

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145811 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/09/2025 |
| NAME OF PROVIDER OR SUPPLIER Arcadia Care Peoria Heights | | STREET ADDRESS, CITY, STATE, ZIP CODE 1629 East Gardner Lane Peoria Heights, IL 61616 | |
| 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 prevent abuse for one (R2) of three residents reviewed for abuse in a sample of four. Findings include: The Facility's Abuse Prevention and Reporting policy, dated 9/2024, 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. 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. Facility incident report to the state surveying agency documents the following: On 06/21/2025 at approximately 9pm, (R2) stated to the nurse on duty that (R1) slapped him two times on the left side of the head. Further investigation has revealed upon interview that (R1) did make physical contact to (R2) on the side of the head with an open hand. (R1) stated to (V1 Administrator) I'm gonna tell you the truth, yes I did make physical contact with him, because he was calling the staff names, and they are good girls they are here to help us, and he doesn't need to talk to them that way. (R1) stated to (V1) that (R2) was cursing at the CNAs/Certified Nurse Aides and calling them inappropriate names and he should not be, that is why (R1) confronted (R2) and made physical contact him in the side of the head. On 6/21/25, R1's nurse's note documents R1 was in a resident room (R2's room) visiting another resident, R2 was in the room, and then R2 went down the hallway and stated R1 hit him on the side of the head, and he was calling (family). On 7/8/25 at 9:25am, V1 stated she is the abuse coordinator and investigated R2's allegation of abuse and reported it to the state surveying agency. At that same time, she verified R1 told her he slapped R2 on the side of the head because he was calling the staff names. R2's BIMS (Brief Interview for Mental Status) score is 15, cognitively intact. On 7/8/25 at 10:30am, R2 stated he was slapped by R1 a while ago. R1's BIMS score is 15, cognitively intact. On 7/9/25 at 8:15am, R1 verified he hit R2 because he was not being nice to the staff that helps them.</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: 145811 |
| | | If continuation sheet Page 1 of 1 |