STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Watseka	715 East Raymond Road Watseka, 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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain resident equipment in a safe operable condition, failed to replace/repair equipment in disrepair after resident fall with injury and failed to implement new interventions post fall and an accident. These failures affected two of three residents (R2 and R3) reviewed for resident injury/injury of unknown origin on the sample list of seven.Findings include:1.) R2's current diagnoses sheet documents the following: Hemiplegia, Unspecified, Affecting Left Nondominant Side; Cerebral Infarction Due to Embolism of Right Vertebral Artery; and Generalized Muscle Weakness.R2's Minimum Data Set (MDS), dated [DATE], documents the following: R2's Brief Interview of Mental Status score was 15 out of a possible 15, indicating R2 has no cognitive impairment. The same MDS documents R2 is dependent on staff to roll left and right, defined as the ability to roll from lying on the back to the left and right side and return to lying on the back in bed, and is dependent on staff for chair/bed-to-chair transfers.R2's Care Plan, updated 4/10/26, documents R2 may be predisposed to develop skin impairment. The intervention following the bruise and skin tears on 4/7/26 is documented as follows: Resident's (R2's) right arm should be elevated on a pillow.R2's Weekly Skin Observation, dated 4/07/26 at 2:49 p.m., documents: Note Text: Resident's weekly skin status. Type of skin concern: Bruising, skin tear. Located to Other (specify) - Left forearm, scattered bruising and skin tears. Treatments include cleanse, pat dry, triple antibiotic ointment, and dry dressing daily until healed. Resident does not complain of pain. No new skin concern or change in skin condition that required MD notification. MD (unidentified physician) was notified of new condition. Family (V19, Power of Attorney) was notified of new condition. New orders received: Care plan reviewed.There was an associated picture taken of R2's left forearm bruise and skin tears. The picture displayed a large, very dark bruise. Measurements were to be determined by a measuring tape laid beside the skin tears and bruise; however, the measuring tape was not legible in the picture.R2's Nursing Note, dated 4/10/26 at 1:47 p.m., documents the first measurement of R2's left forearm injury, written by V6, Licensed Practical Nurse: Note Text: Changed dressing to left forearm. Cleansed with N.S. (normal saline), patted dry, applied TAO (triple antibiotic ointment), covered with a border foam dressing. New bruising/hematoma noted to same arm (length 6.5 cm x width 5 cm), center of the bruise is raised approximately 0.5 cm to 1 cm.R2's Nursing Note, dated 4/10/2026 at 2:25 p.m., documents the following: Note Text: IDT (Interdisciplinary Team) met. Resident (R2) does not have full sensation to the left arm due to past stroke. If the arm is not supported, then the arm will hang or fall. Bruising/skin tear noted to left forearm. Full range of motion without pain. Resident was in a geriatric recliner-type wheeled chair when arm fell and hit side of chair. MD (unidentified), POA (V19, Power of Attorney) notified. Intervention: Arm to be propped on pillow while in chair to prevent hanging. Care plan reviewed and updated.On 4/28/26 at 11:50 a.m., R2 was seated in a partially reclined geriatric wheeled chair in the dining room. R2 had a full-body mechanical lift sling under his body and above the chair seat. R2's left arm was flaccid. R2's left arm was resting on the armrest of the chair at an angle, with his hand on his left abdomen. R2 did not have a pillow to support his left arm, as later identified on R2's care plan.R2 had a large faded purple and green bruise on his left (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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I guess it was some kind of nerve pain when the water hit my arm in the shower. The nurses have been great at cleaning it every day and putting new bandages on it. Today is the first day it has gone uncovered. The nurse looked at it, cleaned it, and said we are leaving it open to heal faster. It is looking good now. At first it was all messed up. The sores have healed, and the bruise was real dark and big. It is not 100 percent healed yet, but is getting there. One of the nurses used a piece of material down in the seat of my chair. I was told it covered the open metal gears that scraped my arm. That material should protect my arm so this does not happen again. I can't move my arm, feel pain, or see very well. I did not know my arm had fallen. I will be reminding the CNAs to wait and make sure my arm is not tucked down in the gears before they push the back of the chair up when I need to sit instead of lay back.On 4/28/26 at 11:55 a.m., V7, Certified Nursing Assistant (CNA), approached R2's partially reclined geriatric wheeled chair. V7 stated: I was the one that reported R2's bruise to the nurse. I know how it happened. I went to give him a shower and saw it. It lines up with this metal next to the armrest. The seat vinyl does not cover the metal like it is supposed to.V7 removed a piece of pool-noodle-like foam material from below the armrest adjacent to the geriatric wheeled chair vinyl seat. The foam material measured approximately four inches long and covered a metal hinge. The metal hinge attached the seat of R2's wheeled chair to the back of the chair. The metal was fully exposed. The vinyl seat material did not cover the metal hinge connection.V7 stated: This stuff was put on the metal to prevent R2 from scraping his arm. You can see how it lines up exactly with R2's bruised area.R2 then stated: It had to have happened when they got me up in the chair that day. V7 stated the incident occurred a couple weeks ago. R2 agreed. Neither V7 nor R2 could recall the date, later documented as 4/7/26.On 4/28/26 at 12:15 p.m., V6, Licensed Practical Nurse (LPN), stated: R2 had a huge bruise on his left arm and skin tears. It made no sense because he had a stroke and does not even move his left arm. I do not know who initially reported the injury or who investigated it. He was not sure when I talked to him what had happened. He is totally dependent on staff. He said he could feel pain when they showered him, but other than that he had no sensation in his left arm. I have done the treatments when I worked and completed measurements. The hematoma was really big and swollen. It was dark purple all around the skin tear. It has faded a ton. What you see now has really faded. You can line his arm up with the geri chair and see the bare metal piece of the chair lines up with his injury. It is supposed to be under the vinyl seat. He is a big man. I think his weight stretches the vinyl material and causes the metal gear to be exposed. The vinyl pulls from the side of the chair. It was obvious a staff member had to have let his arm hang down and caught his arm in the hinges of the geri chair. They had to have pushed the back of the chair to an upright position. Someone put a piece of foam on the exposed metal to prevent it from happening again.On 4/28/26 at 2:25 p.m., R2 was lying in bed. V18, Certified Nursing Assistant (CNA), looked at R2's geriatric wheeled chair sitting outside R2's bedroom door. V18 stated: I am sure his arm got caught inside the chair when someone pushed the back of the chair up. You can tell when he is laid back in the chair his arm drops down that way. I was not here when it happened. I just know he can't control his arm, so we have to protect it for him.V18 confirmed that R2 did not have a pillow supporting his left arm when he was transferred from the chair to bed. V18 stated: This is the first I heard that he is supposed to have a pillow under his arm. It makes sense for sure. I have worked a lot since he got hurt, and nobody said anything about a pillow. I will find one when I get him up later (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one inch wide. V6 stated she had never checked the footboard but was aware a few weeks ago that the Maintenance Department was supposed to look at R3's bed.V6 stated: It is easy to see how R3's bed caused the skin tear now that I see this jagged plastic. V6 rubbed the edge of the seven-inch damaged area of the footboard. V6 also confirmed that R3's bed was against the air conditioner, leaving an approximately twelve-inch path where R3 presumably walked. V6 stated: This is where she said she fell. V6 pointed to the floor and the foot of R3's bed.On 4/28/26 at 2:50 p.m., V2, Director of Nursing (DON), reviewed R3's incident report and confirmed V2 completed R3's fall investigation. V2 then walked to R3's room. R3 was seated on the side of her bed. V2 asked R3 if she could look at the footboard of the bed.R3 stated: I wish you would. There was a guy that looked at it a day or two after I got here (4/1/26 admission). He said he would be back to fix my bed. He never came back. I have mentioned it at least a dozen times to the nursing staff. I also have told anyone that would listen. I don't want my bed up against this radiator thing on my wall. I can't walk past it. I feel there is no room there. That is the side of the bed I am used to getting out of to go to the bathroom. Go ahead and look at the sharp edges on that (pointing to footboard). Run your hand down the edge. That is terribly sharp.V2 leaned down and confirmed the jagged plastic with sharp edges on the footboard of R3's bed. V2 then told R3 she would get the room rearranged to R3's liking and get her a different bed. R3 responded: Can I hold you to that, since you're a manager?V2 left R3's room and told this surveyor the intervention for R3's fall was to rearrange R3's room to create a safe path for R3 to walk. V2 stated: I am not sure why that did not happen. Maintenance was aware R3's bed needed moved away from the wall.V2 also stated she did not evaluate the footboard of R3's bed when she assessed the room during her fall investigation. V2 stated the rough edges of the footboard were the most likely cause of R3's skin tear, as well as the path being too narrow for R3 to safely walk.On 4/29/26 at 1:55 p.m., V1, Regional Administrator, stated: We have a meeting every morning. She had not been here very long when she fell. She brought her request to us about her bed. We discussed the need for a different bed for R3 in morning meeting. V16, Maintenance Director, is off right now and is not available. He was in the daily meeting when R3's bed was discussed. We were aware R3's bed was in disrepair. I checked yesterday and could not find the work order in our system. We have a Regional Maintenance Director (V17) that would have addressed R3's bed had the work order been entered in our system, as it should have been.The facility policy, Fall Prevention Program, revised 01/2026, documents the following safety guidance: Purpose:To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.The same policy documents: Identification of all risks/issues Addresses each fall Interventions are changed with each fall, as appropriate Preventative measuresThe same policy documents: Fall/safety interventions may include but are not limited to: The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards. Lighting will be appropriate for the time of day and in accordance with the resident's desire and the plan of care. Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or a chair and provided care as assigned in accordance with the plan of care.