

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Watseka		STREET ADDRESS, CITY, STATE, ZIP CODE 715 East Raymond Road Watseska, IL 60970	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002</p> <p>Based on interview and record review, the facility failed to protect the residents (R1) right to be free from physical abuse by another resident (R2) for one of five residents (R1) reviewed for abuse in the sample list of 10.</p> <p>Findings include:</p> <p>R1's Facility Census documents R1 was admitted to the facility on [DATE] and has the following medical diagnoses: Sequelae of Cerebrovascular Disease, Hemiplegia and Hemiparesis following Infarction Affecting Right Dominant Side, Schizoaffective Disorder Bipolar type, Anxiety Disorder, Acute Kidney failure, Cerebral Infarction, muscle Weakness and Difficulty in Walking.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview for Mental Status (BIMS) score 11, moderate cognitive impairment.</p> <p>R1's Abuse and Neglect Screening assessment dated [DATE] documents R1 is a high risk for abuse.</p> <p>R1's Social Service Note dated 1/31/25 at 12:04pm documents Psychosocial assessment reviewed for R1. Assessment completed due to Verbal Altercation - R1 to R2. Behavioral diagnosis includes A new onset or increase in behaviors include Increased agitation yelling out. R1 has a history of: Alcohol use. Triggers that alarm or distress resident are loud noises fighting or angry outbursts. Interventions in place include Activity Food/Snacks Redirect.</p> <p>R1's incident note dated 1/31/25, late note at 12:25 am documents V1 (Administrator) was notified of a physical altercation with R2. Medical Doctor, R1's Power of Attorney (POA), and Ombudsman notified. Investigation initiated.</p> <p>R2's Facility Census documents R2 was admitted to the facility on [DATE] and has the following medical diagnoses: Dementia with Agitation and Bipolar Disorder.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview for Mental Status (BIMS) score 9, moderate cognitive impairment.</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
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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>R2's Incident Note date 1/31/25 at 12:21 pm documents V1 (Administrator) was notified of a physical altercation with R1. Medical Doctor, R2's Power of Attorney (POA), and ombudsman notified. Investigation initiated.</p> <p>On 2/19/25 at 10:50 am V7 (Cook) stated, on 1/31/25 at 10:30am V7 heard resident's arguing in the dining room. V7 stated, V7 went into the dining room and observed R1 and R2 arguing, both were in their wheelchairs. V7 stated, V7 grabbed the back handles of R2's wheelchair to remove R2 from R1 at which time R2 swung R2's left arm striking R1 in the right shoulder.</p> <p>On 2/19/25 at 10:55 am V6 (Cook) stated, on 1/31/25 at 10:30 am V6 was in the Dietary Mangers office and heard resident's arguing in the dining room. V6 stated, V6 looked out and observed V7 (Cook) behind R2 who was seated in R2's wheelchair, and R1 was to R2's left in R1's wheelchair. V6 stated, while V7 was attempting to separate R2 from the area, R2 swung R2's left arm hitting R1 in the right shoulder.</p> <p>On 2/19/25 at 11:04am V1 (Administrator) said, on 1/31/25 V1 was notified of an incident in the dining room between R1 and R2. V1 said, V1 responded and both residents were separated and being assessed by V2 (Director of Nursing). V1 said, V1 interviewed V6 (Cook) and V7 (Cook) who informed V1 that they heard arguing in the dining room, and upon entering the dining room they observed R1 and R2 arguing. V1 said, as V7 was attempting to remove R2, R2 swung R2's left arm and struck R1 in the right shoulder.</p> <p>The Facility's Abuse Prevention Policy dated 9/24 documents: Guidelines: This facility affirms the right of our residents to be free from 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. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002</p> <p>Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan with intervention for behaviors. This failure affects one resident (R6) of four residents reviewed for behaviors in the sample list of ten.</p> <p>Findings include:</p> <p>R6's Facility Census documents R6 was admitted to the facility on [DATE] and has the following medical diagnoses: Dementia and Schizophrenia.</p> <p>R6's Minimum Data Set (MDS) dated [DATE] documents R6's Brief Interview for Mental Status (BIMS) score 10, moderate cognitive impairment.</p> <p>R6's Nursing Note dated 1/4/25 at 3:49am documents R6 was restless during night shift and declined to go to sleep. R6 also refused help with personal cares from Certified Nursing Aides and R6 also refused to wear brief.</p> <p>R6's Nursing Note dated 1/15/25 at 5:57am documents R6 came out of R6's room around 2:00am, with no pants/underwear or (brief) on. R6 did have on a hat, coat, gloves and appropriate footwear. When writer told R6, R6 didn't have any pants, R6 responded with 'I don't care' and 'so what'. Writer attempted to educate R6 on importance of pants, R6 started speaking loudly and reiterating 'I don't care' 'so what' 'it doesn't matter.' R6 went into dining room and sat in usual meal spot chair. Certified Nursing Assistant was able to redirect R6 back to R6's room and dress appropriately.</p> <p>V9 Certified Nursing Assistant (CNA) Witness Statement dated 2/18/25 documents on 2/18/25 V9 did note that R6 was up and down at the desk most of the night. R6 usually is up throughout the night, R6 routinely takes R6's clothes and brief off and walks the hallway and needs continuous redirection.</p> <p>The Facility's Comprehensive Care Plan policy dated 10/24/24 documents: Purpose: To develop a comprehensive care plan that directs the care team and incorporate the residents goals, preferences, and services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. Guidelines: The facility will develop and implement a comprehensive care person-centered care plan for each resident, consistent with the residents rights, that includes measurable objectives and timeframe's to meet a residents medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment.</p> <p>On 2/19/25 at 11:45am V10 (CNA) said, V10 works the day shift. V10 said, R6 is independent with transfers and uses a walker to ambulate. V10 said, when R6 uses the restroom, R6 removes all R6's clothes and when R6 gets done, R6 sometimes forgets to get dressed and will come out of R6's room naked. V10 said, V10 or other staff will bring R6 back to R6's room to get dressed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/19/25 at 2:35pm V4 Licensed Practical Nurse (LPN) said, R6 does walk around the halls all night and likes to sit in the TV area across from the nurse's station. V4 said, sometimes when R6 goes to the bathroom, R6 will come out and be naked, and is told to go get dressed, and will go back into R6's room and get dressed.</p> <p>On 2/19/25 at 2:50pm V8 (CNA) said, R6 sometimes does go to the bathroom and remove all R6's clothes and when R6's done will forget to get dressed and comes out naked. V8 said, staff will tell R6 to go get dressed and R6 will go get dressed.</p> <p>On 2/19/25 at 3:00pm V1 (Administrator) confirmed that R6 does not have a comprehensive care plan regarding R6's behavior of undressing and walking around naked, nor any intervention for this behavior.</p>