STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145371	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Bloomington	1509 North Calhoun Street Bloomington, IL 61701

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34058 Based on observation, interview, and record review, the facility failed to maintain a sanitary, homelike, and comfortable environment in, shower rooms, resident rooms, and a dining room. These failures affect thirteen residents (R2, R8, R11, and R19 through R28) utilizing the shower room on the 100 Hall, nineteen residents (R4, R6, R7, R10, R12, and R29 through R42) utilizing the shower room on the 300 Hall Dementia Unit, seven residents (R3 and R13 through R18) who usually have meals in the small dining room, one resident (R6) with a hole in the drywall and missing paint in her room, and one resident (R12) with a padded floor mat adhered to the floor by food debris next to her bed. all from a total facility census of 83. Findings include: 1. On 2/18/25 at 2:25 PM, R6's room had an outside corner adjacent to the bathroom door which was missing paint in an area two inches wide by four feet high on both sides of the corner where there had previously been a plastic corner protector, along with a patch of missing paint approximately one foot vertical by seven inches horizontal, obviously torn away from the wall in the process of the corner protector being removed from the wall. There was a one and one quarter inch diameter hole in the wall next to the roommate's unoccupied bed. The roommate's bed was missing the mattress. There was an area on the wall next to the roommate's bed approximately three feet by three feet which had deep scratches of missing paint and exposed drywall which appeared to be caused by the bed being raised and lowered over time. R6 stated she had spoken to a state guy last week (Ombudsman) who was trying to arrange for a different facility to live in because of the multiple problems in her room. On 2/19/25 at 2:45 PM, V16, Maintenance Director, stated he had accompanied a bank appraiser on a comprehensive tour of the facility and had knowledge of many area of the facility that are missing paint and had black wheelchair scuff marks on the walls and doors in the hallways and resident rooms. V16 further stated he tried to keep up with the smaller maintenance items and does get some extra stuff done. V16 stated the facility was waiting to hear back from the bank and to get some corporate direction on fixing more of the problems. V16 continued to say that the building is in mostly original construction and there was a whole lot with this building that needs fixed. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 2/18/25 at 2:50 PM, the common shower room on the 300 Hall was notably cold and had a continuous stream of water emitting from the shower head. The floor to wall junction of the shower stall area had a blackened substance along the junction and on the wall portions approximately eighteen inches up from the floor in the corner and sloping downwards extending out to a point approximately seven feet from the inner corner of the shower stall area into the shower room proper behind the tub fixture. There was blackened substance and reddish pink gelatinous slimy substance along the plastic shower chair legs and cross bars between the legs. On 2/19/25 at 1:15 PM, R10 beckoned (surveyor) to come look at the 300 Hall shower room. R10 was pointing to the blackened areas in the shower stall area and said, Look at all that black stuff on the walls, I have asked them many times to get rid of that but it isn't gone, this is an atrocity, this is mildew, do you know what that can do to people? On 2/19/25 at 2:45 PM, V16 stated he was aware of the condition of the shower rooms in the facility. V16 stated he had one of the Housekeepers (V20) scrub the 300 Hall shower room wall in the shower stall area and a lot of it had been cleaned just prior to this tour and interview. V16 stated what was left he would probably have to go in and clean himself. V16 reached down to scrape at one of the remaining blackened areas and stated he thought it was soap scum. V16 stated he was familiar with the pink slimy gelatinous substance as he had previously encountered it in some plastic tubing from a drain. The facility's Resident Roster dated 2/13/25 documents R4, R6, R7, R10, R12 and R29 through R42 reside on the facility's 300 Hall and utilize the shower room on this hallway. 3. On 2/19/25 at 1:07 PM, the common shower room on the 100 Hall had a constant dripping of water from the shower head. There was a crack in the tile grout approximately one-quarter inch wide in the corner of the shower stall area from the floor upwards approximately four feet vertical, allowing water to penetrate behind the wall. On 2/19/25 at 2:45 PM, V16 stated the 100 Hall shower room could not be examined due to a resident being in the shower at that time. V16 stated he had seen the very wide area of caulking in the corner of the 300 Hall shower room, in the exact position as the crack in the 100 Hall shower room, so he could picture where the crack would be for the 100 Hall shower room. The facility Resident Roster dated 2/13/25 documents R2, R8, R11 and R19 through R28 reside on the facility's 100 Hall and utilize the shower room on this hallway. 4. On 2/18/25 at 10:25 AM, the small dining room directly across the hall from the central nursing station was notably cold and there was food crumb debris on the tables and floor, as well as small areas of dried food smears on the floor. There were three bath blankets folded and placed along the window sills. 2:45 PM, V16 stated he was aware of the cold temperature in the small dining room. V16 extended a hand to the lower portions of the window sill and stated there was a draft coming in along the sill. V16 explained that someone in the past had placed a wide (approximately six inches wide) sticky tape to seal out the draft, but over time the tape had lost stickiness and was no longer effective. V16 stated the staff had placed the bath blankets along the sill in an attempt to block out some of the draft. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/19/25 at 3:30 PM, using a Public Health automatic calibration digital thermometer, the small dining room measured in the 55 to 56 degree Fahrenheit range along the window sill. Using the same thermometer, the entrance doorway to this small dining room, approximately twelve feet away from the window, measured in the 65 to 66 degree Fahrenheit range. On 2/20/25 at 11:30 AM, V3, Licensed Practical Nurse, identified the residents who usually eat in the small dining room as R3, R13, R14, R15, R16, R17, and R18. V3 stated these residents did not want to continue to eat in the small dining room because of the cold temperature and had been eating in their rooms. V3 stated each of these residents required verbal cues and supervision during meals. V3 stated there had been some plastic placed over the window in the small dining room last year but had not been placed this year. On 2/20/25 at 12:50 PM, R11, speaking with V18, Social Services Director, stated he thought it was good that there weren't any residents eating in the small dining room because it was very cold. V18 concurred and said she could feel the cold just walking by the small dining room. Throughout the course of the survey on 2/13/25, 2/18/25, 2/19/25, and 2/20/25 approximately half of the direct care staff were wearing long sleeve jackets or coats, and two employees were wearing ear muffs and making complaints about the cold temperature in the hallways. The conference room occupied by (survey team) also measured in the 65 to 66 degree Fahrenheit range. V16 was observed at various locations in the hallways and the conference room using an infrared thermometer to check temperatures at heating outlets and making statements such as this one is just blowing cool return air. On 2/20/25 at 1:15 PM, V16 stated he had found a large piece of material against the surface of the heating unit on the roof which supplies heat to the conference room. The measured temperature did not change in the conference room. 5. On 2/18/25 at 2:40 PM, there was a padded floor mat next to the bed of R12. This floor mat was adhered to the floor and took a considerable amount of effort to lift a corner of the mat. There was dried food debris and smears under the mat. On 2/18/25 at 2:45 PM, V20, Housekeeper, stated she had not noticed the floor mat was stuck in place and had not been trained to clean underneath mats. On 2/19/25 at 2:45 PM, V16 stated he had just become aware of the mat in R12's room being stuck on the floor. On 2/20/25 at 2:08 PM, V16 was in process of replacing twelve vinyl one foot square tiles on the floor next to R12's bed. V16 stated that pulling up the floor mat had damaged the tiles so that they needed to be replaced.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50430 Based on interview and record review, the facility failed to protect the residents right to be free from mental and emotional abuse. This failure affects one (R1) resident out of three residents reviewed for abuse in the sample of 43. Findings include: The facilities Abuse Prevention and Reporting policy effective 9/2024 documents mental abuse is the use of verbal or nonverbal conduct which causes, or has the potential to cause, the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. When an allegation of abuse, exploitation, neglect, or mistreatment has occurred the Department of Public Health shall be informed by telephone or fax. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively impaired. R1 was unable to complete a brief interview for mental status and required a staff assessment indicating R1 experiences inattention and disorganized thinking, long term and short term memory problems, unable to recall staff faces, location of R1's room and the seasons. R1's Comprehensive Incident Fall assessment dated [DATE] at 10:30 PM documents R1 sustained a witnessed fall coming out of the shower room into the hallway. On 2/13/25 at 1:40 PM, V8 Licensed Practical Nurse, stated (on 1/28/25) she saw R1 stumbling backwards out of the shower room door into the hallway attempting to reach the grab bar on the hallway wall and fell on the floor. V8 stated V12, Certified Nursing Assistant, was standing in hallway watching R1 and was laughing hysterically. V8 further stated V12 did not attempt to stop R1 from falling or help R1 after he fell . On 2/18/25 at 10:30 AM, V2, Director of Nursing, stated that on 1/29/25 V2 came to work and witness statements from R1's fall on 1/28/25 were on her desk. V2 stated she read the statements from V12 and V13, Certified Nursing Assistants and felt like this incident needed to be investigated. V2 stated V1, Administrator, was able to pull up camera footage from the camera in hallway facing the shower room. V2 stated she observed V12 and V13 open the shower room door and go inside. V12 came out of the shower room door and stood in the hallway looking into the shower room laughing. V2 further stated V12 then continued laughing very hard and moved out of the way of the shower room door. V2 stated she then observed R1 quickly stumbling out of the shower room and grabbed the side rail on the wall on other side of hallway and then fell on floor. V2 stated V12 continued laughing and didn't attempt to stop R1 from falling or help R1 after he fell . V2 stated we did an inappropriate fall investigation, and determined V12 and V13 would not return to work for inappropriate care of residents and not reporting a fall. V2 further stated laughing at a resident for falling is abuse and I don't tolerate it. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 1:13 PM, V9, Registered Nurse/ Minimum Data Set Nurse, stated she watched the video of R1 falling with V2 and V1 at the facility. V9 stated she could only see R1 coming out of shower room. V9 stated because of the angle of the camera V9 was unable to see inside the door of the shower room. V9 stated she observed R1 stumble fast out of the shower room and V12 moved to the side and was laughing. V9 stated V12 did not try to stop the fall or help R1 after he fell . On 2/18/25 at 12:00 PM, V5, Family Member, stated prior to R1's cognitive decline if R1 had fallen and someone laughed, R1 would have been hurt and humiliated.

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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** 50430 Based on interview and record review the facility failed to report allegations of mental abuse for one (R1) of three residents reviewed for abuse out of a sample list of 43. Findings include: The facilities Abuse Prevention and Reporting policy effective 9/2024 documents mental abuse is the use of verbal or nonverbal conduct which causes, or has the potential to cause, the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. When an allegation of abuse, exploitation, neglect, or mistreatment has occurred the Department of Public Health shall be informed by telephone or fax. R1's Comprehensive Incident Fall assessment dated [DATE] at 10:30 PM, documents R1 sustained a witnessed fall coming out of the shower room into the hallway. The Assessment further documents R1 was walking out of the shower room and R1 attempted to grab V13 Certified Nursing Assistant by the neck, V13 blocked R1's hand then R1 tried to grab V13's arm, V13 pulled her arm back and R1 then stumbled into the hallway trying to reach the grab bar in hallway and fell . On 2/18/25 at 10:30 AM, V2 Director of Nursing stated that on 1/29/25, V2 came to work and the witness statements from the fall on 1/28/25 were on her desk. V2 stated after reviewing the statements she felt the incident needed further investigation and went to V1 Administrator immediately to report concerns. On 2/13/25 at 12:25 PM, V1 Administrator stated there was an abuse allegation that a staff member hit/pushed R1 on 1/28/25 resulting in a fall. V1 stated she investigated the allegation and there was no evidence anything happened, so it wasn't reported.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430 Based on interview and record review, the facility staff failed to wait for a licensed nurse assessment before standing a resident up after a witnessed fall. This failure affects one resident (R1) out of three reviewed for abuse allegations on the sample of 43. Findings include: The Facility's Fall Prevention Program policy revised 5/2022 documents a Fall Assessment will be completed after any fall. R1's Comprehensive Incident Fall assessment dated [DATE] at 10:30 PM documents R1 sustained a witnessed fall coming out of shower room into the hallway. On 2/13/25 at 1:40 PM, V8 Licensed Practical Nurse stated she walked onto the unit as R1 was falling onto the hallway floor. V8 stated that she told V12 and V13 Certified Nursing Assistants that she would be back to assess R1 and to stay with him until she was finished providing care for another resident. V8 stated when she came out into the hallway R1 was no longer laying on the floor and V13 told her that they put R1 to bed and he was fine. V8 further stated when she went into R1's room to assess him R1 was complaining of pain and wouldn't move. On 2/18/25 at 11:22 AM, V12 Certified Nursing Assistant stated she didn't want to get R1 up from the floor because R1 was complaining of pain after he fell , stating his back was hurting. V12 further stated the V13 Certified Nursing Assistant and another resident tried to stand R1 up and R1 was complaining of pain. V12 stated she got a wheelchair and sat R1 in it and V13 took R1 to his room. On 2/18/25 at 10:30 AM, V2 Director of Nursing stated we did an inappropriate fall investigation, and V12 and V13 should have not got R1 up off the floor without nurse, R1 could have been hurt worse.