| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145371 | A. Building<br>B. Wing | 01/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Arcadia Care Bloomington | 1509 North Calhoun Street<br>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) |
|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682<br><br>Based on observation, interview, and record review the facility failed to maintain residents' privacy while in their rooms from one resident (R1) who has wandering behaviors. This failure has the potential to affect 18 of 20 residents (R3-R20) reviewed for resident rights in the sample of 20.<br><br>Findings include:<br><br>The Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities policy dated 11/2018 documents, Your rights to safety: Your facility must be safe, clean, comfortable, and homelike. You have the right to privacy.<br><br>R1's MDS ((Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired and exhibits physical, verbal, and other behaviors directed towards others, that puts R1 and others at risk for physical illness or injury, and significantly intrudes on the privacy and activity of others. This same MDS also documents R1 wanders daily, and the wandering significantly intrudes on the privacy or activities of others.<br><br>R1's Psychiatry Progress Note dated 12-17-24 documents, (R1) is calm and wanders the unit. (R1) is intrusive at times. (R1) is nonsensical (makes no sense).<br><br>R1's Nursing Note dated 12-28-2024 at 10:00 AM documents, CNA (Certified Nursing Assistant) reports (R1) having aggressive behaviors towards others, walking in and out of other resident's bedrooms, touching and picking up others' belongings. Difficult to re-direct at times with aggressive behaviors towards staff. (R1) refusing cares.<br><br>R1's Behavior Note dated 12-28-2024 at 12:57 PM and signed by V9 (LPN/Licensed Practical Nurse) documents, (R1) has been wandering into other resident's room and messing with their belongings, causing behaviors. (R1) has been redirected by staff several times; unsuccessful.<br><br>R1's Behavior Note dated 12-28-2024 at 12:50 PM and signed by V9 (LPN) documents, (R1) had altercation with roommate (R2). Both residents were separated and moved to different room to prevent any future altercations.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R1's Behavior Note dated 12-30-2024 at 10:49 AM and signed by V7 (LPN) documents, I (V7) was down in the activity room on 300 when I heard a CNA yelling out for help. When I went out I noted her (CNA/V8) in (R3's) room with (R1). (V8) was trying to pry (R1) off of the other resident (R3). (R1) had been wondering the halls and (V8) stated that (R1) had went into (R3's) room and went for (R3). When I made it into the room, (R1) had a tight grip on (R3's) legs and was hitting (R3's) leg with (R1's) left arm. I was able to grab (R1's) arm and with the help of (V8), get the other arm loose. (R1) was pushing back but I was able to get (R1) out of the room. I redirected (R1) back into his room and stayed with him. (R1) was then kept 1:1 care.<br><br>R1's Nursing Note dated 12-30-2024 at 2:55 PM documents, (R1) continues to roam hallway on 300 going in and out of rooms. Staff trying their best to re-direct. (R1) was showing signs of agitation towards staff leading him out of rooms. (R1) given prn (as needed) Ativan. It has not been effective so far after first dose.<br><br>On 1-24-25 from 10:00 AM to 10:20 AM and 12:05 PM to 12:25 PM R1 was wandering aimlessly up and down the hallways of a unit secured by a door that requires a code to open.<br><br>On 1-25-25 at 10:20 AM R1 was wandering aimlessly up and down the hallways of a unit secured by the door that requires a code to open.<br><br>On 1-24-25 at 9:55 AM R4 stated, (R1) comes in my room all the time. I think (R1) is just mental. I don't like him coming in here anytime he pleases.<br><br>On 1-24-25 at 9:58 AM R5 stated, Sometimes a strange man just comes into my room.<br><br>On 1-24-25 at 10:05 AM V4 (CNA) stated, (R1) wanders in and out of all of the resident rooms on this unit and sometimes is very hard to re-direct.<br><br>On 1-24-25 at 10:08 AM V5 (CNA) stated, (R1) wanders all over and in resident rooms. (R4) does not like when (R1) comes into his room. (R4) will yell at (R1) to Get out! This is the wrong room!<br><br>On 1-24-25 at 10:45 AM V8 (CNA) stated, On 12-30-24 I heard (R3) yelling for help. I went into (R3's) room and (R1) was lying on top of (R3) on (R3's) bed. (R3) was trying to get out from under (R1). (R1) wanders into the other residents' rooms and is very hard to keep an eye on. There are too many residents for the staff we have to keep an eye on (R1) all the time. (R1) is not on one-on-one staff supervision.<br><br>On 1-24-25 at 11:20 AM V7 (LPN) stated, (R1) wanders in and out of other residents' rooms and can sometimes be hard to re-direct.<br><br>On 1-24-25 at 11:25 AM V9 (LPN) stated, (R1) goes in all of the residents' rooms. (R13) gets upset and does not like men in her room. (R13) will yell (R1) is in my room again! Get (R1) out! (R16) also gets scared whenever (R1) goes into her room. (R3 and R8) get really upset when (R1) is in their room.<br><br>On 1-24-25 at 12:00 PM V12 (CNA) stated, (R1) wanders all day long and goes in and out of the residents' rooms. There is not enough of us (staff) to watch (R1) all the time. (R3 and R8) get really upset when (R1) goes into their rooms. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682<br><br>Based on record review and interview the facility failed to prevent resident-to-resident verbal and physical abuse for three of three residents (R1, R2, R3) reviewed for Abuse in the sample of 20.<br><br>Findings include:<br><br>The facility's Abuse Prevention and Reporting policy dated 09/2024 documents, This facility affirms the right of our resident to be free abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental, and psychosocial well-being.<br><br>R1's Admission Record documents R1 was admitted to the facility on [DATE] with the diagnoses of Wernicke's Encephalopathy, Major Depressive Disorder, Anxiety Disorder, Epilepsy, and Alcohol Dependence.<br><br>R1's MDS ((Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired and exhibits physical, verbal, and other behaviors directed towards others, that puts R1 and others at risk for physical illness or injury, and significantly intrudes on the privacy and activity of others. This same MDS also documents R1 wanders daily, and the wandering significantly intrudes on the privacy or activities of others.<br><br>R2's Admission Record documents R2 was admitted to the facility on [DATE] with the diagnoses of Dementia with Severe Mood Disturbance, Major Depressive Disorder, and Alcohol Abuse.<br><br>R2's MDS assessment dated [DATE] documents R2 is moderately cognitively impaired.<br><br>R3's Admission Record documents R3 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease and Dementia with other Behavioral Disturbance.<br><br>R3's MDS assessment dated [DATE] documents R3 is moderately cognitively impaired.<br><br>R1's Nursing Note dated 12-28-2024 at 10:00 AM documents, CNA (Certified Nursing Assistant) reports (R1) having aggressive behaviors towards others, walking in and out of other resident's bedrooms, touching and picking up others' belongings. Difficult to re-direct at times with aggressive behaviors towards staff. (R1) refusing cares.<br><br>R1's Behavior Note dated 12-28-2024 at 12:57 PM and signed by V9 (LPN/Licensed Practical Nurse) documents, (R1) has been wandering into other resident's room and messing with their belongings, causing behaviors. (R1) has been redirected by staff several times; unsuccessful.<br><br>(continued on next page) |

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R1's Behavior Note dated 12-28-2024 at 12:50 PM and signed by V9 (LPN) documents, (R1) had altercation with roommate (R2). Both residents were separated and moved to different room to prevent any future altercations.<br><br>R1's Incident Follow-Up Note dated 12-28-2024 at 12:42 PM documents, (R1) threw a TV remote at roommate (R2).<br><br>R1 and R2's Final Abuse Investigation Report dated 1-3-25 documents, Facts determined: 3. On 12-28-24 at 12:48 PM, (CNA) and nurse reported an allegation of Physical Abuse of (R1). CNA witnessed roommates (R1) on (R2's) side of the room. (R2) was yelling that (R1) threw a TV remote at him, so (R2) stated he punched (R1) in the arm.<br><br>R1's Behavior Note dated 12-30-2024 at 10:49 AM and signed by V7 (LPN) documents, I (V7) was down in the activity room on 300 when I heard a CNA yelling out for help. When I went out I noted her (CNA/V8) in (R3's) room with (R1). (V8) was trying to pry (R1) off the other resident (R3). (R1) had been wondering the halls and (V8) stated that (R1) had went into (R3's) room and went for (R3). When I made it into the room, (R1) had a tight grip on (R3's) legs and was hitting (R3's) leg with (R1's) left arm. I was able to grab (R1's) arm and with the help of (V8), get the other arm loose. (R1) was pushing back but I was able to get (R1) out of the room. I redirected (R1) back into his room and stayed with him. (R1) was then kept 1:1 care.<br><br>R3's Incident Note dated 12-30-2024 10:23 AM and signed by V1 (Administrator) documents, Another resident (R1) was observed going into (R3's) room. (R1) became physically aggressive with (R3).<br><br>R1 and R3's Final Abuse Investigation Report dated 1-3-25 documents, On 12-30-24 at 9:00 AM, CNA and nurse reported an allegation of physical abuse of (R1). CNA witnessed (R1) going into (R3's) room. (R1) was witnessed by staff grabbing (R3's) legs while he was lying in bed.<br><br>On 1-24-25 at 10:45 AM V8 (CNA) stated, On 12-30-24 I heard (R3) yelling for help. I went into (R3's) room and (R1) was lying on top of (R3) on (R3's) bed. (R3) was trying to get out from under (R1).<br><br>On 1-24-25 at 11:20 V7 (LPN) stated, On 12-30-24 (R1) was in (R3's) room and was pulling on (R3's) legs very aggressively. (R3) was yelling for help.<br><br>On 1-24-25 at 12:00 PM V12 (CNA) stated, On 12-28-24 I heard yelling and cussing from (R1 and R2's) room. I went in the room and (R1 and R2) were sitting on their beds facing each other. (R2) yelled at (R1) If you take my stuff again you stupid mother- f****r I'll punch you! I'll f**k you up! (R2) then punched (R1) in the left arm. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682<br><br>Based on record review and interview the facility failed to follow their Abuse Policy to update the care plan and implement approaches to safely monitor and increase supervision of a resident with a history of aggressive behaviors to prevent resident-to-resident abuse for three of three residents (R1, R2, R3) reviewed for Abuse in the sample of 20.<br><br>Findings include:<br><br>The facility's Abuse Prevention and Reporting policy dated 09/2024 documents, This facility affirms the right of our resident to be free abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS (Minimum Data Set) Assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma, or misappropriation of property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor for goals and approaches on a regular basis and update as necessary. Staff Supervision: Supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual care needs. Protections of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other resident and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents, including, but not limited to, the separation of the residents.<br><br>R1's Admission Record documents R1 was admitted to the facility on [DATE] with the diagnoses of Wernicke's Encephalopathy, Major Depressive Disorder, Anxiety Disorder, Epilepsy, and Alcohol Dependence. This same record documents R1 has a history of aggression.<br><br>R1's MDS ((Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired and exhibits physical, verbal, and other behaviors directed towards others, that puts R1 and others at risk for physical illness or injury, and significantly intrudes on the privacy and activity of others. This same MDS also documents R1 wanders daily, and the wandering significantly intrudes on the privacy or activities of others.<br><br>R2's Admission Record documents R2 was admitted to the facility on [DATE] with the diagnoses of Dementia with Severe Mood Disturbance, Major Depressive Disorder, and Alcohol Abuse.<br><br>R2's MDS assessment dated [DATE] documents R2 is moderately cognitively impaired.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R3's Admission Record documents R3 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease and Dementia with other Behavioral Disturbance.<br><br>R3's MDS assessment dated [DATE] documents R3 is moderately cognitively impaired.<br><br>R1's Nursing Note dated 12-28-2024 at 10:00 AM documents, CNA (Certified Nursing Assistant) reports (R1) having aggressive behaviors towards others, walking in and out of other resident's bedrooms, touching and picking up others' belongings. Difficult to re-direct at times with aggressive behaviors towards staff. (R1) refusing cares.<br><br>R1's Behavior Note dated 12-28-2024 at 12:57 PM and signed by V9 (LPN/Licensed Practical Nurse) documents, (R1) has been wandering into other resident's room and messing with their belongings, causing behaviors. (R1) has been redirected by staff several times; unsuccessful.<br><br>R1's Behavior Note dated 12-28-2024 at 12:50 PM and signed by V9 (LPN) documents, (R1) had altercation with roommate (R2). Both residents were separated and moved to different room to prevent any future altercations.<br><br>R1's Incident Follow-Up Note dated 12-28-024 at 12:42 PM documents, (R1) threw a TV remote at roommate (R2).<br><br>R1 and R2's Final Abuse Investigation Report dated 1-3-25 documents, Facts determined: 3. On 12/28/24 at 12:48 PM, (CNA) and nurse reported an allegation of Physical Abuse of (R1). CNA witnessed roommates (R1) on (R2's) side of the room. (R2) was yelling that (R1) threw a TV remote at him, so (R2) stated he punched (R1) in the arm.<br><br>R1's Behavior Note dated 12-30-24 at 10:49 AM and signed by V7 (LPN) documents, I (V7) was down in the activity room on 300 when I heard a CNA yelling out for help. When I went out noted her (CNA/V8) in (R3's) room with (R1). (V8) was trying to pry (R1) off the other resident (R3). (R1) had been wondering the halls and (V8) stated that (R1) had went into (R3's) room and went for (R3). When I made it into the room, (R1) had a tight grip on (R3's) legs and was hitting (R3's) leg with (R1's) left arm. I was able to grab (R1's) arm and with the help of (V8), get the other arm loose. (R1) was pushing back but I was able to get (R1) out of the room.<br><br>R3's Incident Note dated 12-30-2024 10:23 AM and signed by V1 (Administrator) documents, Another resident (R1) was observed going into (R3's) room. (R1) became physically aggressive with (R3).<br><br>R1's Nursing Note dated 12-30-2024 at 10:00 AM documents, Spoke with (V11/Nurse Practitioner) regarding (R1's) behaviors. Received orders for (R1) to be on 1:1 (one-on-one) monitoring, Ativan orders singed by (V11). OK to send (R1) out to the hospital for evaluation if needed.<br><br>R1's Nursing Note dated 1-2-25 documents R1's one-on-one monitoring was discontinued, and new orders were received to monitor R1 every 15 minutes.<br><br>R1's Care Plan dated 12-28-24 (date of first resident-to-resident altercation) to 1-25-25 does not include R1's ordered interventions to increase supervision to one-on-one and then to 15 minutes checks to prevent further altercations.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1-24-25 at 10:45 AM V8 (CNA) stated, On 12-30-24 I heard (R3) yelling for help. I went into (R3's) room and (R1) was lying on top of (R3) on (R3's) bed. (R3) was trying to get out from under (R1). (R1) did not have any interventions to increase supervision at this time. There is not enough of us to watch (R1) closely all the time.<br><br>On 1-24-25 at 11:20 V7 (LPN) stated, On 12-30-24 (R1) was in (R3's) room and was pulling on (R3's) legs very aggressively. (R3) was yelling for help. (R1) was not being monitored by one-on-one staff.<br><br>On 1-25-25 at 1:00 PM V15 (Care Plan Coordinator) stated R1's care plan was never updated with the orders for increased supervision of one-on-one supervision or 15-minute checks. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>31682<br><br>Based on observation, interview, and record review the facility failed to implement an ongoing program of activities daily and record the residents' attendance and levels of participation in activities, as instructed by the facility's Activities Program policy, for 19 of 20 residents (R1, R3-R20) reviewed for Activities in the sample of 20.<br><br>Findings include:<br><br>The facility's Activities Program policy dated 03/2024 documents, Purpose: To provide an ongoing program of activities designated to appeal to the residents' interests and to enhance his or her highest practicable level of physical, mental, and psychosocial well-being. Guidelines: The Activity Director, trained staff, or volunteer will: 1. Identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs. 3. A minimum of four-seven organized activities will be scheduled daily. 4. Provide programs for residents who will not, or cannot, effectively plan their own activities pursuits. 5. Provide for residents needing specialized or extended programs to enhance their overall daily routine and activity pursuit needs. 6. The program of activities will include a combination of large and small groups, one-to-ones, and self-directed activities. 7. The program of activities will include a system that allows the activity staff to develop, implement, and evaluate the resident's interested and involvement in the activities provided and adjust the daily programming as needed in order to meet the needs of the residents. Activity Participation Records: The activity staff shall record resident's activity attendance and participation on a daily basis. The system used will record the activity attended, the resident's level of participation and whether the resident was invited to the activity but declined the invitation or had a conflict and was not available. Make use of attendance records as date for summary within resident activity assessments and/or progress notes.<br><br>The facility's Diagnoses Report dated 1-25-25 documents all residents who reside on the 300-hallway (memory care unit) have a diagnosis that causes memory impairment.<br><br>The facility's Activity Calendars dated 12-1-24 through 1-31-25 do not document any scheduled activities being offered after 3:00 PM daily, and no scheduled activities on Sundays.<br><br>R1 and R3-R20's Medical Records do not include activity attendance or level of participation in activities.<br><br>On 1-24-25 from 10:00 AM to 10:20 AM and 12:05 PM to 12:25 PM R1 was wandering aimlessly up and down the hallways of a unit secured by a door that requires a code to open. R3-R20 were in their rooms during this time and no activities were being offered on this unit.<br><br>On 1-25-25 at 10:20 AM R1 was wandering aimlessly up and down the hallways of a unit secured by the door that requires a code to open. R3 was in the hospital during this time. R4-R20 were in their rooms during this time and no activities were being offered on this unit.<br><br>On 1-24-25 at 9:55 AM R4 stated, I just watch TV. There is not anything else to do.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Arcadia Care Bloomington | 1509 North Calhoun Street<br>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) |
|---|---|
| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1-24-25 at 10:05 AM V4 (CNA/Certified Nursing Assistant) stated, Activities do not come to this hallway. There are only two of us CNA's. We (CNAs) do not have time to do activities with the residents. No activities have been offered today.<br><br>On 1-24-25 at 11:25 AM V9 (LPN/Licensed Practical Nurse) stated, There are no activities offered on this unit (memory care unit). I work 7:00 AM to 7:00 PM and there are never any second shift activities either. The CNAs do not have time to do activities with the residents. The residents on this unit need some sort of activities to keep them busy.<br><br>On 1-24-25 at 12:00 PM V12 (CNA) stated, There is usually only two CNAs on this unit, and we have no time to do activities with the residents. We have been telling management this for months. We need help. (R1) keeps us busy all day. The activity department does not even come down to this hallway to do activities. The residents did not get any activities today.<br><br>On 1-24-25 at 1:45 PM V13 (Social Service Director) stated, I just started covering activities yesterday. I know there were no activities offered on the 300-hallway (memory care unit) today.<br><br>On 1-25-25 at 11:15 AM V14 (Former Activity Director) stated, My last day as the activity director was December 6, 2024. When I was activity director, I never tracked the residents' activity attendance or activity interests/needs. On the 300-hallway there was maybe two activities offered a day at times. There were never any activities offered on second shift. |