

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/15/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility failed to perform weekly skin assessments for three of three residents (R2, R8, R15) reviewed for wound care management in a total sample of 18. Findings include: Findings include: R2's Care Plan initiated 5/8/2026 documents R2 was admitted to the facility 5/7/26 and has diagnoses of Congestive Heart Failure, Morbid (severe) Obesity Due to Excess Calories, Type 2 Diabetes Mellitus with Foot Ulcer, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Charcot Foot due to Diabetes Mellitus, Chronic Kidney Disease Stage 5, End Stage Renal Disease on Hemodialysis, Atherosclerosis of Native Artery of Both Lower Extremities with Intermittent Claudication. R2's Care Plan dated 5/12/2026 documents R2 is at risk for skin impairment related to decreased mobility. R2's physician's order dated 5/13/2026 documents an order for weekly skin assessment every night shift every Wednesday, notify doctor if new impairment. R2's skin-other-skin assessment dated [DATE] documents a skin assessment was completed on 5/11/26. R2's Medical Record does not document additional skin assessments completed during R2's stay at the facility. R2's Minimum Data Set (MDS) section C dated 5/12/2026 documents R2 is cognitively intact. R2's electronic medical records dated 5/30/26 document R2 was re-admitted to the hospital from the facility with a new deep tissue injury to the left foot upon arrival to emergency department. R2's hospital records dated 5/30/2026 included a Clinical Note documenting the following wounds 0304 (AM) right gluteal pressure injury, stage 2-wound thickness: partial, wound 05/30/26 0400 (AM) right lateral; plantar foot surgical, non-healing-wound thickness: partial, wound 05/30/26 0400 (AM) left dorsal toe, great pressure injury, deep tissue grade 1-wound thickness: partial, wound 05/30/26 0400 (AM) scrotum MASD (moisture associated skin damage)-wound thickness: partial, wound 05/30/26 0918 (AM) left plantar foot pressure injury, deep tissue-wound thickness: full, wound 05/30/26 1233 (PM) coccyx MASD (moisture associated skin damage)-wound thickness: partial, and wound 05/30/26 1233 (PM) left coccyx pressure injury, deep tissue-wound thickness: partial. On 6/12/2026 at 10:00 a.m., V3 Family Member confirmed seeing R2's new wound to the left foot upon arriving to the emergency room on 5/30/2026. On 6/12/2026 at 12:10 p.m., V16 Licensed Practical Nurse (LPN) stated R2 had a wound to the right foot during R2's stay at the facility but was unaware R2 had a wound to the left foot. On 6/12/2026 at 12:18 p.m. V19 CNA (Certified Nursing Assistant) stated V19 only remembers R2's wound to the right foot with wound vac. On 6/15/2026 at 12:05 p.m., V38 LPN stated weekly skin assessment should be performed and documented under the skin assessment tab after completing the assessment. On 6/15/2026 at 2:31 p.m. V16 LPN confirmed a weekly assessment was completed if a skin assessment was documentation under the assessment tab in the resident's electronic medical record. On 6/15/2026 at 9:14 a.m., V17 Director of Nursing (DON) stated being aware of R2's chronic wound to the right foot, however V17 was unaware of R2 having a wound to the left foot. V17 stated she expects the nurses to perform weekly skin assessments for residents with increased risk for skin impairment. High Risk weekly skin assessments and the assessments should be documented under the skin assessment tab on the resident's electronic medical records. On 6/15/2026 at 11:30 a.m., V37 Nurse Practitioner (NP) confirmed R2 had a chronic wound to the right foot, however V37 was unaware of a wound to the left (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145371	If continuation sheet Page 1 of 5

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	foot. V37 stated she expects the nurses to perform more frequent skin assessments than weekly due to R2's comorbidities and already preexisting wounds. V37 stated she expects at least daily if not every shift skin assessments for R2. The Facility Wound Report dated 3/17/2026-6/14/2026 and the Wound Round Report pulled on 6/12/2026 at 11:10 a.m. documents R8 has active wounds to the Left lower leg classified as abrasions staged as superficial with a date identified as 3/20/2026 and R8 has an active wound to the right great plantar toe classified as a blister and staged as partial thickness with date identified as 7/28/2025. R8's record review documents skin assessment completed on 6/19/2025 and 11/25/2025 for the last 12 months. R15's physician order dated 8/27/2025 documents a physician order of weekly skin assessment every night shift on Wednesday. The Facility Wound Report dated 3/17/2026-6/14/2026 and the Wound Round Report pulled on 6/13/2026 at 1:00 p.m. document R15 has wounds to the left plantar foot since 8/26/2025 and the right lateral foot since 12/26/2025 that are vascular diabetic, and the right lower leg since 4/23/2026 that are abrasions. R15's record review documents skin assessment was completed 9/4/2025, 9/20/2025 and 11/3/2025 for the period of nine months. On 6/15/26 at 9:14 AM V17 DON stated V17 expects nurses to complete weekly assessment on all residents. The Facility's Skin Condition Assessment and Monitoring- Pressure and Non-Pressure Policy dated 12/2025 documents A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. Residents identified will have a weekly skin assessment by a licensed nurse. Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to utilize appropriate personal protective equipment (PPE) when providing care for residents on Enhanced Barrier Precautions, failed to remove soiled PPE prior to exiting a resident's room, failed to prevent potential cross contamination during incontinence/face care, and failed to ensure soiled linens were not placed on the floor for three of three residents (R8, R13, and R15) reviewed for infection control in a sample of 18. On 6/12/26 at 11:53 a.m., V2 Assistant Director of Nursing/Wound Nurse/Infection Control, entered R8's room to perform wound care. A sign on R8's door documents R8 requires Enhance Barrier Precautions (EBP). V2 did not don a gown a before entering R8's room or during wound care. On 6/15/2026 at 8:02 a.m., V15 Certified Nurse Assistant (CNA) stated staff should wear gloves, a gown and a mask when providing care for residents on Enhance Barrier Precautions (EBP). On 6/12/26 at 11:45 a.m., V2 Assistant Director of Nursing/Wound Nurse/Infection Control stated she has been providing wound care/treatments since last week. V2 stated V2 does wound treatment for residents. V2 stated she has not received training for wound care or infection control. On 6/15/2026 at 7:57 a.m., V16 Licensed Practical Nurse (LPN) stated, staff should wear gloves, a gown and a mask when providing care for residents on Enhance Barrier Precautions. On 6/15/2026 at 9:14 a.m. V17 Director of Nursing (DON) stated Enhance Barrier Precautions (EBP) signs indicate staff should wear personal protective equipment such as a gown, gloves and a mask when providing care. V17 stated, I have been telling staff to wear the mask when going in Enhance Barrier Precautions rooms just to be safe with all the respiratory infections going around. R8's Care Plan dated initiated on 6/19/2025 documents R8 is on Enhanced Barrier Precautions related to a suprapubic catheter. The Care Plan also states to educate staff/resident/family on enhanced barrier precautions as needed and states to use gown and gloves during high contact resident care activities (such as dressing, bathing, showering, changing briefs, assisting with toileting, or wound care). R8's Minimum Data Set (MDS) dated [DATE] documents R8 is cognitively intact. R8's physician's order dated 6/15/25 documents R8 requires Enhanced Barrier Precautions related to Suprapubic Catheter every shift. 2. R13's Minimum Data Set (MDS) dated [DATE] documents R13 is cognitively intact. R13's physician's order dated 1/19/2026 documents to use Enhanced Barrier Precautions related to dialysis port. R13's Care Plan dated 1/19/2026 documents to use Enhanced Barrier Precautions (EBP) related to a central line needed for dialysis treatment. Interventions include gown and glove during high contact (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care activities (such as dressing, bathing, showering, changing briefs, assisting with toileting or wound care). On 6/13/26 at 11:00 a.m., V7 Certified Nurse's Assistant (CNA), provided incontinence care for R13. R13 has a sign on R13's door documenting R13 requires EBP. V7 did not wear a gown during cares. V7 removed R13's soiled incontinence brief and tossed the brief onto the floor. V7 cleansed R13's perineal area with a dampened washcloth and threw it on the floor also. V7 dampened a clean washcloth and wiped R13's face and threw it on the floor. V7 removed soiled linens from R13's room without placing the linens into a bag then V7 proceeded to walk down the hall with dirty gloves on and dirty linens in hand. V7 dropped the dirty linens onto the hall floor due to not having the dirty linen hamper available and V7 walked away. V7 did not change gloves between dirty to clean cares. On 6/13/26 at 11:15 a.m., V7 confirmed R13 had an EBP sign on the door and V7 stated she should have worn a gown when provided cares. V7 stated she should have put the dirty linens in a trash bag before taking it out of R13's room and placed it in a dirty linen hamper and not on the floor. V7 stated she should have changed gloves between dirty to clean areas. On 6/15/26 at 8:36 a.m., V11 Registered Nurse (RN) stated staff should wear gloves when providing care to the residents on EBP precautions. V11 stated dirty linens should be transported in a plastic bag and not to be placed on the floor. On 6/15/2026 at 9:14 a.m., V17 Director of Nursing (DON) stated an Enhanced Barrier Precautions (EBP) sign on the door means staff should wear Personal Protective Equipment (PPE) such as gown, gloves and mask. V17 stated, I have been telling staff to wear the mask when entering Enhance Barrier Precautions rooms just to be safe with all the respiratory infections going around. 3. On 6/13/26 at 1:45 p.m., V2 ADON/Wound Nurse/IP provided wound care for R15. After completing the wound care, V2 left R15's room with gown and gloves on and proceeded to walk down the 200 hall rolling a bedside table draped with a hand towel and used wound supplies on top of the table. V2 placed the bedside table in front of a resident room and walked down to the end of the 400-hall still wearing the dirty gown and gloves. V2 then removed the dirty gown and gloves on the 400-hall and then returned to medication cart. On 6/13/26 at 11:15 a.m., V2 stated she should have removed the Personal Protective Equipment (PPE) before leaving the resident's room. V2 stated staff should not wear used PPE in the hallway. V2 stated she was newly hired and has not been trained in infection control and wound care. On 6/15/2026 at 9:14 a.m., V17 Director of Nursing (DON) stated she would expect the staff to remove PPE prior to leaving the room and perform hand hygiene. On 6/15/26 at 2:30 p.m., V1 Administrator stated the facility provided in-services to staff regarding Enhanced Barrier Precaution (EBP). V1 stated there are signs on the door for residents that are on EBP, and staff are expected to wear complete PPE or follow the instructions written on what to wear. R15's Minimum Data Set (MDS) dated [DATE] documents R15 is cognitively intact. R15's physician's order dated 9/4/2025 documents Enhanced Barrier Precautions for Central Venous Catheter (CVC) port. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Care Plan dated 9/5/2025 documents Enhanced Barrier Precautions (EBP) related to CVC dialysis port. Interventions include gown and glove during high contact resident care activities (such as dressing, bathing, showering, changing briefs, assisting with toileting or wound care). The Facility's Policy for Enhanced Barrier Precautions dated 12/2025 documents Personal Protective Equipment: Standard Precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: dressing, bathing/showering, providing hygiene, changing linens, incontinence care, medical device care, wound care.		