, dementia, dysphagia, occlusion/stenosis of carotid artery, arteriosclerotic heart disease (ASHD), muscle wasting and atrophy, anemia, major depressive disorder, esophageal obstruction, HTN, polyosteoarthritis, and hyperlipidemia. R3's Care Plan, dated 10/23/25, documents R3 is at risk for falls. Interventions: Anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, 10/26/25: Ensure that the resident is wearing appropriate footwear, 10/25/25: Moved to a room across from the nurse's station for maximum monitoring, reminder signs added in room to remind her to call for staff assistance. It continues R3's Care Plan, dated 10/23/25, documents R3 has an ADL self-care performance deficit. Interventions: Side rails: up per order for safety during care provision, to assist with bed mobility, repositioning.R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and requires substantial/maximal assistance for ADLs and is dependent on staff for toileting. R3 is frequently incontinent of urine and occasionally incontinent of bowel.R3's Skilled Charting Note, dated 10/25/25 at 1:59 AM, documents in part, Narrative: Mental Status: Resident is in an unrousable/coma/persistent vegetative state. Resident is alert. Oriented to: Person Short term memory impairment, Impaired decision-making ability, Confusion. GU: Incontinent of urine. Toileting hygiene: Substantial/maximal assistance. Sit to lying: Substantial/maximal assistance. Lying to sitting on side of bed: Substantial/maximal assistance. Sit to stand; Substantial/maximal assistance. Chair/bed-to-chair transfer: Substantial/maximal assistance. Toilet transfer Substantial/maximal assistance.R3's admission Assessment: Falls, dated 10/23/25 at 3:15 PM, documents R3 is at risk for falls. There is no Fall Risk Assessment documented.R3's admission Assessment: Side Rails, dated 10/23/25 at 3:15 PM, documents, Benefits of bed rail use: Increased bed mobility, side rails indicated to promote mobility and independence. Intervention: SIDE RAILS: Up per order for safety during care provision, to assist with bed mobility, repositioning.R3's Incident Note, dated 10/25/25 at 8:59 AM, documents, Late Entry: Note Text: Resident sustained a fall on 10/25/2025 7:30 AM. The incident occurred in the Resident room. Resident is alert and disoriented per (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usual baseline. No changes in range of motion from normal baseline. Physician notified on: 10/25/2025 9:00 AM. Date/time family/responsible party notified: 10/25/2025 8:00 AM. Resident denies pain. No new skin concern or change in skin condition noted.R3's Incident Note, dated 10/25/25 at 11:15 PM, documents, Late Entry: Note Text: Resident sustained a fall on 10/25/2025 11:15 PM. The incident occurred in the resident's bathroom. Resident is alert and disoriented per usual baseline. No changes in range of motion from normal baseline. Physician notified on: 10/25/25 11:20 PM. Date/time family/responsible party notified: 10/25/25 11:15 PM. Resident denies pain. No new skin concern or change in skin condition noted. Care plan reviewed.R3's Comprehensive Incident Fall Assessment, dated 10/25/25 at 11:15 PM, documents R3 experienced an unwitnessed fall, observed by staff on the bathroom floor, resident unable to state what had happened. Actions taken - resident assessed in place and assisted back to bed with staff x 2 and mechanical lift. New Intervention: resident to be placed in a high traffic area when she is noted to be restless. R3's Nursing Note, dated 10/26/25 at 00:02 AM, documents, CNA reported to writer resident is on the floor. Writer entered room resident could be seen laying on back in restroom facing the entrance way. The lights were off in room. Resident states she was attempting to use the restroom. resident has pulled out (urinary catheter) with bulb intact. Vitals obtained, head to toe assessment, no injuries to note at this time. Resident denies hitting head, resident denies pain, writer offered Tylenol. Completed neuros initiated, MD - no new orders, continue to monitor, leave the (urinary catheter) out monitor urine output. notified, left message for POA to call back no answer.R3's IDT Note, dated 10/27/25 at 2:24 PM, documents, Late Entry: Attendees present: IDT Summary of IDT meeting: Per resident interview I was trying to go to the bathroom Intervention: Resident moved to a room across from the nurse's station for maximum monitoring.R3's IDT Note, dated 10/27/25 at 3:24 PM, documents, Late Entry: Attendees present: IDT Summary of IDT meeting: Resident unable to state what happened. Per staff interviews the resident was attempting to self-transfer. Intervention: Reminder signs added in resident's room to remind her to call for staff assistance.R3's Nurse Practitioner (NP) consultation note, dated 10/27/25 at 1:52 AM, documents in part: Date of Service: 10/27/25. CC: (chief complaint) Muscle atrophy and deconditioning secondary to age related debility and recent hospitalization. (R3) is a [AGE] year-old female with PMH (past medical history) significant for dementia. She arrived via EMS from her assisted-living facility after two falls and generalized weakness with right knee pain and was admitted . Interval History: Patient seen and examined. She is in bed with HOB (head of bed) elevated at time of examination. Reports right knee pain. She reportedly fell out of bed twice on 10/25/25. Psych: Normal mood. Normal affect. Patient responds appropriately to examiner. Judgment and insight appear impaired.There was no Fall Risk Assessment completed upon admission, other than the initial admission nursing assessment. There are no further fall risk assessments completed after each fall. 3. On 11/25/2025 at 10:15 AM, R12 was sitting up to his wheelchair, wheelchair was at the foot of his bed, and he was staring out the window. R12's call light was no within reach if he needed to call for assistance. R12 stated that he has had a couple of falls at the facility, and he knows better to ask for help and use his call light.R2's MDS, dated [DATE], documented that his cognition was intact.R2's Physicians order sheet, dated November 2025, documented diagnoses of Type 2 Diabetes Mellitus without complications, Epilepsy and Anxiety Disorder.R2's Care Plan, dated 5/20/2024, documented, Be sure call light is within reach and encourage me to use it for assistance as needed.R2's Medical Chart did not document any Fall Risk Assessment prior to R2's falls on 10/27/2025 and 11/9/2025.On 11/26/25 at 2:10 PM, V14, LPN, stated, Anytime there is a resident fall, I go into (electronic medical record) and go under 'Risk Management' and answer all the questions it has. Once you answer all of the questions, it determines what steps we take next. I follow it step by step. I complete a fall and incident report and will put what new intervention that I put in place. I would complete the fall risk assessment after each fall. Once completed the Risk Management will automatically trigger certain forms and follow-ups that will need to be done for the next few days. I know that the call lights are supposed to be within the resident's reach, however, sometimes they (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unclip it or it falls on the floor. On 11/26/25 at 2:00 PM, V1, Administrator, stated, I expect all staff to follow a resident's fall interventions in order to keep them safe. I expect the nurses to complete a fall risk assessment upon admission, quarterly, and after any fall the resident has. I expect all staff to keep the resident's call light in reach and to verbalize the placement of that call light to visually impaired residents. The facility's Fall Prevention Program Policy, dated 5/2025, documents in part Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines: Use and implementation of professional standards of practice. Care Plan incorporates: Identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, and preventive measures. Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions will be implemented for each resident identified at risk. Fall/Safety interventions may include but are not limited to: At the time of admission and in accordance with the plan of care the resident will be oriented to use the nurse call device. The nurse call device will be placed within the resident's reach at all times. The location of the placement will be verbalized for those residents with visual deficits.		