

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 06/12/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse. This failure resulted in R2 shoving R1 on the shoulders and a second incident of R2 slapping R1 on the head. This failure affects two residents (R1, R2) of three reviewed for abuse in the sample of five.</p> <p>Findings include:</p> <p>The facility Abuse Prevention and Reporting policy (September, 2024) documents: This 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 facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.</p> <p>R1's Medical Diagnosis list (6/13/2025) documents R1's diagnoses include: Metabolic Encephalopathy (brain dysfunction resulting from metabolic problems), Major Depressive Disorder, and Severe Dementia.</p> <p>R1's Resident Assessment (5/8/2025) documents R1 has severely impaired cognition.</p> <p>R1's psychiatry notes (5/8/2025) document R1 resides on a locked dementia unit in the facility and frequently wanders throughout the unit.</p> <p>R1's psychiatry notes (5/15/2025) document R1 appears confused and was observed wandering the dementia unit in the facility.</p> <p>The facility abuse investigation file (5/27/2025) documents R2 approached V3 (Certified Nurse Aide) in the facility hallway on 5/19/2025 and requested V3 to remove R1 from the room R1 and R2 were sharing as roommates because R1 was allegedly urinating onto the floor. The same record documents V3 and R2 returned to R2's room where R1 was located followed by an altercation occurring between R1 and R2 and R2 stating to V3 get (R1) out of my room before I beat his (expletive). The investigation documents R2 then shoved R1 on the shoulders with both of R2's hands with R1 stumbling backwards and being intercepted by V3.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145371
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility abuse investigation file (6/11/2025) documents V11 (Certified Nurse Aide) overheard residents yelling at each other on 6/8/2025 and when V11 entered R3's room where the noise was located, R2 was standing in front of R1 who was sitting on the edge of R3's bed while yelling at R1. The same record documents V11 intervened between R1 and R2 and when V11 and R2 were exiting the room, R2 struck R1 in the head. The investigation documents a statement from V12 (Licensed Practical Nurse) who took a report from V11 at the time of the incident detailing R2 pinning R1 up against R3's bed and hitting R1.</p> <p>On 6/12/2025 at 1:56PM, V11 reported observing the altercation between R1 and R2 on 6/8/2025. V11 reported entering the room of R3 where R1 was sitting on the edge of R3's bed and R2 was standing over R1. V11 reported hearing R2 and it sounded like (R2) hit (R1) on top of the head. V11 reported seeing R2's arm up (in the air) and hearing R1 state stop, please don't to R2. V11 reported intervening between R1 and R2, and when R2 was leaving R3's room, R2 slapped R1 on top of the head with an open hand. V11 reported during the altercation, R2 told V11 to tell R1 to quit coming into R1's room. V11 reported R1 doesn't know what is going on but R2 is aware and deliberately slapped R1. V11 stated R2 definitely knows what (R2) is doing.</p> <p>On 6/10/2025 at 2:37PM, R2 reported R1 constantly wanders and is in R2's room frequently and also messes with R2's personal belongings. R2 reported having to defend R2's self from R1 which has involved a little push and shove and reported R1 is an (expletive) and had they both been outside, he would kick R1's (expletive).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate and document allegations of resident-to-resident physical abuse. This failure affects two residents (R1, R2) of three reviewed for abuse in the sample of five.</p> <p>Findings include:</p> <p>The facility Abuse Prevention and Reporting policy (September, 2024) documents the facility will implement systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and make the necessary changes to prevent future occurrences. The same policy documents the facility final investigation report will contain the following: name, age, diagnosis, and mental status of the resident who was allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated; the original allegation (noting the day, time, location, specific allegation, alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence, and any noted injuries); a summary of facts determined during the process of the investigation, a review of medical records, and interviews of witnesses; a conclusion of the investigation based on known facts, and the police report, if applicable.</p> <p>1. The facility abuse investigation file (5/27/2025) documents R2 approached V3 (Certified Nurse Aide) in the facility hallway on 5/19/2025 and requested V3 to remove R1 from the room R1 and R2 were sharing as roommates because R1 was allegedly urinating onto the floor. The same record documents V3 and R2 returned to R2's room where R1 was located followed by an altercation occurring between R1 and R2 and R2 stating to V3 get (R1) out of my room before I beat his (expletive). The investigation documents R2 then shoved R1 on the shoulders with both of R2's hands with R1 stumbling backwards and being intercepted by V3.</p> <p>The investigation file did not document the identity of who reported the allegation to the administrator, if other residents were interviewed about the alleged perpetrator, whether any additional witnesses were present during the altercation, or any specific and immediate interventions the facility put in place or when long-term interventions were instated to protect residents from the potential for further abuse.</p> <p>On 6/10/2025 at 10:00AM, V1 (Administrator) reported reported the facility abuse incident investigation file for the 5/19/2025 incident between R1 and R2 is the complete file and contains the entire facility incident investigation.</p> <p>2. The facility abuse investigation file (6/11/2025) documents V11 (Certified Nurse Aide) overheard residents yelling at each other on 6/8/2025 and when V11 entered R3's room where the noise was located, R2 was standing in front of R1 who was sitting on the edge of R3's bed while yelling at R1. The same record documents V11 intervened between R1 and R2 and when V11 and R2 were exiting the room, R2 struck R1 in the head. The investigation documents a statement from V12 (Licensed Practical Nurse) who took a report from V11 at the time of the incident detailing R2 pinning R1 up against R3's bed and hitting R1.</p> <p>The investigation file did not document the identity of who reported the allegation to the administrator, any specific and immediate interventions the facility put in place or when long-term interventions were instated to protect residents from the potential for further abuse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/2025 at 3:00PM, V1 (Administrator) reported the facility abuse incident investigation file for the 6/8/2025 incident between R1 and R2 is the complete file and contains the entire facility incident investigation.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to fully document the details of resident-to-resident physical abuse allegations and investigations in residents' medical records. This failure affects two residents (R1, R2) of three reviewed for abuse in the sample of five.</p> <p>Findings include:</p> <p>1. The facility abuse investigation file (5/27/2025) documents R2 approached V3 (Certified Nurse Aide) in the facility hallway on 5/19/2025 and requested V3 to remove R1 from the room R1 and R2 were sharing as roommates because R1 was allegedly urinating onto the floor. The same record documents V3 and R2 returned to R2's room where R1 was located followed by an altercation occurring between R1 and R2 and R2 stating to V3 get (R1) out of my room before I beat his (expletive). The investigation documents R2 then shoved R1 on the shoulders with both of R2's hands with R1 stumbling backwards and being intercepted by V3. The investigation file did not document the identity of who reported the allegation to the administrator, if other residents were interviewed about the alleged perpetrator, whether any additional witnesses were present during the altercation, or any specific and immediate interventions the facility put in place or when long-term interventions were instated to protect residents from the potential for further abuse.</p> <p>R1's progress notes (5/19/2025) document: CNA, reported an alleged physical altercation between (R1) and another resident. No other details of the incident were documented in R1's electronic medical record.</p> <p>R2's progress notes (5/19/2025) document: CNA, reported an alleged physical altercation between (R2) and another resident. Residents were separated. MD, POA, Ombudsman, and Police contacted. No other details of the incident were documented in R2's electronic medical record.</p> <p>On 6/12/2025 at 1:04PM, V1 (Administrator) reported the above progress notes are the only entries into R1 and R2's medical records documenting their 5/19/2025 altercation.</p> <p>2. The facility abuse investigation file (6/11/2025) documents V11 (Certified Nurse Aide) overheard residents yelling at each other on 6/8/2025 and when V11 entered R3's room where the noise was located, R2 was standing in front of R1 who was sitting on the edge of R3's bed while yelling at R1. The same record documents V11 intervened between R1 and R2 and when V11 and R2 were exiting the room, R2 struck R1 in the head. The investigation documents a statement from V12 (Licensed Practical Nurse) who took a report from V11 at the time of the incident detailing R2 pinning R1 up against R3's bed and hitting R1. The investigation file did not document the identity of who reported the allegation to the administrator, any specific and immediate interventions the facility put in place or when long-term interventions were instated to protect residents from the potential for further abuse.</p> <p>R1's progress notes (6/8/2025) document: Staff, reported an alleged physical altercation between (R1) and another resident. No other details of the incident were documented in R1's electronic medical record.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's progress notes (6/8/2025) document: Staff, reported an alleged physical altercation between (R2) and another resident. Residents were separated. MD, POA, Ombudsman, and Police contacted. No other details of the incident were documented in R2's electronic medical record.</p> <p>On 6/12/2025 at 1:04PM, V1 (Administrator) reported the above progress notes are the only entries into R1 and R2's medical records documenting their 5/19/2025 altercation.</p>		