

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 07/27/2026
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and treat a stage three pressure ulcer for one (R28) of three residents reviewed for wound care in a sample list of 121 Findings include: R28's Face Sheet documents R28 has the diagnoses of Metabolic Encephalopathy, Major Depressive Disorder, Acute Kidney Failure, Severe Morbid Obesity, and Diabetes Mellitus Type two. R28's Braden Scale dated 4/30/26 documents a risk score of 13, indicating R28 is at moderate risk of skin breakdown. R28's Minimum Data Set (MDS) dated [DATE] documents R28 is alert and oriented and is dependent on staff for Activities of Daily Living, including turning and positioning. This MDS documents R28 had no pressure ulcers but was at risk for developing pressure ulcers. R28's Care Plan dated 11/12/25 documents, I am at risk for a skin impairment related to diabetes, diuretics, impaired mobility and incontinence. I was admitted with multiple wounds. The goal for this care plan documents, I will maintain or develop clean and intact skin by the review date of 9/27/26. Interventions for this care plan include assess/record changes in skin status, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the Medical Doctor (MD). R28's Care Plan does not address the stage three pressure ulcer on R28's coccyx. R28's Order Summary Report dated 7/15/26 documents the following order dated 6/30/26: Treatment: Cleanse open area to coccyx with normal saline, pat dry, apply collagen particles to area and secure with bordered foam. Notify MD/Nurse Practitioner (NP) for signs and symptoms of infection one time a day and as needed. The orders include the order dated 1/30/26: Barrier cream to groin each shift, after incontinence episode and as needed. On 7/15/26 at 9:03 AM, R28 was lying on R28's back. V54 Certified Nursing Assistant (CNA) turned R28 over onto R28's side. R28 had a large open wound on R28's coccyx with a moist wound bed and a brownish/black area in the middle covering about 50% of the wound bed. There was no dressing on the wound. On 7/15/26 at 9:05 AM, V54 CNA stated the open wound to R28's coccyx is always left open without a dressing. V54 stated V54 is usually asked to apply barrier ointment to the area. On 7/15/26 at 3:39 PM, R28 was lying on R28's back. V61 CNA rolled R28 onto R28's side in bed. There was still no dressing on R28's coccyx wound. On 7/16/26 at 10:32 AM, V52 Wound Care Licensed Practical Nurse (LPN) rolled R28 onto R28's side and peeled back a dressing covering a wound to R28's right lower back. V52 stated V52 would not describe this wound to R28's right lower back as the coccyx. There was no dressing or ointment on R28's actual coccyx wound. V52 stated V52 was not aware of R28's wound to coccyx. V52 stated V52 would describe R28's coccyx wound as a pressure ulcer. V52 described R28's coccyx wound as having skin stripping and dark tissue. V52 stated V52 would not want a barrier ointment on this type of wound and stated this type of wound would require an actual dressing. V52 stated there was no order to treat the pressure ulcer on R28's coccyx. On 7/16/26 at 1:14 PM, V54 CNA stated V54 was asked by V52 Wound Care (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 0686 Level of Harm - Actual harm Residents Affected - Few	LPN around two and a half weeks ago to begin applying ointment to the area on R28's coccyx. V54 stated R28's coccyx wound began as an unopened reddened area. V54 stated two days ago V54 asked a nurse to reassess the coccyx wound because it had changed. V54 stated V54 is unsure whether anyone has reassessed the wound. On 7/16/26 at 3:14 PM, V52 Wound Care LPN and V19 Regional Nurse Consultant clarified that the wound referred to in R28's physician orders dated 6/30/26 and R28's Care Plan dated 11/12/25 was the wound on R28's right lower back and not R28's coccyx. V52 stated this wound location was documented incorrectly. V52 stated the treatment order dated 6/30/26 was to treat the right lower back wound, not the coccyx. V52 stated V52 does not remember looking at R28's coccyx two and a half weeks ago, does not remember instructing any CNA staff to apply ointment to the area. On 7/16/26 at 11:41 AM, V65 Wound Care NP assessed the wounds to R28's coccyx and right lower back. V65 measured the coccyx wound. V65 stated the measurements for the coccyx wound are 3.8 centimeters (cm) length by 3 cm width by 0.1 cm depth. V65 stated V65 would classify the current coccyx wound as a stage three pressure ulcer. V65 stated V65 was seeing R28 for management of this coccyx wound around a month ago but had stopped seeing R28 because the coccyx wound had healed. V65 stated usually with turning, repositioning, and preventative cares, it would take months for a person to develop a stage three pressure ulcer. R28's Wound Physician Progress Note by V65, dated 5/6/26, documents a pressure ulcer to R28's coccyx was acquired on 3/4/26 and was resolved on 5/6/26. The progress note documented the follow up order to continue to monitor for any further wounds. There were no additional visits by V65 to R28 for wound assessment or treatment. On 7/16/26 at 1:21 PM, V68 LPN stated V68 was R28's nurse today and was aware of the wound to R28's right lower back. V68 stated R28 has had this wound to right lower back for a long time. V68 stated V68 not aware that R28 had a new wound to the coccyx. On 7/16/26 at 2:34 PM, V65 Wound Care NP stated R28's coccyx wound would have been at risk of progressing and worsening if it had not been identified and treated. The facility's Skin Condition Assessment and Monitoring- Pressure and Non-Pressure policy last revised in December 2025 documents the purpose of the policy is to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented.		

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F 0689 Level of Harm - 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 observation, interview and record review, the facility failed to safely transfer a resident, investigate a fall to determine root cause, and failed to initiate progressive interventions to prevent further falls for 3 of 3 residents (R2, R5 and R6) reviewed for falls in the sample list of 121. This failure resulted in R2 suffering significant pain during multiple transfers. Findings include: 1. On [DATE] at 1:44 PM, R2 was observed alert and seated upright in a wheelchair with a mechanical lift sling positioned underneath the resident. V39 and V53, Certified Nursing Assistants (CNAs), entered the room and manually transferred R2 from the wheelchair to the bed by placing their bent elbows under R2's arm pits and grasping the waistband of R2's pants to lift the resident onto the bed. R2 did not bear weight on their feet and was completely lifted by V39 and V53. V39 and V53 did not use the mechanical lift, despite the lift sling remaining underneath the resident, and did not utilize a gait belt during the transfer. R2 moaned and grimaced in pain during the transfer. Following completion of the transfer, V39 and V53 apologized to R2 for the pain during the transfer. On [DATE] at 9:05 AM, R2 stated it hurt R2's arm and shoulder when staff transferred R2. R2 stated that more than half the time staff did not use the lift thing and instead transferred R2 with one or two staff members depending on who was available. R2 stated R2 had a previous injury to their right rotator cuff, and that R2 had told staff the transfers hurt R2's rotator cuff, but staff did not listen. On [DATE] at 11:40 AM, V64, Physical Therapy Assistant (PTA), stated R2's functional status fluctuated due to dialysis treatments. V64 stated the preferred transfer method for R2 was a mechanical lift because manual transfers could increase pain and further injure the resident's rotator cuff. V64 further stated that if a manual transfer became necessary, staff should use a gait belt. On [DATE] at 2:33 PM, V39 stated the facility's mechanical lifts were frequently broken or had uncharged batteries, requiring staff to search other units for a functioning lift. On [DATE] at 2:45 PM, V14 Certified Nursing Assistant (CNA) stated the facility had only one functioning mechanical lift. On [DATE] at 9:26 AM, V39 stated that when the mechanical lift was unavailable, staff either delayed resident care or completed manual two-person transfers. Per V39, the staff must either transfer the residents with a two-person transfer or they will have to wait until a mechanical lift is available. On [DATE] at 1:30 PM, R2 stated they had been transferred that morning by one big man and pointed to both shoulders while stating the transfer was painful. On [DATE] at 1:34 PM, V14, CNA, stated the mechanical lift was unavailable this morning when they transferred R2 from her bed to her wheelchair due to the remaining lifts being broken. V14 stated he (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transferred R2 by themselves. R2's Face Sheet dated [DATE] documents their diagnoses to include End Stage Renal Disease, Weakness, and Right Rotator Cuff Tear. R2's Care Plan documents the focus: R2 is at risk of falls dated [DATE]. R2's Physician Order dated [DATE] documents: Skilled Physical Therapy services including therapeutic exercise, therapeutic activities, gait training, wheelchair management, and mobility interventions. The facility's policy, Transfers & Manual, Gait Belt and Mechanical Lifts, last revised [DATE], states: Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted. Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. 2. R6's Progress Note dated [DATE] at 10:56 AM, documented by V2, Director of Nursing (DON) documents R6 fell on [DATE] and was found on the floor in their room. The progress note documents R6 had a skin injury to the left side of their head and left elbow. Per the note, R6 was transferred to the emergency room (ER) for further evaluation. No other charting was found regarding the incident. R6's hospital records printed [DATE] documents R6 was admitted to the hospital on [DATE] with the admitting diagnosis of Exacerbation of Chronic Obstructive Pulmonary Disease (COPD). The hospital records included a history and physical dated [DATE] which documented R6 had initially presented to the ER for evaluation of a fall but was admitted due to COPD exacerbation. While evaluated in the ER, R6 had a head computed tomography (CT) which resulted in a superficial scalp contusion on the left without underlying acute displaced calvarial fracture. R6's Minimum Data Set (MDS) dated [DATE] documents R6 was alert and oriented to person, place and time and required staff assistance for transfers and toileting. R6's Care Plan dated [DATE] documents the focus: I am at risk of falls related to gait/balance problems, incontinence, and psychoactive medication. The interventions document R6 was dependent on staff for toileting and required partial to moderate assistance for transfers. On [DATE] at 10:20 AM, V2 stated that a fall investigation was not completed on R6, and the incident was not reported to Illinois Department of Public Health (IDPH) because R6 never returned to the facility. On [DATE] at 12:15 PM V10, Registered Nurse (RN) stated they were told in report that R6 was at the hospital due to tripping over their oxygen tubing. V10 states that R6 fell on the evening shift. On [DATE] at 12:34 PM V24, Certified Nursing Assistant (CNA) stated they were working the hall during the time of R6's fall. V24 stated R6 was prescribed stool softeners and attempted to go to the (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bathroom, and they tripped over their oxygen tubing and fell. On [DATE] at 9:24 AM V44, CNA, stated R6 was stubborn about calling out for assistance even after being educated many times. V44 stated R6 was trying to transfer themself to the bathroom when they became tangled in their oxygen tubing and tripped. V44 stated they were across the hall when R6 fell, and they ran right in because they heard R6 yell. A death certificate documents that R6 died from COPD and natural causes on [DATE]. 3. R5's progress note dated [DATE] at 2:35 PM documented: Resident was witnessed by another resident that (R5) just fell face first out of chair as if they lost consciousness. Resident was on the ground not saying anything with a big knot on the front of their head. Patient was assessed and vitals were out of range 46/44, respirations 12, pulse 36, O2 85, resident was sent out to (local hospital). R5's progress note dated [DATE] at 10:12 AM documents they returned from the hospital with no new orders and no report of an injury. R5's hospital report dated [DATE] at 12:39 PM documents, CT scan showed large stool burden, prescription for (enema) and MiraLAX sent to patient's pharmacy. Patient was given 1 dose of antibiotics in the emergency department for suspected UTI (Urinary Tract Infection). If urine cultures are positive antibiotics will be sent to patient's pharmacy. Use over the counter medications for headache associated with the fall. Patient will likely be sore over the next few days. Feel free to return to the emergency department if symptoms worsen or any new medical concerns arise. R5's Care Plan, updated [DATE], documents R5 is at risk for falls related to gait/balance problems and incontinence. This care plan does not document a progressive intervention after their fall on [DATE]. On [DATE] at 12:45 PM, V2 stated that there should always be a post-fall intervention placed after each fall occurrence and a fall investigation to find the root cause. A policy named Fall Prevention Program revised on 05/2022 states, .Interventions are changed with each fall, as appropriate.preventative measures. Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions. The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. In addition, Director of Nursing is responsible for informing the Administrator of program analysis. A policy named Incident and Accidents-Illinois last revised 5/2022 states The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations or theft and abuse registered by residents, visitors or other, and resident-to-resident altercations. An incident/accident report is to be completed by an RN or LPN, and is to include: A. Date and time of an incident/accident B. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, (continued on next page)		

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and notification of appropriate parties.3. The Director of Nursing, Assistant Director of Nursing, or Nursing Supervisor must notify the following if an actual injury occurs: A narrative summary of the incident is to be sent to the Illinois Department of Public Health within five working days.All incident/accident reports are reviewed, signed, and investigated by: The Administrator; and The Director of Nursing or the Assistant Director of Nursing; and The Medical Director (monthly signature on report list). A policy named Transfers-Manual Gait Belt and Mechanical Lifts last revised 8/2023 states 1. Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted. 3. Mechanical lifts shall be made readily available and accessible to staff 24 hours a day.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide the services of a Registered Nurse eight consecutive hours per day/seven days per week. This failure has the potential to affect all 121 residents in the sample list of 121 in the facility. Findings include: On 7/21/26 at 12:33 PM, V87 Human Resource Director, provided timecard report for V101 Registered Nurse (RN) and stated, this is the only RN on for 7/4/26 and 7/5/26. V101's timecard report for 7/4/26 shows V101 clocked in at 10:50am and clocked out at 12:59pm for a total of two hours and nine minutes. V101's timecard for 7/5/26 shows V101 clocked in at 10:00 am and clocked out at 11:45am for a total of one hour and forty-five minutes. On 7/21/26 at 12:56 PM, V19 Regional Nurse Consultant stated, I'm going with 100%, no we did not have agency RNs on that weekend (7/4/26 and 7/5/26). We didn't use agency nurse staffing then. We are now due to the staffing stuff but not then. On 7/22/26 at 1:45pm, V19 stated the facility does not have a staffing policy and that they follow state regulations for staffing. On 7/24/26 at 2:42 PM, V16 stated, I just confirmed with V19 that there was no Regional Nurse Consultant here. It was a holiday weekend and they're not going to be here unless it is an emergency situation. The facility's daily census sheet dated 7/13/26 documents that there were 121 residents residing in the facility at that time.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to provide a clean, sanitary, and homelike environment for the residents. This failure has the potential to affect all 121 residents in a sample of 121 residing in the facility. Findings include: The facility's Daily Census Report dated 7/13/26 documents there are 121 residents residing in the facility. On 7/13/26 at 4:15 AM, a tour of the facility was conducted, and the following was observed: The parking lot of the facility was littered with disposable foam food and drink containers, empty cigarette packs, rubber gloves, and cigarette butts. A blue dumpster was open and had a large accumulation of pieces of disposable foam food and drink containers, paper trash and broken chairs and mattresses outside the container. Upon entering the facility, there was a strong musty odor and the front desk reception area had paper trash scattered on the floor in front of it. The activity area had sweetener packets, a large area of white powdery substance and other food crumb debris beneath the table on the floor and on the windowsills. The 200 hall floors had a sticky surface that made an audible ripping sound with each footstep. There was dark built-up grime along the baseboards and floor. There were brown colored drippings and stains on the bottom half of the walls. There were paper trash, plastic food wrappers and glucose testing strips scattered throughout the hallway on the floor. A dirty incontinence brief and hospital gown could be seen through an open doorway on R45's floor. The facility's elevator floors had built up black grime and food crumb debris in the corners and along the edges, and dried spill streaks on the walls. The third-floor hallway was sticky, and an audible ripping sound could be heard with footsteps. There was a ring shaped brown spill that had dried in the middle of the walkway. Black build-up of grime continues throughout the hallway along the baseboards and the floor. The floor was littered with pieces of paper trash and food crumb debris scattered. On 7/13/2026 at 7:15 AM, R3's room was observed to have a sticky floor with an audible ripping sound with each footstep, paper trash and food debris on the floor. There was opened and half eaten food items in R3's bed with a brown smear on bottom sheet. On 7/13/2026 at 7:33 AM, R33's bed had a large white stain on vinyl cover of mattress, stacked personal items and food items in the corners, sticky floors that had an audible ripping sound with each footstep, trash and food debris scattered on the floor. A strong, musty, body odor smell was noted in room. On 7/13/2026 at 7:33 AM, R34's bed had a puddle of unknown liquid underneath, personal items and open aluminum cans on bedside table. The floor next to R34's bed was sticky and had an audible ripping sound with each footstep. On 7/13/2026 at 7:44 AM, R35's room had a sticky floor with an audible ripping sound with each footstep. On 7/13/2026 at 7:45 AM, R36's floor in front of their bed was sticky with an audible ripping sound with each footstep. On 7/13/26 at 9:00 AM, a tour of the basement was conducted, and the following was observed: a pile of trash in the hallway, multiple empty rooms with trash piles that contained clothes, shoes, empty cardboard boxes and trash. There was a puddle of standing water at end of hallway that was the length and width of the hallway. The outside exit door was propped opened by a black object. There were swarms of flies, dripping water from the overhead pipes and trash and empty boxes sitting in the water. Several walls were missing drywall leaving wooden studs and metal pipes visible. On 7/14/26 at 2:05 PM, V29 Floor Technician was using a scrubber on the floors in front of the elevators on the third floor. The small puddles of bubbly liquid on the floor were dark greyish/brown in color. V29 stated the color is from the mildew inside of the floor scrubbing machine. V29 opened up the top of the floor scrubber and the water inside was black in color. On 7/15/2026 at 9:10 AM, R17's room had open soda cans on floor and cardboard boxes on floor in the closet. On 7/15/2026 at 9:20 AM, Discolored residue was visible on the (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	floor's surface causing shoes to adhere to the floor and a loud audible ripping sound occurred with each step. On 7/15/2026 at 9:45 AM a tour of the dry food pantry on the 400 hall was conducted with V84, Dietary Manager. There were two open food containers observed on bottom shelf, there were orange fish shaped cheese flavored crackers and crumbs on the floor next to the food storage shelves. On 7/16/2026 at 8:58 AM, a tour of the kitchen was conducted, and there were plastic disposable drinking cups, resident dishware, paper trash and food crumbs and dirt debris underneath the ice machine and work station. There was a wire shelf rack storing baking pans and a pot lid that had food crumbs and dust debris on top. There was an open plastic bread bag on a shelf that had a hole where it appeared the plastic melted open. The bread in the bag had different colors of green and white fuzz on the surface. There was a buildup of dust and food debris on the worktable shelves along the edges and on the spice and seasonings shelf. On 7/16/2026 at 1:34 PM, The area under the covered pavilion outside the facility had scattered plastic bags, cigarette butts, cat food, and disposable foam food containers. A strong musty odor of wet cigarette smell noted. On 7/13/2026 at 5:13 AM, V76 floor technician, stated floor techs are responsible for cleaning the floors, and emptying trash out of rooms. V76 stated, The floors are to be cleaned every day if needed, but I will check to see if the floors are really bad. V76 stated he doesn't have enough cleaning supplies for the building. V76 stated the last time V76 cleaned the floors was Thursday July 9th. On 7/13/2026 at 5:36 AM, V76 floor technician stated the facility orders supplies once a month and the supplies don't last the full month, V76 stated the facility has run out of supplies and V76 has had to tell the residents that housekeeping can't provide paper towels and trash bags for their rooms due to no supply. On 7/13/26 at 7:26 AM, V41 CNA stated the facility could be cleaner and housekeeping could do more cleaning. On 7/13/26 at 7:40 AM, V85 housekeeper stated they clean the floors every day and the facility has run out of cleaning supplies. On 7/14/2026 at 2:05 PM, V29 Floor tech, stated the color is from the mildew inside of the floor scrubbing machine. On 7/14/2026 at 4:10 PM, V63 R33's sister, stated R33's room is filthy, the mattress is stained and sunk in the middle, there was pee on the floor, the floor hadn't been mopped. V63 stated, I have to clean her room every time I come. R33 has had breakfast tray left in bedroom till 4:00 pm. On 7/14/2026 at 4:15 pm, V35 Housekeeping Supervisor stated there is a deep cleaning schedule and some housekeeping staff do it and some don't. V35 stated they are aware of one housekeeper working today who doesn't do it. On 7/15/2026 at 9:28 AM, V38 housekeeper stated the facility has run out of supplies and has gone and bought their own supplies to clean the building, V38 did report no supplies to the housekeeping supervisor but it is still a problem. On 7/15/2026 at 9:45 AM, V84 Dietary Manager stated the facility is filthy. On 7/16/2026 at 10:35 AM, V72 Regional Dietary Manager stated the kitchen cleanliness was decent. On 7/21/2026 at 11:57 AM, V35 confirmed housekeeping staff do not document that a room is deep clean, the staff write out their daily duties and scratch off the rooms after cleaning is completed or they send pictures of the room clean. On 7/21/2026 at 3:40 PM, V94 R60's sister stated they bring cleaning supplies to clean R60's room during visits because the room is not adequately cleaned. V94 stated they have used a utility putty knife to scrape residue from the floor and reported the bathrooms are dirty and that they have brought ant traps into the room due to ants. V94 stated they placed a message board above R60's bed requesting housekeeping clean the floors, but the floors were not cleaned. V94 stated they have reported these concerns to nursing staff and administration on multiple occasions. On 7/21/2026 at 10:00 AM, A day shift daily cleaning schedule documents that on 7/5,7/8,7/9 and 7/11 the following tasks were not performed: wash and sanitize can opener, food processor, slicer, mixer, cutting boards, prep tables/countertops, beverage table, coffee urns, pots and pans, clean stovetop/grill, sweep and mop kitchen floor cook area, sweep and mop dish area, (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	clean microwave oven, clean handwashing sink, clean food carts, clean and sanitize pot and pan sink. On 7/21/2026 at 10:10 AM, A day shift daily cleaning schedule documents that on 7/6,7/7 and 7/10 the following tasks were not performed: wash and sanitize mixer, prep tables/countertops, beverage table, coffee urns, pots and pans, sweep and mop dish area, clean microwave oven, clean handwashing sink, clean food carts, clean and sanitize pot and pan sink. On 7/21/2026 at 10:15 AM, A dietary night shift daily cleaning schedule documents that on 7/5,7/6,7/9 and 7/10 the following tasks were not performed: wash and sanitize prep tables/countertops, beverage table, coffee urns, pots and pans, sweep and mop dish area, clean microwave oven, clean handwashing sink, clean food carts, clean and sanitize pot and pan sink. On 7/21/2026 at 10:20 AM, The dietary night shift daily cleaning schedule documents that on 7/7 and 7/8 the following tasks were not performed: wash and sanitize can opener, food processor, slicer, cutting boards, prep tables/countertops, beverage table, coffee urns, pots and pans, clean stovetop/grill, sweep and mop kitchen floor, sweep and mop dish area, clean microwave oven, clean handwashing sink, clean food carts, clean and sanitize pot and pan sink. On 7/21/2026 at 10:25 AM, The dietary night shift daily cleaning schedule documents that on 7/11 the following were not performed: wash and sanitize can opener, food processor, slicer, cutting boards, clean stovetop/grill, and sweep and mop kitchen floor. On 7/21/2026 at 10:52 AM, A monthly cleaning schedule documents that for the months of January, February, March, April, May and June a solid line is marked through the following tasks: clean refrigerators, clean freezers, clean and sanitize ingredient bins, drain, clean and sanitize ice machine, clean walls/backsplash, clean windows (as needed) and clean ceilings (annually or as needed) garbage cans (all). On 7/21/2026 at 10:52 AM, A monthly cleaning schedule documents that for the month of July the following tasks have not been performed: clean refrigerators, clean freezers, clean and sanitize ingredient bins, drain, clean and sanitize ice machine, clean walls/backsplash, clean windows (as needed) and clean ceilings (annually or as needed) Garbage cans (all). On 7/21/2026 at 10:58 AM, A housekeeper schedule documents a housekeeper was assigned to clean the kitchen on 7/1 and 7/16. On 7/21/2026 at 11:02 AM, a deep cleaning request form documents a deep clean of the kitchen was performed by outside agency on 5/21/2026. Deep clean included: dish room area floors and walls, walls throughout main kitchen and service line, oven inside and outside, stove, backsplash and flat top grill, floor throughout main kitchen, floors where the walk in coolers are located and paper product hall, inside and outside walking coolers (two) inside and outside coolers in main kitchen (three). On 7/21/2026 at 11:58 AM, a housekeeping deep clean schedule of the facility was reviewed with V35 who confirmed housekeeping staff do not document that a room is deep clean, the staff write out their daily duties and scratch off the rooms after cleaning is completed or they send pictures of the room clean. On 7/21/2026 at 12:31 PM, a housekeeper job description was reviewed that documents the essential duties and responsibilities: Ensure that work/cleaning schedules are followed closely as practical. Clean, wash, sanitize and/or polish fixtures, ledges, room heating/cooling units, bathroom fixtures etc. Clean floors including sweeping, dusting, damp/wet mopping, stripping, waxing, buffing, disinfecting etc. Discard waste/trash into proper containers and reline trash receptacle with plastic liner. On 7/21/2026 at 12:39 PM, A policy titled General Sanitation Practices documents the kitchen will be maintained in a clean and sanitary condition. 7. All utensils, pots, pans, etc. will be properly washed, rinsed and sanitized after each use. On 7/21/2026 at 1:02 PM, a policy titled Sanitation of Dining and Food Service Areas documents 5. A cleaning schedule will be posted for all cleaning tasks.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review the facility failed to implement pest control precautions to prevent pest infestation in the facility. This failure has the potential to affect all 121 residents residing in the facility. Findings include On 7/13/26 at 4:15 AM, The facility's Daily Census Report dated 7/13/26 documents there are 121 residents residing in the facility. On 7/13/26 at 4:15 AM, a tour of the facility was conducted, and the following was observed: The parking lot of the facility was littered with disposable foam food and drink containers, empty cigarette packs, rubber gloves, and cigarette butts. A blue dumpster was open and had a large accumulation of pieces of disposable foam food and drink containers, paper trash and broken chairs and mattresses outside the container. Upon entering the facility, there was a strong musty odor and the front desk reception area had paper trash scattered on the floor in front of it. The activity area had sweetener packets, a large area of white powdery substance and other food crumb debris beneath the table on the floor and on the windowsills. The 200 hall floors had a sticky surface that made an audible ripping sound with each footstep. There was dark built-up grime along the baseboards and floor. There were brown colored drippings and stains on the bottom half of the walls. There were paper trash, plastic food wrappers and glucose testing strips scattered throughout the hallway on the floor. A dirty incontinence brief and hospital gown could be seen through an open doorway on R45's floor. There was a black multilegged insect in the two hundred hall nurse's station bathroom. The facility's elevator floors had built up black grime and food crumb debris in the corners and along the edges, and dried spill streaks on the walls. The third-floor hallway was sticky, and an audible ripping sound could be heard with footsteps. There was a ring shaped brown spill that had dried in the middle of the walkway. Black build-up of grime continues throughout the hallway along the baseboards and the floor. The floor was littered with pieces of paper trash and food crumb debris scattered. On 7/13/2026 at 7:33 AM, R34's room was observed to have stacked personal items and open soda cans on bedside table and small flying insects were noted above R34's bed. On 7/13/2026 at 7:44 AM, R35's room had a sticky floor with an audible ripping sound with each footstep. Underneath R35's bed was a line of mouse droppings along the baseboard. On 7/13/2026 at 7:45 AM, R36's had mouse droppings under the bed and along the base boards and underneath the bedside table dresser. In the corner next to the heating and cooling unit bits of torn up paper observed piled in the corner. On 7/13/26 at 9:00 AM, a tour of the basement was conducted, and the following was observed a pile of trash in the hallway, multiple empty rooms with trash piles that contained clothes, shoes, empty cardboard boxes and trash. There was a puddle of standing water at end of hallway that was the length and width of the hallway. The outside exit door was propped opened by a black object. There were swarms of flies, dripping water from the overhead pipes and trash and empty boxes sitting in the water. Several walls were missing drywall leaving visible wooden studs and metal pipes visible. A large puddle of standing water had collected and was the width of the hallway roughly 8 feet in width and 10 feet in length. 7/15/2026 at 9:20 AM, R37's room was observed to have a cardboard box on floor in closet, crackers in the original box on bedside dresser, a clean container with a lid with a line of mouse droppings. 7/15/2026 at 9:45 AM, A tour of the dry food storage on the fourth floor was conducted with V84 Dietary Manager and the following was observed: two open food containers noted on bottom shelf, fish shaped cheese crackers on the floor next to the storage shelves, mouse droppings on a white wooden shelf attached to wall with dried yellow spot beneath the mouse droppings. 7/15/2026 at 12:43 PM, R83's TV had mouse droppings behind it on the dresser. 7/16/2026 at 8:30 AM, A blue dumpster with attached black lid was left open. 7/16/2026 at 8:58 AM, A kitchen walkthrough was conducted with V84 and the (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following was observed: 1 dead bug in kitchen doorway, 1 cardboard box dated 12/27 with live insect with long antennae and brown shiny almond shaped exoskeleton and spiny legs noted on the bottom shelf of the worktable. 7/16/2026 at 10:35 AM, Pest control service call was observed with V73 Pest Control technician, the following was observed: spraying for roaches along the parameter of the kitchen, checking and rebaiting metal pest control boxes. V73 opened a metal pest control box, and a combination of live and dead roaches were stuck to the glue trap and moving freely within the box. V73 opened a metal pest control box and two dead mice observed stuck to glue trap. V73 uncovered two soup wells on the work table, and one live roach was observed on the rim of the well. V73 opened a metal pest control box, and dead roaches were observed stuck to the glue trap. V73 opened a metal pest control box and eight to ten dead mice in different stages of decay were observed stuck to the glue trap and within the trap. The fourth-floor dry food storage room was treated for pest and the following was observed: the fish shaped cheese flavored crackers remain on the floor and the open food storage containers remain open. V74 Sentinel Pest Control technician opened one of the two metal pest control box in the dry food storage area, and two dead mice were observed stuck to the glue traps inside. On 7/16/2026 at 1:34 PM, a tour of the covered outdoor pavilion area was conducted, and the following was observed: a cardboard box with a pet pillow cushion and a towel draped across the top of the box. There was one bowl of clean water and one bowl full of cat food, with cat food overflowing onto the pavement. One facility door was propped open with grey trash can. On 7/17/2026 at 8:45 AM, A blue dumpster with attached black lid was left open. On 7/13/2026 at 7:15AM, R3 stated they have seen a mouse in their room, R3 stated mouse comes to visit occasionally at least once a week. On 7/13/2026 at 7:20 AM, R31 stated they have seen mice in the facility. On 7/13/2026 at 7:33 AM, R33 saw a mouse on the windowsill one day ago, R33 told the nurse. R33 is very scared of mice and when R33 saw the mouse she did not feel good. On 7/13/2026 at 7:40 AM, V85 housekeeper saw a mouse last week. On 7/13/2026 at 7:50 AM, V60 Minimum Data Set Nurse, stated she has seen reports of mice, knows pest control came out last week. On 7/13/2026 at 8:10 AM, R110 saw a mouse but it's been awhile. On 7/14/2026 at 4:10 PM, V63 R3's sister stated there are mice in R33's room. On 7/14/2026 at 4:15 PM V35 housekeeping supervisor pointed out the swarm of flies above R34's bed while V35 was recleaning R34's room. On 7/14/2026 at 4:30 PM V2 Director of Nursing stated they were aware of the mouse problem in the past but hasn't gotten any reports recently. On 7/15/2026 at 9:10 AM, R17 stated, The mice come and go, they disappear for a while. I don't know when they are supposed to clean my room. A mouse ran across my foot, a little baby one. On 7/15/2026 at 9:12 AM, R41 stated I always have mice in my room. On 7/15/2026 at 9:12 AM, R42 stated they have seen mice in their room. On 7/15/2026 at 9:20 AM, R37 stated they have mice in their room, R37 is afraid of mice. R37 stated. There was one mouse on my bedside table next to my bed. On 7/15/2026 at 9:28 AM, V38 housekeeper stated they have seen mouse droppings but never saw a live mouse. On 7/15/2026 at 9:45 AM, V84 Dietary Manager stated the facility is filthy, on my first day my focus was the roach infestation, the facility knows about the pest problem, pest control comes weekly. On 7/15/2026 at 12:42 PM, V53 Maintenance Director stated pest control doesn't meet with maintenance department after treatment but does provide recommendations such as keeping resident's food in their rooms in containers and stop feeding the outside stray cats. The dumpster lid should be kept closed and the door to the basement should not be left propped open. There should be no standing water in the basement because it would attract roaches. Pest control was out last week-they have been hitting the kitchen real hard; the facility has been fighting the mice for a while. V53 was not aware of any mice in the kitchen but saw a mouse in the facility. V53 will check the traps but no residents have reported mice to him. V53 stated he checks the traps regularly. On (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7/15/2026 at 2:59 PM, V73 Pest Control technician stated the facility had a long standing contract with the facility's previous owners but on 7/15 the contract was updated to reflect the agreement with the new ownership. The agency provides dual service, both interior and exterior pest control. Last time treated the facility was on 7/8/2026 sprayed first floor and second floor for roaches. V53 will get into contact with this agency as needed. V73 confirmed the agency does offer advice to the facility such as keeping snacks and other food items stored in containers, keeping trash off the floor and in bags and containers. V73 confirmed that nesting material would look like bits of shredded paper and indicates they are creating a nest nearby. That would be a clue to lay down more glue traps in that area because mice are creatures of habit. On 7/15/2026 at 4:02 PM, V71 Assistant Dietary Manager stated there was a dead mouse on the glue trap by the dishwasher last night, but the mouse and glue trap wasn't there at the beginning of her shift this morning. On 7/16/2026 at 10:35 AM, V73 stated he communicates with staff as they are his eyes and ears. V84 wasn't aware of the mouse found in kitchen day prior, V71 did not report the mouse to maintenance and V99 Dietary aide saw the dead mouse on the glue trap but did not report it. V73 confirmed the dead bug in kitchen doorway was a roach. V73 had not gotten any communication from facility regarding mouse sightings. V73 stated he was aware of the mice due to state surveyor questioning during phone conversation on 7/15/26. V73 stated it is a constant battle and an ongoing issue that requires team effort with the facility. V73 confirmed that the food debris on pot lid and shelf surfaces would attract pests. V72 Regional Dietary Manager stated the kitchen cleanliness was decent. V74 stated there was lots of mice activity outside based on how much of the bait cube is chewed up. V74 reported that V34 had told him that there were reports of hearing mice in the exterior walls. V73 confirmed loose food in dry food pantry will attract more pests and confirmed mouse droppings on white shelf to be mouse droppings. On 7/16/2026 at 1:34 PM, V69 housekeeper stated the outside door that was propped open leads to the sorting room for trash or laundry. On 7/21/2026 at 12:35 PM, The facility's pest control invoice for the months of April, May, June and July 2026 were reviewed. On 7/21/2026 at 12:39 PM, A policy titled General Sanitation Practices documents the kitchen will be maintained in a clean and sanitary condition. 7. All utensils, pots, pans, etc. will be properly washed, rinsed and sanitized after each use. A. Food service workers will receive training on the following subjects: 13. Avoiding insect and/or pest problems. On 7/22/2026 at 11:41, A policy dated 02/2018 titled Pest Control states the purpose of the policy is to prevent or control insects and rodents from spreading disease. The policy guidelines state 5. Employees are instructed to promptly report all observations of pests to their department heads. 6. Food will be covered and/or refrigerated, as applicable to prevent pest invasion and spoiling. 8. Outside openings shall be protected against the entrance of insects by tight fitting, self-closing doors, closed windows, screening, controlled air currents or other means. 9. The building openings shall be tight-fitting and free of breaks. 10. The facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects or rodents. 12. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food. 13. Garbage and trash shall be promptly removed from the premises in accordance with local and stated waste management guidelines. 17. The dumpster shall be kept clean and maintained in good repair and the lid shall be kept closed.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse for 3 (R19, R38 and R46) of 4 residents reviewed for abuse in a sample list of 53. Findings include: R19's Medical Diagnosis list dated 5/20/2026 documents R19 has a diagnosis of Hypertension, Anxiety, Depression, and Diabetes. 1. R19's Minimum Data Set (MDS) dated [DATE] documents R19 is cognitively intact. On 7/14/2026 at 9:30 AM, R19 stated R19's roommate had spilled fluids on the floor. R19 stated R19 reported the spill. R19 stated V25, Certified Nursing Assistant, (CNA) refused to clean it, stating with curse words it was not their job. R19 stated V25 was rude. R19 stated V25 yells profanities and uses racial slurs in the hallways and at the nurse's station where it can be heard from R19's room. R19's room is located directly across the hall from the nurse's station. R19 stated V25's conversations with other staff are sexual in nature. R19 stated this upsets R19 and feels this is inappropriate and is abusive to everyone that can hear it. R19's Progress Note dated 7/14/2026 at 11:00 AM documents R19 made an allegation of abuse from a staff member. R19's Progress Note dated 7/15/2026 at 3:25 PM documents a staff member was placed on leave pending investigation. V25's Corrective Action Form dated 7/17/2026 documents an allegation of abuse was made against V25. After an investigation was conducted, it was determined that the allegation was founded. The facility cited Appendix A #7 of the Collective Bargaining Agreement that states physical or verbal abuse, neglect, or attempting to injure residents or other person results in discharge. Per this Corrective Action Form, V25 was terminated on 7/17/2026. 2. R38's Progress Note dated 1/21/2026 documents R38 has a diagnosis of Dementia, Anxiety, Depression, Hypertension and Hepatic Disorder. R38's MDS dated [DATE] documents R38 as moderately cognitively impaired. On 7/16/2026 at 9:20 AM, R38 stated one of the nurses had yelled at R38 and told R38 they smelled bad. R38 stated this made R38 feel bad and embarrassed. R38 stated there were other people around. On 7/17/2026 at 10:30 AM, V82 (Dietary Aid) stated when V82 was on the elevator, V80 (CNA) and R38 got on at the 2nd floor. V82 stated there was another resident on the elevator. V82 stated V80 told R38 they smelled like shit, and was trifling and nasty. R38 asked V80 to stop yelling at R38 and V80 stated back to R38 well you smell like shit and I ain't fucking yelling. V82 stated they exited the elevator on the 3rd floor. V82 stated V82 reported this encounter to the Administrator immediately. R38's Progress Note dated 6/15/2026 documents R38 made an allegation of abuse from a staff member. R38's Progress Note dated 6/15/2026 documents a staff member was placed on leave pending investigation. V80's Corrective Action Form dated 6/19/2026 documents an allegation of abuse was made against V80. After an investigation was conducted, it was determined that the allegation was founded. The facility cited Appendix A #7 of the Collective Bargaining Agreement that states physical or verbal abuse, neglect, or attempting to injure residents or other person results in discharge. Per this Corrective Action Form, V80 was terminated on 6/19/2026. 3. R46's History and Physical dated 1/7/2026 documents R46 has a diagnosis of Right Hip Fracture, Osteoporosis, Gastro-Esophageal Disease, Hypertension, and Hyperlipidemia. R46's MDS dated [DATE] documents R46 as cognitively intact. On 7/16/2026 at 8:15 AM, R46 stated R46 went out to lunch and when returned to the facility, R46 asked V75, Licensed Practical Nurse (LPN) for pain medicine. R46 stated V75 grabbed R46's arm, yelled an accusation at R46 about being drunk and pulled R46 to R46's room and slammed the door. R46 stated this made R46 feel helpless, humiliated and scared. R46 stated it hurt. R46 stated V7 (CNA) and V25 (CNA) curse and used racial slurs in the hallway where everyone can hear. R46 stated this makes R46 uncomfortable (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and stated it is inappropriate. R46 states this happens all the time, and it has been reported to other staff members, but no one does anything about it. Reported to V16 (Regional Administrator). On 7/17/2026 at 9:35 AM, V83 (CNA) stated V83 witnessed an incident that involved R46 and V75. V83 stated V75 yelled at R46 about being drunk and refused to give R46 their medications. V83 stated seeing R46 and V75 walking towards R46's room, V75 pushing R46 into the room and slamming the door. V83 stated V75 was aggressive and rude to R46. V83 stated V83 did not report On 7/22/2026 at 11:00 AM, V95 (Receptionist) stated on 4/3/2026, R46 returned to the facility from an outing. R46 was in the dining room and V75 approached R46 yelling and accusing R46 of being drunk. V75 grabbed R46's arm and snatched her up like a child and stood R46 up and yelled in R46's face. V75 forced R46 to her room. V95 stated V95 reported this incident to a nurse. R46's Progress Note dated 4/7/2026 documents R46 made an allegation of abuse from a staff member on 4/3/2026. R46's Progress Note dated 7/15/2026 documents R46 made an allegation of abuse from a staff member. Staff was placed on leave pending an investigation. V75's Corrective Action Plan dated 4/13/2026 documents an allegation of abuse was made against V75. After an investigation was conducted, it was determined that the allegation was founded. The facility cited Appendix A #7 of the Collective Bargaining Agreement that states physical or verbal abuse, neglect, or attempting to injure residents or other person results in discharge. Per this Corrective Action Plan, V75 was terminated 4/13/2026. V7's Corrective Action Plan dated 7/17/2026 documents an allegation of abuse was made against V7. After an investigation was conducted, it was determined that the allegation was founded. The facility cited Appendix A #7 of the Collective Bargaining Agreement that states physical or verbal abuse, neglect, or attempting to injure residents or other person results in discharge. Per this Corrective Action Plan, V7 was terminated 7/17/2026. The facility's Abuse Policy dated March 2026 documents the facility prohibits abuse and mistreatment of residents. The facility's Abuse Policy defines physical abuse as the infliction of injury on a resident that occurs other than by accidental means. The facility Abuse Policy defines verbal abuse as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within hearing distance.		

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NAME OF PROVIDER OR SUPPLIER Arcadia Care on the Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Carpenter Springfield, IL 62702	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of misappropriation of resident property/theft and allegation of physical abuse to the state agency (Illinois Department of Public Health (IDPH) and local police department for two (R1, R8) of seven residents reviewed for abuse in the sample list of 121. Findings include: 1. On 7/14/26 at 1:40PM, V1 stated, The Maintenance Director cut the lock off R1's drawers. I wasn't in the room. Then the family started saying a week later that things were missing. They didn't say anything about it that day, but about a week later. I didn't report it because there isn't any proof of anything missing. I started an investigation; I have a soft chart in my office. On 7/14/26 at 2:10pm, V1 stated, They didn't initially complain of missing items. The family initially said it was \$30 missing, then the next day it was \$500 missing. (R1's) family member said they had the wallet and was missing \$30 out of it, then flipped script to \$500 missing. Family never said they had given R1 \$500. I don't remember if there is a grievance. I did an internal investigation, spoke to billing. I have a soft chart on it. On 7/15/26 at 9:35am, V19, Regional Nurse Consultant, brought in the investigation packet regarding R1's missing wallet and money. The packet contains three written staff statements dated 6/11/26 and a printout of R1's Resident Statement Landscape from 1/2/26 through 6/4/26 with an ending balance of \$545.31 printed on 6/11/26. V19 stated, This is the entire thing. There was no documentation of the facility notifying IDPH or local police of the allegation of R1's missing wallet or money. On 7/15/26 at 9:37 am V1 stated, I watched R1's unnamed family walk out of the room with the wallet in their hand. R1's family came back about 5 days later and was saying money was missing. Originally, R1's family stated it was \$30 dollars but then it became \$500. R1's family had the wallet when they left the building and came back several days later. I started the investigation on the 11th because R1's family didn't say anything was missing until then. I spoke with Social Services about it, but I don't know if we did a grievance. The usual protocol when checking into allegations like this would be to check into it and if they can't get it figured out within an hour, I call it in to IDPH and do an investigation. On 7/15/26 at 11:12 V1 stated, We did not do a grievance about that. On 7/15/26 at 11:33am V44, Certified Nursing Assistant (CNA) stated, I wasn't here the day R1 passed. When R1 passed, R1's family was asking where R1's wallet was. R1's family had all of R1's keys, but some were missing. R1's family kept saying R1 had \$500. I don't know which family member it was; I've never seen them before except the night R1 passed and to get R1's stuff. I told the nurse, V10, that R1's family member was saying money was missing. On 7/16/26 at 9:42am V20 Regional Financial Coordinator stated, I haven't heard about this \$500 issue until you guys (IDPH) started investigating this. 2. The facility's abuse investigation dated 4/15/26 of R8's abuse investigation packet states, At approximately 0230 on 04/09/2026 the administrator was made aware of a Certified Nursing Assistant (CNA) allegedly making physical contact with the resident involving resident R8. The facility's undated preliminary 24-hour Abuse Investigation Report completed by V16 Regional Director of Operations states, Resident was immediately assessed. V97 CNA was immediately suspended pending investigation. Investigation commenced and POA (Power of Attorney), MD (Medical Doctor), Ombudsman, and Local Police notified. Final report to follow. The facility's final investigation report dated 4/15/26 reveals an incomplete investigation. There is no interview for R8, two separate and different interviews by the same employee V66 CNA, an incomplete and unsigned interview of V105 Licensed Practical Nurse, and there was no police report number or report. On 7/23/26 at 10:05 AM, V16 stated, I called the police department, and they didn't find anything in that (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date range (4/8/26- 4/15/26). They said they had something on R8, but not for those dates.R8's Face Sheet documents their diagnosis to include Noninfective Gastroenteritis and Colitis, Chronic Obstructive Pulmonary Disease and Gastrostomy Status.R8's Minimum Data Set (MDS) dated [DATE] documents R8 was alert and oriented.R8's Care Plan revised on 5/7/2025 documents R8 is at moderate risk for abuse/neglect as noted from Abuse screening related to current physical health problems. Interventions for this care plan include Law-enforcement and legal support as needed and provide a safe and secure environment. The facility's policy, Abuse Prevention and Reporting-Illinois, last reviewed 03/2026, states, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. External Reporting: When an allegation on abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by phone, fax, email, or portal. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated. The facility shall also contact the local law enforcement authorities.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of misappropriation of resident property/theft and allegation of physical abuse for three (R1, R8, R46) of seven residents reviewed for abuse in the sample list of 121. Findings include: 1. On 7/14/26 at 1:40PM, V1 stated, The Maintenance Director cut the lock off R1's drawers. I wasn't in the room. Then the family members started saying a week later that things were missing. They didn't say anything about it that day, but about a week later. I didn't report it because there isn't any proof of anything missing. I started an investigation; I have a soft chart in my office. On 7/14/26 at 2:10pm, V1 stated, They didn't initially complain of missing items. The family member initially said it was \$30 missing, then the next day it was \$500 missing. (R1's) family member said they had the wallet and was missing \$30 out of it, then flipped script to \$500 missing. Family never said they had given R1 \$500. I don't remember if there is a grievance. I did an internal investigation, spoke to billing. I have a soft chart on it. On 7/15/26 at 9:35am, V19, Regional Nurse Consultant, brought in the investigation packet regarding R1's missing wallet and money. The packet contains three written staff statements dated 6/11/26 and a printout of R1's Resident Statement Landscape from 1/2/26 through 6/4/26 with an ending balance of \$545.31 printed on 6/11/26. V19 stated, This is the entire thing. On 7/15/26 at 9:37am V1 stated, I watched her (R1's unnamed family member) walk out of the room with the wallet in their hand. They came back about 5 days later and was saying money was missing. Originally, they stated it was \$30 dollars but then it became \$500. They had the wallet when they left the building and came back several days later. I started the investigation on the 11th because they (R1s unnamed family member) didn't say anything was missing until then. I spoke with Social Services about it, but I don't know if we did a grievance. The usual protocol when checking into allegations like this would be to check into it and if they can't get it figured out within an hour, I call it in to IDPH and do an investigation. On 7/15/26 at 11:12 V1 stated, We did not do a grievance about that. On 7/15/26 at 11:33am V44, Certified Nursing Assistant (CNA) stated, I wasn't here the day R1 passed. When R1 passed, R1's Family member was asking where R1's wallet was. They had all R1s keys, but some were missing. They kept saying R1 had \$500. I don't know which Family Member it was; I've never seen them before except the night R1 passed and to get R1's stuff. I told the nurse, V10, that the family member was saying money was missing. On 7/16/26 at 9:42am V20 Regional Financial Coordinator stated, I haven't heard about this \$500 issue until you guys (IDPH) started investigating this. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility's abuse investigation dated 4/15/26 of R8's abuse investigation packet states, At approximately 0230 on 04/09/2026 the administrator was made aware of a Certified Nursing Assistant (CNA) allegedly making physical contact with the resident involving resident R8. The facility's undated preliminary 24-hour Abuse Investigation Report completed by V16 Regional Director of Operations states, Resident was immediately assessed. V97 CNA was immediately suspended pending investigation. Investigation commenced and POA (Power of Attorney), MD (Medical Doctor), Ombudsman, and Local Police notified. Final report to follow. The facility's final investigation report dated 4/15/26 reveals an incomplete investigation. There is no interview for R8, two separate and different interviews by the same employee V66 CNA, an incomplete and unsigned interview of V105 Licensed Practical Nurse, and there was no police report number or report. On 7/23/26 at 10:05 AM, V16 stated, I called the police department, and they didn't find anything in that date range (4/8/26- 4/15/26). They said they had something on R8, but not for those dates. The facility's policy, Abuse Prevention and Reporting-Illinois, last reviewed 03/2026, states, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This will be done by implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent further occurrences. Internal Investigation: All incidents will be documented, whether or not abuse, neglect, retaliation, exploitation, mistreatment or misappropriation of property occurred, was alleged or suspected. Any incident or allegation involving abuse, neglect, exploitation, retaliation, mistreatment or misappropriation of resident property will result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. The Facility Abuse policy dated 3/2026 documents supervisors will monitor the ability of staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur. The Facility Abuse policy dated 3/2026 documents employees are required to report any incident, allegation or suspicion of potential abuse, neglect, retaliation, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. 3. R46's History and Physical dated 1/7/2026 documents R46 has a diagnosis of Right Hip Fracture, Osteoporosis, Gastro-Esophageal Disease, Hypertension, and Hyperlipidemia. R46's MDS dated [DATE] documents R46 as cognitively intact. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/2026 at 8:15 AM, R46 stated R46 went out to lunch on 4/3/2026 and when returned to the facility, R46 asked V75 (Licensed Practical Nurse, LPN) for pain medicine. R46 stated V75 grabbed R46's arm, yelled an accusation at R46 about being drunk, and pulled R46 to R46's room and slammed the door. R46 stated this made R46 feel helpless, humiliated and scared. R46 stated it hurt. On 7/17/2026 at 9:35 AM, V83 (CNA) stated V83 witnessed an incident that involved R46 and V75 (LPN). V83 stated V75 yelled at R46 about being drunk and refused to give R46 their medications. V83 stated V83 saw R46 and V75 walking towards R46's room, V75 pushing R46 into the room and slamming the door. V83 stated V75 was aggressive and rude to R46. V83 stated V83 did not report this incident to anyone at the time it happened. On 7/22/2026 at 11:00 AM, V95 (Receptionist) stated on 4/3/2026, R46 returned to the facility from an outing. R46 was in the dining room and V75 approached R46 yelling and accusing R46 of being drunk. V75 grabbed R46's arm and snatched them up like a child and stood R46 up and yelled in R46's face. V75 forced R46 to their room. V95 stated V95 reported the incident at the time it happened to a nurse but is unable to recall who. The facility abuse investigation report dated 4/6/2026 documents the Administrator was notified of the allegation of abuse on 4/6/2026 at 9:00 AM. On 7/21/2026 at 1:30 PM, V21 (Social Service Director) stated V1 (Administrator) instructed V21 to back date R46's Psychosocial Assessments for 4/3, 4/4, and 4/5. R46's Psychosocial Assessments dated 4/3/2026 has an original date of entry on 4/7/2026 and documents R46 reported a physical abuse allegation against a staff member. R46's Psychosocial assessment dated [DATE] has an original date of entry on 4/7/2026 and documents R46 reported a physical abuse allegation yesterday by a staff member. R46's Psychosocial assessment dated [DATE] has an original date of entry on 4/7/2026 and documents R46 reported an allegation of physical abuse Friday afternoon. R46 is able to recall the incident that occurred. R46's Psychosocial assessment dated [DATE] has an original date of entry on 4/7/2026 and documents R46 reported allegation of physical abuse. The timecard for V75 (LPN) recorded on 4/3/2026 to 4/6/2026 documents V75 worked in the facility on 4/3/2026 from 1:38 PM to 4/4/2026 at 6:21 AM (double shift), on 4/4/2026 from 1:43 PM to 4/5/2026 at 5:06 AM (double shift), and on 4/5/2026 at 1:43 PM to 9:11 PM. V75 continued to work in the facility providing resident care for 3 days before V75 was suspended on 4/6/2026. On 7/21/2026 at 2:04 PM, V1 (Administrator) stated V1 was not aware of the allegation of abuse on 4/3/2026 and was not notified until 4/6/2026. R46's Progress Note dated 4/7/2026 documents R46 made an allegation of abuse from a staff (continued on next page)		

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member on 4/3/2026. V75's Corrective Action Plan dated 4/13/2026 documents an allegation of abuse was made against V75. After an investigation was conducted, it was determined that the allegation was founded. The facility cited Appendix A #7 of the Collective Bargaining Agreement that states physical or verbal abuse, neglect, or attempting to injure residents or other person results in discharge. Per this Corrective Action Plan, V75 was terminated 4/13/2026.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders for 2 of 2 residents (R2 and R5) reviewed in the sample list of 121 for physician-order implementation. The facility failed to administer R5's intravenous antibiotic at the ordered frequency and failed to follow R2's orders for Midodrine administration and management of a 1,500-milliliter daily fluid restriction. These failures placed R5 at risk for ineffective treatment of an acute infection and placed R2 at risk for medication-related adverse effects and complications associated with improperly managed fluid intake. 1. R2 Review of R2's clinical record showed diagnoses that included end-stage renal disease requiring dialysis, heart failure, essential hypertension, and hypotension. Review of R2's physician orders showed an order for Midodrine HCl 2.5 milligrams by mouth in the morning for hypotension. The order directed staff to give the medication before dialysis and send one tablet with R2 to dialysis on Monday, Wednesday, and Friday. The order further directed staff to hold the medication when R2's systolic blood pressure was greater than 130 mmHg. Review of R2's Medication Administration Record showed Midodrine was administered on 7/11/26 when R2's blood pressure was 168/70 mmHg. R2's systolic blood pressure was 38 mmHg above the physician-ordered hold parameter. Review of R2's Medication Administration Record showed that Midodrine was administered again on 7/14/26 when R2's blood pressure was 140/76 mmHg. R2's systolic blood pressure was 10 mmHg above the physician-ordered hold parameter. Review of R2's Medication Administration Record showed that Midodrine was administered on 7/21/26 when R2's blood pressure was 168/89 mmHg. R2's systolic blood pressure was 38 mmHg above the physician-ordered hold parameter. The facility administered Midodrine to R2 on three occasions when R2's systolic blood pressure exceeded the physician-ordered hold parameter. Review of R2's physician orders showed an order for a no-added-salt diet, regular texture, thin liquids, and a 1,500-milliliter daily fluid restriction, with 1,000 milliliters allotted to dietary and 500 milliliters allotted to nursing. On 7/15/26 at 3:45 PM, V45 stated Certified Nursing Assistants were expected to report residents' fluid intake to the nurses and document intake in the point-of-care tasks. After reviewing R2's documentation, V45 confirmed R2's oral intake was not being monitored or documented and that only output from R2's indwelling urinary catheter was documented. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V42 stated that dietary staff did not monitor R2's total fluid intake. V42 stated R2 was alert and oriented and that R2's family visited daily and monitored the fluid restriction. On 7/15/26 at 3:55 PM, V2, Director of Nursing, stated that Certified Nursing Assistants were responsible for reporting and documenting resident intake and output in the point-of-care tasks. V2 stated an alert and oriented resident or the resident's family could monitor a fluid restriction. V2 stated they were not aware of any residents or family members who were independently monitoring residents' total intake and output. On 7/15/26 at 4:02 PM, V71, Assistant Dietary Manager, stated dietary staff used resident meal tickets to identify restrictions. V71 stated water was omitted from a resident's meal tray when the resident had a fluid restriction and the red cups provided on meal trays held eight ounces. On 7/16/26 at 2:40 PM, V70 stated nursing staff did not monitor R2's total oral intake because there was no separate order directing staff to monitor intake. V70 stated the facility monitored only R2's urinary-catheter output and that dietary staff determined the amount of fluid placed on R2's meal trays. V70 stated R2 received morning medications with a four-ounce health shake and no additional water. V70 stated Certified Nursing Assistants were expected to document intake consumed with meals. On 7/21/26 at 12:25 PM, V89, Registered Nurse at R2's dialysis center, stated R2 routinely arrived for dialysis with Midodrine sent by the facility. V89 stated the medication was frequently not administered at dialysis because R2's blood pressure was elevated and did not meet the physician-ordered parameters for administration. On 7/24/26 at 2:22 PM, V112, Medical Doctor, stated the facility was expected to monitor all of R2's oral intake and not only the fluids consumed during meals. V112 stated if the facility did not monitor all oral intake, staff should, at minimum, monitor R2's weight one to two times per week. V112 stated a three-pound weight loss within three days would be concerning for dehydration. V112 stated the facility was not following physician orders by failing to monitor R2's total oral intake and by administering medication when R2's blood pressure was outside the physician-ordered parameters. The facility failed to follow R2's physician orders by administering Midodrine on three occasions when R2's systolic blood pressure exceeded the ordered hold parameter and by failing to measure, monitor, and document R2's total oral intake in accordance with the physician-ordered 1,500-milliliter daily fluid restriction. 2. R5 On 7/23/2026 at 2:00PM, record review of R5's progress note dated 3/22/2026 documents, CNA reported decreased urinary output and R5 was sent to a local hospital for further evaluation. R5 was admitted for acute pyelonephritis and returned to the facility on 3/30/2026 with a new order for ceftazidime 2 grams to be administered every eight hours for seven days and a midline. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/2026 at 2:10 PM, record review of R5's physician orders documents an order for ceftazidime intravenous solution reconstituted 2 GM (Ceftazidime) Use two grams three times a day related acute pyelonephritis (N10) until 4-6-2026. On 7/23/2026 at 2:13PM, record review of R5's medication administration record documents on 3/31/2026 at 7:39 AM Ceftazidime two gram was given by V92 LPN. On 3/31/2026 at 7: 23 PM Ceftazidime two gram was given by V45 RN. On 3/31/2026 at 11:55 PM Ceftazidime two gram was given by V109 RN. On 4/1/2026 at 7:36 AM Ceftazidime two gram was given by V60 RN. On 4/1/2026 at 2:55 PM Ceftazidime two gram was given by V60 RN. On 4/1/2026 at 10:51 PM Ceftazidime two gram was given by V45 RN. On 4/2/2026 at 7:14 AM Ceftazidime two gram was given by V92 LPN. On 4/2/2026 at 7:48 PM Ceftazidime two gram was given by V45 RN. On 4/3/2026 at 1:08 AM Ceftazidime two gram was given by V5 LPN. On 4/3/2026 at 7:27 AM Ceftazidime two gram was given by V60 RN. On 4/3/2026 at 12:52 PM Ceftazidime two gram was given by V60 RN. On 4/3/2026 at 4:31 PM R5's progress note documents at 1600 CNA reported to writer that this resident had pulled out his SP Cath. vs 120/70 98.4 70 18 98% bs 120. area cleansed no blood noted res combative and striking out at staff he denies pain call placed to POA made aware also Primary made aware report called to ER to give report, and given ER charge [NAME]. On 4/3/2026 at 9:29 PM R5's progress note documents resident returned from MMC at 2100 with SP Cath replaced. No additional orders noted. On 4/4/2026 at 1:48 AM Ceftazidime two gram was given by V5 LPN. On 4/4/2026 at 7:03 AM Ceftazidime two gram was given by V110 LPN. On 4/4/2026 4:18 PM Ceftazidime two gram was give by V5 LPN. On 4/4/2026 at 11:48 PM Ceftazidime two gram was given by V5 LPN. A review of R5's location of administration record documents the medication was administered on 3/31/2026 at 7:23 PM, the medication was ordered to be given at 4:00PM. A review of R5's location of administration record documents the medication was administered on 4/02/2026 at 7:48 PM, the medication was ordered to be given at 4:00PM. A review of R5's location of administration record documents the medication was administered on 4/03/2026 at 12:52 PM, the medication was ordered to be given at 4:00PM. (continued on next page)		

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

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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 07/27/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R5's location of administration record documents the medication was administered on 4/05/2026 at 11:34 AM, the medication was ordered to be given at 8:00AM. A review of R5's location of administration record documents the medication was administered on 4/06/2026 at 1:03 PM, the medication was ordered to be given at 4:00PM. On 7/24/26 at 2:22 PM, V112, Medical Doctor, stated that he would expect the facility to follow physician orders as written. The facility's policy titled Medication Administration Policy dated 01/2015 documents II. Medications must be administered in accordance with a physician's order e.g. right resident, right medication, right dosage, right route, right time.		