STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001010	A. BUILDING: _____ B. WING _____	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE BLOOMINGTON	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 12/19/21/IL141886	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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S9999	Continued From page 2	S9999		

resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure residents were free from physical, verbal, and mental abuse. These failures affect four residents (R1, R2, R9, R10) reviewed for abuse. This failure resulted in R9 being verbally and mentally abused by R10, resulting in R9 withdrawing from activities and isolating R9's self in R9's room.

Findings include:

The facility's Abuse Prevention and Reporting policy dated 12/17/21 documents the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, regardless of mental or physical condition, cause physical harm, pain or mental anguish. This policy documents abuse includes verbal, sexual, physical and mental abuse. "Willful, as used in this definition of abuse, means the individual must have acted deliberately, not

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S9999	Continued From page 3 that the individual must have intended to inflict injury or harm." 1. R9's Face Sheet dated 1/6/22 documents R9's diagnoses including Major Depressive Disorder, Suicidal Ideations, Anxiety and Alcohol Abuse. R9's Abuse/Neglect Screening dated 8/27/21 documents R9 is at a moderate risk for abuse/neglect. R9's Care Plans dated 9/17/21 document R9 is a social person and enjoys people with interests including art and socializing with peers and staff. R9 will continue pattern of life by maintaining level of socialization to enhance the quality of life. These Care Plans do not document a Care Plan for R9's risk for abuse. R9's Minimum Data Set (MDS) dated 11/15/21 documents R9 is cognitively intact with no behaviors, no hallucinations and no delusions. On 1/4/22 at 3:10pm, R9 was tearful and stated, "sometime before" Christmas, R10 called R9 "racial slurs" including "w****** and s***" and R12 a resident who no longer resides at the facility overheard R10 call R9 those racial slurs. R9 stated V11, Activity Assistant came in while R9 and R10 were "getting in to it" because of the statements that had just been made toward R9. R9 stated, "it hurt me" when R10 called me those racial slurs. R9 stated R9 is having a "difficult time coping" with being referred to as derogative/racist names and has stopped participating in activities and "misses them (activities) so much." R9 stated R9 was always helping and attending activities, "but not anymore." R9 stated R9 no longer participates in group activities since R10 called R9 those racial slurs and stayed away from the Christmas party because of R10 and not wanting to be around R10 due to R9 did not want R10 calling R9 that	S9999		

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S9999	Continued From page 4	S9999		

again. R9 stated R10 had made additional "racist" comments including asking R9 for R9's "green card." R9 stated R9 tries to stay away from R10 and leave the area if R10 comes to the same area. R9 stated V11 was aware of R10 being verbally abusive to R9 and notified V10, Activity Director but R9 stated R10 continued to try to approach R9. R9 stated V1, Administrator talked to R9 regarding R10's behaviors toward R9 but V1 "only asked a couple questions," nothing else was done.

On 1/6/22 at 10:20am, V10, Activity Director stated V11, Activity Aide called V10 sometime around the end of November and reported R10 had called R9 "some names, racial slurs" and R9 and R10 had a verbal altercation. V11 stated R10 called R9 a couple racial slurs. V10 remembered one of the racial slurs of "s***" which V10 described as offensive and that the racial slurs were "very offensive" to R9. V10 stated this verbal/mental abuse allegation occurred sometime toward the end of November. V10 stated R9 typically has been very involved with activities and after R10 did that to R9, R9 became very withdrawn and withdrew from the activities group which was not like R9. V10 stated R9 would help with many activities including R9 helped with all of the Halloween activities. V10 stated R10 has a history of saying derogatory things and had frequently made negative comments to others.

2. The facility's abuse investigation for an alleged physical abuse altercation between R1 and R2 documents R2 was observed "swinging" at R1 in the living room by the television by V6, Activity Aide on 12/19/21. V6, Activity Aide's Abuse Allegation Interview form documents on 12/21/21, V6 reported R1 was in the living room with

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"family" and V6 observed R2 "swing" at R1 but could not see if contact was made "from (V6's) angle." V6 removed R2 from the living room and reported to V1, Administrator. R2's Abuse Allegation Interview form dated 12/21/21 documents R1 and "some guy" were going through R2's "stuff" and R2 asked "them" to get out and they left. R2 went to the living room and asked "them" why they were going through R2's stuff and "the i**** (R1)" asked R2 if R2 "wanted to take it outside so (R2) went to hit "(R1)" but family was standing there. R1's Abuse Allegation Interview form dated 12/21/21 documents R2 and R1 "got into it. We (R1 and R2) were going to take it outside. (R1) could kick (R2's) a**."

On 1/4/22 at 3:03pm, R2 stated "(R2) had a big problem, my roommate (R1) was going through R2's stuff. R2 stated R1 and R2 "did not get along anyway." R2 stated R2 told R1 to "get out" and R2 was "p***** off." R2 stated R2 went and found R1 and hit R1 because R2 was tired of R1.

The Final Abuse Investigation Report Resident to Resident documents a Physical Abuse Allegation with initial report date of 12/19/21 and Final Report date of 12/24/21. This report documents R1 and R2 were both "interviewed twice" and both R1 and R2 "gave conflicting stories" about events related to allegation although there is no documentation of multiple interviews for R1 and R2 This report documents V7, R1's Family was interviewed about the alleged physical allegation as V7 was visiting R1 at the time and stated" physical contact was made" between R1 and R2.

On 1/6/22 at 3:27pm, V1, Administrator stated V1 felt the physical abuse altercation between R1 and R2 was not physical abuse because both R1 and R2 were both agitated and wanted to fight

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S9999	Continued From page 6 each other. V1 stated V7, R1's Family and R1 were in the room R1 and R2 shared going through R1's clothes and R2 came in thinking they were going through R2's things. V7 stated V7 and R1 were standing talking in the front lounge area and R2 came up confronting V7 and R1 "again" and R1 said let's take this outside and R2 hit R1. V1 stated V1 could "see contact was made" when reviewing the facility camera footage and when R2 hit R1, R1's glasses moved. (B)	S9999		