

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Arcadia Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 North Calhoun Street Bloomington, IL 61701	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380</p> <p>Based on interview and record review, the facility failed to transfer a resident (R3) with a mechanical lift with two people for one of three residents reviewed for falls in the sample list of three.</p> <p>Findings include:</p> <p>R3's Diagnosis list dated 7/31/24, documents R3's diagnoses as: Muscle Weakness, other abnormalities of Gait and Mobility, Difficulty Walking not elsewhere classified, Weakness, Osteoarthritis, unspecified site, and Morbid (severe) Obesity due to excess calories.</p> <p>R3's Clinical Summary dated 3/22/24, documents R3 has unsteady gait requiring supervision, requires substantial/maximal assist of a mechanical lift, and is dependent for chair/bed to chair transfers.</p> <p>R3's Fall Risk assessment dated [DATE], documents R3 has had 1-2 falls in the past three months, is chair bound, and not able to perform gait/balance assessment.</p> <p>R3's Care Plan dated 3/22/24, documents R3 requires a mechanical lift with two person assist to transfer between surfaces.</p> <p>R3's Witness Fall Report dated 5/18/24, documents: R3 attempted self-transfer, R3 lowered to ground by V5 Certified Nursing Assistance (CNA) when R3's knees gave out; R3 refused mechanical lift and told V5, who is not familiar with R3, that R3 did not need to use a mechanical lift. V5's statement on this fall report documents per V5: I (V5) do not work on 200 hall, V5 is always on 300 hall; V5 was assisting staff on 200 hall by answering R3's call light; R3 asked V5 to get R3 up from the bed; V5 sat R3 on the edge of the bed and got R3 dressed; when it was time to transfer R3 yelled R3 did not need to use a mechanical lift; V5 documented V5 has never worked with R3 before and V5 believed R3 not needing a mechanical lift to transfer; R3 refused a walker; V5 went to transfer R3 by letting R3 stand with V5's assist and R3's knees gave out and V5 lowered R3 to the floor.</p> <p>On 8/1/24 at 2:00 PM, V4 Licensed Practical Nurse (LPN) stated V5 CNA should have known how to care for R3 when answering R3's call light. V4 stated one cannot always believe what the resident's are telling the staff. V4 stated V5 should have used the mechanical lift for R3 because R3 is not supposed to be transferred without a mechanical lift.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Arcadia Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 North Calhoun Street Bloomington, IL 61701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 2:14 PM, V2 Director of Nursing (DON) stated V5 CNA is the primary CNA on hall 300 and was helping on hall 200. V2 stated V5 should have looked up what type of transfer R3 was supposed to be using. V2 stated V5 did not know R3, was not familiar with R3 and not aware of how to transfer R3.</p> <p>The facility's CNA job description dated Revised 7/2023, documents the primary purpose of a CNA is to provide residents with nursing and personal care to safeguard the health, safety, and welfare of all residents in accordance with the facility's established policies and procedures.</p> <p>The facility's Fall Prevention Program policy dated Revised 5/2022, documents this policy is to ensure the safety of all residents in the facility which includes assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices utilized as necessary.</p>		