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 03/23/2023

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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 Complaint Investigation 2362109/IL157503	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on interview and record review, the facility failed to notify a physician of a change in condition, failed to implement physician's orders timely and failed to document a thorough assessment for multiple days after a resident's fall, for one of three residents (R1) reviewed for falls on the sample of five. These failures resulted in R1's left leg/hip pain progressively worsening with R1's range of motion declining to the left leg and R1's decline in bed mobility, transfers and ambulation. These failures also caused a delay in repair of R1's left femoral/hip fracture. Findings include: The fall investigation for R1's fall on 2/15/23 at 4:45 AM documents a final report to the State Survey Agency dated 2/23/23 with a summary as follows: On 2/15/23 R1 was observed on the floor of R1's room per witness statement. R1 was assessed with no changes noted. "Later assessment reveals increased signs and symptoms of pain" and that V9 (R1's Physician) was notified with a new order received to get a "STAT x-ray" of the left hip and leg. This report states the portable in-house x-ray documented an Acute Non-displaced Left Intertrochanteric Femoral/Hip Fracture with mild varus angulation of the fracture site. V9 (Physician) was made aware of the results and R1 was sent to the emergency room and admitted to the hospital for surgical intervention to the left hip. R1's Progress Notes dated as follows document: 2/15/23 at 4:48am - R1 has a new skin concern, a Hematoma, located to R1's rear "Left Iliac Crest." Monitor R1's Hematoma to the left iliac crest and R1 complains of pain.	S9999		

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S9999	Continued From page 3 There is no documentation of a description/details of circumstances of R1's Fall on 2/15/23 in R1's Progress Notes. 2/15/23 at 7:54am - R1's "follow up assessment post-fall." This note documents R1 is alert and oriented. No changes in Range of Motion (ROM), No pain. 2/16/23 at 4:36pm - R1 is alert and oriented, intermittent confusion, with rating pain 4/10 to R1's left hip. This note documents "swelling observed at site. Reddish-purple bruising noted." There is no documentation V9 (R1's Physician) was notified of these observations. 2/17/23 at 8:22am - Follow up assessment of Hematoma. R1 is alert and disoriented "per usual baseline." R1 having pain at a 3/10 on the pain scale and not of new onset. This note documents no changes in range of motion and that R1 has swelling and deep purple bruising to the site. 2/17/23 at 1:03pm - Follow up assessment post-fall. Follow-up assessment of Hematoma. This note documents "new injury noted on assessment, Hematoma on left hip" with pain 3/10 on the pain scale and that V9 (R1's Physician) notified of "new pain onset." This note documents R1 also has a "new onset of limitation in ROM." There is no documentation of the location of limitation of ROM or that V9 was notified of R1's limitation in ROM. This note documents swelling was observed with deep purple bruising noted.	S9999		

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S9999	Continued From page 4 There are no Progress Notes from 2/17/23 at 1:03pm until 2/19/23 at 7:03am documenting "at 9:00pm (on 2/18/23), an unidentified Certified Nursing Assistant (CNA) reported change in condition" advising that R1 "has been in bed unable to walk or move for three days." This note documents on assessment, R1 unable to perform baseline ROM, with 2+ edema noted to the left distal ankle with grimacing noted. This note also documents, "Per (V9), stat X-ray processed." There is no documentation of when the facility's Mobile X-ray company was notified of the STAT X-ray order for R1. R1's Medication Administration Record dated February 2023 documents R1's administration of Acetaminophen 650mg by mouth twice daily scheduled with a pain level as follows: 2/15/23 evening/dinnertime 4/10 2/16/23 day/breakfast and evening/dinner time 0 2/17/23 day/breakfast 0 and evening/dinner time 2/10 2/18/23 day/breakfast and evening/dinner time both 3/10 2/19/23 day/breakfast "NA (not applicable)" and evening/dinnertime 4/10. This record also documents R1's pain on 2/17/23 at 8:47pm as pain rating of 10/10 and on 2/18/23 at 8:08pm as pain rating of 5/10 with Acetaminophen (Analgesic) 650mg administered. R1's Progress Notes dated as follows document: 2/19/23 at 1:07pm the facility's Mobile Radiology company arrived at 12:00pm and completed X-ray to R1's hip, leg and ankle. 2/19/23 1:09pm, R1 with increased pain in the left	S9999		

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S9999	Continued From page 5 hip, waiting on X-ray results, "called V9 about stronger pain medication." There is no documentation of a response, orders received from V9 or a follow-up with V9 related to the request for stronger pain medication for R1's increased left hip pain. 2/19/23 at 2:34pm, R1 skin concern "bruising" to the left trochanter (hip) with swelling and slight bruising. R1 complains of pain, has facial grimacing with complaints of pain in left hip with difficulty with changing positions. 2/19/23 at 2:51pm documents V2 (Director of Nursing/DON) notified of R1's X-ray results of fractured hip. 2/19/23 at 3:55pm, R1 sent to the local emergency room for evaluation and treatment due to left hip fracture. R1's Radiology Results Report dated 2/19/23 documents R1's Left Hip and Pelvis X-ray was performed on 2/19/23 at 12:31pm and reported date of 2/19/23 at 1:58pm. This report documents R1 has an Acute Non-displaced Left Intertrochanteric Femoral/Hip Fracture with mild varus angulation of the fracture site. R1's hospital History and Physical (H&P) dated 2/19/23 documents R1 "with likely memory difficulty/undiagnosed Dementia," presented to the local emergency room for left hip pain and "reportedly suffered from a fall 3 days ago, had X-rays done, notable for left hip fracture and (R1) was subsequently sent to ED (Emergency Department)." This H&P documents R1 has a history of Alcohol Abuse and Peripheral Vascular Disease (PVD) and that R1 has been taking Enteric Coated Aspirin 81mg (milligrams)	S9999		

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S9999	Continued From page 6	S9999		

(Antiplatelet Agent), one tablet by mouth daily and Clopidogrel (Antiplatelet Agent) 75 mg, one tablet by mouth daily. This H&P also documents R1's physical assessment at the hospital including R1 had "tenderness (left hip/groin)" with left leg externally rotated and shortened. R1's H&P documents R1's results of X-rays of the pelvis and left femur performed at the hospital as a Comminuted Displaced Left Intertrochanteric Fracture.

On 3/20/23 at 1:57pm, V12 (Certified Nursing Assistant/CNA) stated on 2/18/23, R1 was in "quite a bit of pain" and V12 told V14 (Licensed Practical Nurse/LPN) because V14 had come to the unit to check in. V12 (CNA) stated V13 (CNA) and V12 told V14 that something was wrong/different with R1. V12 stated R1 had stayed in bed all day, which is not normal for R1. V12 stated R1 is usually independent for transferring, ambulation and toileting. V12 stated earlier in the day on 2/18/23, V12 mentioned to V15 (LPN) that something was going on with R1 and that R1 was not R1's self. V12 stated it wasn't until V14 was notified of R1's pain and not getting out of bed that the facility got orders for testing. V12 stated R1 just "progressively worsened" until R1 was sent out on 2/19/23 after receiving the results from R1's X-ray that R1 had a hip fracture. V12 stated after R1's fall, V12 noticed someone had given R1 a urinal and R1 was using that instead of independently ambulating to use the restroom. V12 stated R1 having a "urinal threw (V12) off" because R1 had never used one before. R1 did not get out of bed on 2/18/23 during V12's shift. V12 stated R1 was in a lot of pain, making sounds and grimacing in pain when staff would assist R1 with bed mobility/cares.

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S9999	Continued From page 7 On 3/22/23 at 11:45am, V11 (R1's family) stated V11 was notified of R1's fall on 2/15/23 but "was told (R1) was okay." V11 stated the facility did not notify V11 of R1's hematoma/bruising to the left hip nor that R1 was having pain. V11 stated the facility should have never let R1 sit in pain and with the swelling and bruising of R1's left hip area for over three days before getting an order to x-ray the hip. V11 stated the facility told V11 that R1 had been assessed when they initially reported the fall and V11 was not notified of the additional details of injury nor that an x-ray to assess the hip had not been done. V11 stated V11 assumed an X-ray would have been done to assess to make sure there were no injuries after the fall or at least with the signs of the injury to the left hip. V11 stated the facility should have identified there were problems/potential internal injuries and if they would have assessed R1 thoroughly, the facility would have found the fracture sooner and R1 would not have had to lay in bed in pain and declining. V11 stated V11 came to the facility on 2/19/23 and R1 could not get out of bed and was complaining of pain to the left hip area. V11 stated R1 has a history of drug abuse and does not want narcotics so many times does not notify the facility of pain unless R1 is asked. In the morning of 2/19/23, the facility called V11 to notify V11 that R1 was not getting out of bed and was concerned for injury, so the facility was going to obtain x-rays. On 3/23/23 at 1:34pm, V2 (DON) stated on 2/15/23 at 4:45am when R1 fell, V2 was the nurse on hall. R1 was found sitting on R1's buttocks with R1's right side against the wall by R1's closet. V2 stated at that time, R1 was not complaining of pain. The facility assisted R1 back into bed. R1 had no facial grimacing or signs of pain. When asked about R1's range of motion	S9999		

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S9999	Continued From page 8 (ROM), V2 stated R1 "was asked to pick leg up and out and could" but this is not documented in R1's progress notes. V2 stated R1's skin to R1's thigh area was raised but not discolored, and R1 stated R1's left hip/thigh "hurts when it is pushed on" and stated "ouch," but nothing indicating severe pain. V2 stated V2 would not have expected the facility to notify V9 (R1's Physician) of the "new bruising" because there was already injury so bruising would be expected. V2 stated the facility was not measuring the raised area or bruising and there is no documentation of measurements of the raised area or size of the bruising. V2 stated V2 would have assumed V15 (LPN) would have told V9 R1 had new findings of limitation of range of motion. V2 stated V2 expects an X-ray ordered STAT should be completed within 4 hours. V2 stated if there is a delay, the facility should call the physician and follow up for further orders if X-ray cannot get here timely to complete testing as ordered. The facility's Physician-Family Notification-Change in Condition policy dated November 2018 documents the purpose of the policy is to ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient and effective manner. This policy documents the facility will inform the resident, consult with the physician and if known, notify the residents legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental or psychosocial status, or a need to alter a treatment significantly.	S9999		

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S9999	Continued From page 9 (A) (Violation 2 of 2) 300.610a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.2420j) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 10 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. These requirements were not met as evidenced by: Based on interview and record review the facility failed to complete and document thorough investigations to determine root cause of falls (R1) and failed to maintain a wheelchair in safe condition (R4) for two of three residents (R1, R4) reviewed for falls on the sample of five. Failing to	S9999		

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S9999	Continued From page 11 maintain R4's wheelchair resulted in R4 sustaining a puncture/laceration wound to the right thigh requiring six sutures when R4 fell onto an uncovered wheelchair hand break while attempting to self-transfer from the bed to the wheelchair. Findings include: The facility's Fall Prevention Program dated May 2022 documents the Fall Prevention Program includes methods to identify risk factors, methods to identify residents at risk for falls, assessment time frames, use and implementation of professional standards of practice, notification of physician, communication with direct care staff members, documentation requirements, care plan incorporates identification of fall risk, addresses each fall, and preventative measures. This policy documents a fall risk assessment will be performed on admission, quarterly and with each significant change in mental or functional status and after any fall incident. Accident/Incident reports involving falls will be reviewed by the Interdisciplinary team to ensure appropriate care and services were provided and determine possible safety interventions. The facility's Incident and Accidents policy dated May 2022 documents an incident/accident report is to be completed by a licensed nurse and is to include the date and time of the incident/accident, a full written statement and possible cause of incident, physical assessment, injuries noted, treatment rendered and notification of appropriate parties. Documentation in nurses' notes is to include a description of the occurrence, the extent of injury (if any), assessment of the resident including vital signs, treatment rendered and parties notified. Mental and physical state,	S9999		

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S9999	Continued From page 12 follow-up, tests, procedures, and findings are to be documented. 1. R4's Admission Record dated 3/23/23 documents R4's diagnoses including Laceration of muscle, Fascia and Tendon of the Posterior Muscle Group on Right Thigh, Repeated Falls, Cerebral Infarction, Alzheimer's Disease and Anxiety. R4's Minimum Data Set (MDS) dated 3/4/23 documents R4 requires extensive assistance of staff for bed mobility, transfers, dressing, and toilet use. This MDS documents R4 is not steady, only able to stabilize with staff assistance when moving from seated to standing position, moving on and off toilet and surface to surface transfer. R4's Care Plans with a revision date of 2/28/23 document R4 has alteration in urinary elimination as evidenced by urinary incontinence/stress incontinence. Interventions for this plan of care include toilet upon rising, before and after meals, in the evening and as needed. R4's Progress Notes dated as follows documents: 2/18/23 at 4:07am document R4 has "a new skin concern" of a "puncture wound" to the right rear thigh. This note documents R4 complains of pain "from injury," the physician was notified and R4's care plan was reviewed. This note does not document how R4 got the laceration. 2/18/23 at 11:07am - attempt to notify "emergency contact" and unable to reach by phone. There is no documentation of reason for attempting to notify R4's emergency contact or who that contact is.	S9999		

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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
S9999	Continued From page 13 2/18/23 at 12:33pm - R4 "continues on fall vitals." There is no documentation in R4's Progress Notes dated 2/1/23-2/18/23 documenting R4 had a recent fall. 2/18/23 at 4:56pm - R4 returned from the local hospital on 2/18/23 at 1:50pm. R4 has a laceration to the right inner thigh with 6 sutures measuring 7cm (centimeters) long. R4's dressing to the thigh was noted to have a moderate amount of "bloody drainage" and was changed as well as pressure applied to the wound. R4's hospital After Visit Summary (AVS) dated 2/18/23 documents R4's diagnoses including laceration of the right thigh and Hematoma. This AVS documents there are 6 sutures that were placed to the laceration and that there is a hematoma in the area of the wound. The facility's Final Report to the State Survey Agency dated 2/23/23 documents R4 was observed on the floor of R4's bedroom with a laceration to the right inner leg on 2/18/23 at 3:30am. This report documents R4 was seen in the emergency room and received 6 sutures to the right inner leg laceration. This report documents R4 returned to the facility on 2/18/23 from the hospital. The facility's investigation for R4's fall on 2/18/23 documents witness statements including V18 (Certified Nursing Assistant/CNA) stated V18 was on another hall when R4's call light came on. V18 stated V18 answered the call light and observed R4 and V19 (Licensed Practical Nurse/LPN) sitting on the ground with blood present, due to R4's leg being cut. This statement documents R4 "said (R4) slipped and cut it on the brake." This typed statement documents there were "no	S9999		

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S9999	Continued From page 14 jagged edges to brake" but does not document what time V18 responded to the call light being on. This investigation also documents V19's (LPN) statement. V19's typed statement documents R4 was last seen laying in R4's bed around 2:00am and R4 was wearing a pajama top and pull up brief. This statement documents V19 observed R4 on the floor laying on R4's back between the bed and the wheelchair with R4's "knees up" but does not document what time V19 observed/found R4. R4 stated R4 was trying to go to the bathroom and had forgotten to put R4's shoes on. R4 was not wearing shoes at the time of this fall. This investigation does not document when R4 was last toileted/offered toileting assistance. This investigation does not document how long R4's call light was sounding or the position of R4's wheelchair in relation to R4's position on the floor at the time of the fall. There is no documentation in this investigation if R4 had been incontinent at the time of the fall. On 3/23/23 at 1:34pm, V2 (Director of Nursing/DON) stated R4 fell onto R4's wheelchair and received a laceration to R4's right medial/posterior thigh. The facility reported the fall to V2 and told V2 that R4's wheelchair had "gone into" R4's leg, making a puncture wound. V2 stated V2 had the staff remove R4's wheelchair and replace R4's wheelchair with a different one after noticing R4's wheelchair brake did not have the silicone cover over the brake. V2 stated the facility looked at R4's wheelchair wheels and wheelchair brakes. R4's wheelchair was missing the handle cover for the brake that punctured R4's thigh. V2 stated R4 stated R4 was trying to go to the bathroom and fell. V2 stated V2 knows V19 (LPN) saw R4 last at 2:00am and R4 was asleep at that time. V2 was unsure of which CNA was assigned to care for R4 on 2/18/23 at	S9999		

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S9999	Continued From page 15 the time of R4's fall. V2 stated V2 did not talk to anyone else/other staff regarding R4's fall or cares provided on 2/18/23 prior to R4's fall. V2 stated V2 did not ask staff about when R4 was last assisted with toileting. V2 stated R4 did not have shoes on and R4 stated R4 forgot to put them on. V2 stated V2 does not recall asking about where R4's shoes were at the time of R4's fall on 2/18/23. V2 stated the root cause of R4's fall on 2/18/23 was that R4 "slipped" trying to get out of bed to use the toilet because R4 did not have shoes on. V2 stated R4 "tries to toilet (R4's) self frequently" and has a history of falling due to that reason. 2. The facility's investigation documents R1 sustained an unwitnessed fall on 2/15/23 at 4:45am. This investigation documents a final report to the State Survey Agency. This final report documents a summary as follows: On 2/15/23 R1 was observed on the floor of R1's room per witness statement. R1 was assessed with no changes noted. Later assessment reveals increased signs and symptoms of pain and that V9 (R1's Physician) was notified with a new order received to get a STAT x-ray of the left hip and leg. Portable in-house x-ray revealed acute non-displaced left intertrochanteric femoral/hip fracture with mild varus angulation of the fracture site. This investigation does not document a statement from the Certified Nursing Assistant caring for R1 at the time of this fall. R1's Progress Notes dated as follows document: 2/15/23 at 4:48am - R1 has a new skin concern, a Hematoma, located to R1's rear "Left Iliac Crest." Monitor R1's Hematoma to the left iliac crest and R1 complains of pain.	S9999		

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S9999	Continued From page 16 There is no documentation of a description/details of circumstances of R1's Fall on 2/15/23 in R1's Progress Notes. R1's Incident Report dated 3/13/23 at 9:22am documents V10 (LPN) was called to R1's room where R1 was noted to be lying on the floor next to R1's bed. R1 had been using the trash can for a toilet and lost R1's balance and was on the floor. This report documents R1 did not have any injuries observed. R1 was sent to the local emergency department for evaluation. This report does not document R1's mental status at the time of this fall. There is no documentation in the investigation of fall prevention interventions that were in place at the time of this fall. Pre-disposing Physiological factors, decline in cognitive skills is marked, but no additional details documented. This report documents predisposing situation factors including "behavior symptoms." This report documents "no witnesses found." There is no documentation of interviews with staff who were responsible for R1's care/supervision on 3/13/23. On 3/23/23 at 1:34pm, V2 (DON) stated V2 could not remember who the CNA was taking care of R1 at the time of R1's fall on 2/15/23. V2 stated the only witness statement obtained was from V8 (CNA) although V8 was not working at the time of R1's fall on 2/15/23. V2 stated "all interventions would have been in place" at the time of R1's fall on 3/13/23, but V2 did not detail what the fall interventions were for R1. V2 stated "family" requested toileting after meals. V2 stated V2 did not interview the CNA responsible for caring for R1 on 3/13/23. V2 stated V2 reviews the nurses notes and counts that as the nurse's statement.	S9999		

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