

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Arcadia Care Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 North Bowman Danville, IL 61832	
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** 31284</p> <p>Based on observation, interview and record review, the facility failed to protect a resident's (R206) right to be free from sexual abuse and failed to protect a resident's (R208) right to be free from physical abuse from another resident. R206 and R208 are two of four residents reviewed for abuse in the sample list of 36.</p> <p>Findings include:</p> <p>1. R206's Diagnosis Sheet (current) includes the following diagnoses: Alzheimer's Disease, Difficulty in Walking and Fracture of the Left Femur.</p> <p>R206's Minimum Data Set (MDS) dated [DATE] documents R206 as being Severely Cognitively Impaired and uses a wheelchair for mobility.</p> <p>A facility report titled, Final Abuse Investigation, dated 4/5/24, documents an incident of alleged sexual abuse on 4/1/24 involving R206 with R205 as the alleged perpetrator. The Abuse Investigation Report documents that on 4/1/24 R205 and R206 were in the dining room eating. R205 self-propelled R205's wheelchair over to R206 and touched (R206's) chest over the top of (R206's) clothes. There was no physical injury to (R206).</p> <p>A witness (V21 Dietary Aide) statement for the above Abuse Investigation Report is included in the investigation and is documented as follows: Around 6:37 pm, (R205) was grabbing (R206's) chest area and didn't let go. (R206) pulled away from (R205) and (R205) still refused to let (R206) go.</p> <p>R205's MDS dated [DATE] documents R205 as being moderately cognitively impaired and uses a wheelchair for mobility.</p> <p>R205's Psychiatric Notes dated 3/26/24 includes the following diagnoses: schizoaffective disorder - Bipolar type, Generalized Anxiety, and Inappropriate Sexual Behavior.</p> <p>On 4/10/26 at 10:25, R206 was sitting in R206's wheelchair involved in an activity. R206 appeared calm, engaged, and happy.</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>On 4/10/24 at 1:30 pm, R205 was sitting in R205's room. R205, without prompting, blurted out I won't do it again. R205 reiterated, I grabbed a lady's breast, I won't do it again. R205 confirmed that R205 knew grabbing R206's breast was wrong and stated, I just got the urge to do it.</p> <p>On 4/10/24 at 3:10 pm, V21 confirmed that V21 had witnessed the actual sexual abuse of R206 by R205. V21 stated V21 was coming out of the kitchen and V21 saw R205 grab R206's breast. V21 told R205 to let go but R205 wouldn't. V21 confirmed that R206 tried to pull away from R205 and R205 still wouldn't let go of R206's breast.</p> <p>On 4/12/24 at 10:07 am, video of the above sexual abuse was observed. The video recording visibly shows R205 intentionally self-propel over to R206, cupping R205's hand and placing it on R206's left breast. V21 is present in the video.</p> <p>2. R208's Diagnoses Sheet (current) includes the following diagnoses: Dementia, Difficulty in Walking and Alzheimer's Disease.</p> <p>R208's MDS dated [DATE] documents R208 as being moderately cognitively impaired.</p> <p>A facility report titled, Final Abuse Investigation Report, dated 4/11/24, documents an allegation of physical abuse on 4/4/24 involving R208 with R209 as the alleged perpetrator. The report documents on 4/4/24 that R209 was walking down the hall of the facility yelling that R208 had stolen R209's jacket. R208 was standing in the doorway of R208's room and R209 made contact with (R208). Both residents lost their balance during the contact and fell to the floor.</p> <p>The above report includes two witness statements by N14 Nurse Practitioner and V35 Certified Nurse Assistant.</p> <p>V14's statement dated 4/4/24 documents the following: I was in the hallway walking towards a resident's room when I realized (R209) was behind me. (R208) was standing by (R208's) room's door. (R209) walked toward (R208's) room, stood in front of (R208) and yelled at (R208) and said, 'You stole my garbage can.' (R208) said 'No, I didn't.' (R209) continued yelling at (R208). (R209) was out of control, and I was not able to pull (R209) back away from (R208). (R209) yelled at (R208) and finally they grappled. While grappling, (R209) walked backward, and they both fell against the hallway wall at which moment staff arrived and separated them.</p> <p>V35's statement dated 4/4/24 documents the following: It was at approximately 1:00 pm, I was standing at the nurses station. Resident (R209) started yelling and following the NP (V14 Nurse Practitioner) as (V14) was walking down the hall. (R209) was yelling '(R208) stole my leather coat and sold it for drug money.' (R209) stopped at the doorway of resident room (R208). (R209) became physical and both ended up on the floor. (R209) kept saying 'you stole my stuff.' (R209) struck (R208) with a closed fist, then they tussled to the floor and was rolling around. We immediately separated them and placed (R209) on a 1 on 1 supervision.</p> <p>R209's Diagnosis Sheet (current) includes the following diagnoses: Dementia with Behaviors and Psychosis.</p> <p>R209's MDS dated [DATE] documents R209 as being severely cognitively impaired. R209's Care Plan (current) documents R209 with potential aggressive behaviors.</p> <p>(continued on next page)</p>		

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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>On 4/12/24, R208 and R209 refused to be interviewed.</p> <p>On 4/12/24 at 11:40 am, V14 confirmed R209 had followed V14 down the hall and was yelling and when arriving at R208's door, R209 hit R208, and they fought and fell to the ground. V14 stated, I could not get them apart.</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>31284</p> <p>Based on interview and record review, the facility failed to do complete a thorough investigation of an allegation of sexual abuse between two residents (R205) and (R206). R205 and R208 are two of four residents reviewed for abuse in the sample list of 36.</p> <p>Findings include:</p> <p>A facility report titled, Final Abuse Investigation, dated 4/5/24, documents an incident of alleged sexual abuse on 4/1/24 involving R206 with R205 as the alleged perpetrator. The Abuse Investigation Report documents that on 4/1/24 R205 and R206 were in the dining room eating. R205 self-propelled R205's wheelchair over to R206 and touched (R206's) chest over the top of (R206's) clothes.</p> <p>The above investigation in its entirety documents two statements from staff, V21 Dietary Aide as a witness that documents V21 seeing R205 grab R206's chest area and another staff member, Certified Nurse Assistant (V34) who was called for assistance to retrieve R205 and take R205 to a separate area. This investigation also documents V1 Administrator asked the (unidentified) Interdisciplinary Team if they had knowledge of R205's sexual inappropriate behaviors before and V1 documents they had not. There are no documented interviews from any of the Interdisciplinary Team (IDT). There are no other interviews in the above investigation of other staff or residents who may have experienced R205's inappropriate sexual behavior.</p> <p>On 4/11/24 at 10:30 am V1, Administrator confirmed there were no other residents in the dining room when the alleged sexual abuse happened. V1 also confirmed V1 did not interview other facility residents that could have potential knowledge of, or experienced sexual abuse themselves and not reported. V1 confirmed the IDT discussed the incident, and they knew nothing about R205 being sexually inappropriate, but did not document these interviews and or statements from the IDT.</p>		