

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2024
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NAME OF PROVIDER OR SUPPLIER ARCADIA CARE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701
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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: One of Two: 300.610a) 300.1210a) 300.1210b)4) 300.1210c) 300.1210d)4)C) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
04/19/24

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S9999	<p>Continued From page 1</p> <p>comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.</p> <p>c) Each direct care-giving staff shall review</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:</p> <p>C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to promote residents' dignity by failing to care for and treat them with respect and in a manner that promotes their quality of life and individualized needs. This failure affects two of six residents (R8, R52) reviewed for dignity in the sample list of 39. This failure resulted in emotional distress and a significant increase in anxiety for one resident (R52).</p> <p>Findings Include:</p> <p>The facility policy titled 'Dignity' effective March 2024 documents the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall consider the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>resident's lifestyle and personal choices identified through the assessment processes to obtain a picture of his/her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. Maintaining a resident's dignity should include promoting resident independence and dignity while dining, protecting resident's private space, including residents in conversations during activities or when care is provided and refraining from practices demeaning to residents.</p> <p>1.) R52's Diagnoses List dated March 2024 documents R52 is diagnosed with Dependency on Renal Dialysis, Anxiety, Depression, Legal Blindness, Homelessness, and Bipolar Disorder.</p> <p>R52's Minimum Data Set (MDS) dated 1/10/24 documents R52 is cognitively intact.</p> <p>R52's Care Plan dated 12/27/23 documents R52 requires assistance bathing, transfers, mobility, and eating. R52 has issues with anxiety and depression and takes psychotropic medications. R52 has had episodes of suicidal ideations and suicidal attempts due to his current level of care and mental health diagnoses. R52 is at risk for abuse and neglect. R52 has impaired vision and is legally blind. R52 requires staff to verbalize things when they are taking care of him. Staff need to verbalize when they are approaching R52 and inform him of who they are and their role. Staff need to inform R52 of where they are places items he needs and and be consistent.</p> <p>On 3/24/24 at 10:30 AM R52 stated often staff enter his room without knocking or introducing themselves. R52 stated staff will wait until they are right beside his bed to say anything and</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>because he is blind, this startles him and causes him anxiety. R52 stated staff also often bring in his food tray and set it on his bedside table without making sure he knows it is there. By the time he realizes it is there, the food is cold and he does not even know what food is on his tray. R52 states he feels staff should be telling him they are bringing his food tray and letting him know what is on the plate for him to eat and assisting him in setting up his meals if needed.</p> <p>On 3/25/24 at 1:45 PM R52 stated the Transportation Driver (V23) often comes up behind him and wraps his arm around R52 (upper chest, shoulder neck area) and startles him. R52 stated V23 also sneaks into his room and shake his bed and yells his name to startle him. R52 also stated V23 has tipped his wheelchair backward as if he was falling during times V23 has transported R52. R52 stated V23 has caused him a significant increase in anxiety and emotional stress which is something he struggles with already. R52 stated he has repeatedly asked V23 to stop and he just keeps on doing these things. R52 stated he has told other residents and some staff members about V23's behavior but it continues. R52 stated he is fed up with it and he doesn't want to be around V23 Transportation Driver.</p> <p>On 3/25/24 at 3:30 PM V20 Activity Aide confirmed R52 has mentioned V23 makes him uncomfortable with the way he treats him and the disregard for his (R52) vulnerabilities (blindness).</p> <p>On 3/25/24 at 3:00 PM V1 Administrator confirmed it would be inappropriate and unprofessional for any staff member to try to startle or scare R52 in any way, and staff need to be cognizant of R52's vulnerabilities (blindness)</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>and individualize his care accordingly. V23 was away from the facility and unable to be reached during this time.</p> <p>On 3/25/24 at 4:08 PM V22 Certified Nurses Assistant stated R52 has complained to her on multiple occasions about staff not introducing themselves when they enter his room, about staff not telling him they are delivering his food tray or informing him what is on the tray, and about V23 Driver making R52 feel uncomfortable by purposefully scaring him and startling him even after R52 has asked him to stop.</p> <p>On 3/27/24 at 10:15 AM V2 Director of Nurses confirmed staff need to be sensitive to R52's medical conditions, specifically being blind. Staff need to knock upon entry to his room and announce who they are and what their role is. They need to tell him what they are going to be doing and if they deliver food, they need to make sure R52 knows what he has on his tray to eat. V2 stated V23 Driver should not be purposefully startling or scaring R52 and his actions are inappropriate and unprofessional. V2 confirmed if R52 had asked V23 to stop and he continued to startle and do things to scare R52, it is understandable that R52's anxiety would increase.</p> <p>2.) R8's undated Medical Diagnosis List documents R8's medical diagnoses of Dementia, Delusional Disorders and Heart Failure.</p> <p>R8's Minimum Data Set (MDS) dated 2/2/24 documents R8 as severely cognitively impaired. This same MDS documents R8 requires maximum assistance with toileting, bathing, lower body dressing and moderate assistance with personal hygiene.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>R8's Care Plan interventions dated 8/17/23 document R8 requires one person assistance with personal hygiene, toileting, dressing and bathing.</p> <p>On 3/24/24 at 9:35 AM R8 was sitting in his wheelchair with bedside table in front of him. R8's breakfast plate, personal items and can of shaving cream was sitting on R8's bedside table. R8's hands, bedside table and breakfast plate were all covered with small mounds of smeared shaving cream. The lid to the can of shaving cream was sitting on the floor. R8's incontinence brief completely saturated hanging down exposing the front of R8's perineal area. R8 was not wearing pants. R8 stated 'I wanted to wear pants but they (staff) were too busy. I'm a mess and I am cold. Can you put those pants on me?'</p> <p>On 3/24/24 at 9:40 AM V6 Licensed Practical Nurse (LPN) stated R8 should not be left with shaving cream. V13 stated "(R8) always makes a mess with it. (R8) doesn't shave himself so he really doesn't need that shaving cream anyway. I will make sure he gets cleaned up before he eats any of it."</p> <p>(B)</p> <p>Two of Two</p> <p>300.610a) 300.1210a) 300.1210b)</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to maintain the dignity for three residents (R11, R33, R55) affected negatively by another resident's (R289) yelling and cussing outbursts. This failure affects four (R11, R33, R55, R289) residents out of six residents reviewed for dignity in a sample list of 39 residents.</p> <p>Findings include:</p> <p>1.) R11's Minimum Data Set (MDS) dated 2/6/24 documents R11 as cognitively intact. R11's Care Plan intervention dated 9/14/22 instructs staff to provide a safe and secure environment for R11.</p> <p>On 3/24/24 at 1:05 PM R11 stated "(R289) needs to move somewhere else. (R289) yells and hollers out all kinds of curse words right in front of me. I told (V1) about it last week but nothing gets done. (R289) was out of control last night (3/23/24) at supper. (R289) was yelling the 'f' (expletive) word and calling people names. I couldn't tell if (R289) was yelling at staff or residents but he was yelling loud enough everyone in the dining room could hear and the dining room was full. I was getting ready to call the cops on (R289) because he scared me because he was so out of control. The staff walked him (R289) to his room but then he came</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>right back and started yelling again. I don't know why (R289) gets so mad but they ought to do something to control him before he hurts someone. (R289's) face gets so red and he yells so loud. You can tell (R289) is about to explode. That is why I wanted to call the cops."</p> <p>2.) R33's Minimum Data Set (MDS) dated 1/19/24 documents R33 as cognitively intact. R33's Care Plan intervention dated 12/27/23 documents R33 as a moderate risk for abuse.</p> <p>On 3/24/24 at 1:10 PM R33 stated "(R289) yells and cusses in front of everyone. (R289) was in the hallway this morning at 5:00 AM yelling at the staff to get their 'head out of their a** (expletive)'. I heard every word of it. The whole hall could hear (R289) yelling. I don't like it at all. I don't talk to people like that and I don't like it when people talk to me like that."</p> <p>3.) R55's Minimum Data Set (MDS) dated 12/11/23 documents R55 as moderately cognitively impaired. R55's Care Plan initiated 1/7/24 documents R55 is at moderate risk of being abused.</p> <p>On 3/25/24 at 1:30 PM R55 stated "(R289) yells and cusses all the time. (R289) screams out the 'f' (expletive) word and so much worse in the halls, the dining room during meal time, during the day, during the night. (R289) woke me up the other morning when he was screaming obscenities in the hall. I told the nurse to make him be quiet. I was afraid (R289) would come into my room. (R289's) room is not too far away. (R289) rolls around here (facility) scaring people and they (facility) won't do anything about him. (R289) is so intimidating because of his size and how he gets so angry when he yells."</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>R289's undated Face Sheet documents R289 admitted to facility on 3/15/24.</p> <p>R289's Electronic Medical Record (EMR) documents R289's medical diagnoses as Developmental Delay, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disorder (COPD) and Heart Failure.</p> <p>R289's Brief Interview for Mental Status (BIMS) dated 3/19/24 documents R289 as cognitively intact.</p> <p>R289's Care Plan does not include a focus area, goal nor interventions for behaviors.</p> <p>R289's Nurse Progress Note dated 3/19/24 at 4:59 PM documents "Kitchen staff notified (V6) Licensed Practical Nurse (LPN) that (R289) was in the dining room yelling at other staff members and residents. (R289) has been noted to have this behavior continuously. (R289) was removed from dining room and escorted to his room to prevent any further altercations."</p> <p>On 3/24/24 at 12:55 PM V4 Cook stated "(R289) acts up all the time in the dining room during mealtime. (R289) was yelling "you are a f***** (expletive) b**** (expletive)' and 'get your f***** (expletive) a** (expletive) over here'. (R289) yells things like that all the time. (R289) was doing it last night during supper. There are a lot of other residents around."</p> <p>On 3/24/24 at 1:00 PM V5 Dietary Aide stated "(R289) is out of control in the dining room. At lunch today (R289) was yelling at the staff 'you f***** (expletive) b**** (expletive)' and 'this food s**** (expletive)' and 'you f***** (expletive) stupid</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>b**** (expletive)'. I went over to talk to (R289) and he just kept yelling so loud. (R289) does that about every meal. I don't know why they (facility) doesn't control that somehow. Other residents don't like it at all."</p> <p>On 3/25/24 at 11:50 AM R289 stated "I get angry sometimes. I yell and scream at other residents when they say mean things to me. The other night one lady (unknown resident) told me to 'Shut up' and it made me mad so I yelled at her back. Yesterday (3/24/24) I yelled really loud in the dining room. There were a lot of people in there but I don't care. Somebody told me to shut up because I was mad at one of the kitchen staff so I yelled at all of them. They can't tell me what to do. Then they made me go to my room but I was so mad I went back to the dining room."</p> <p>On 3/26/24 at 8:00 AM V1 Administrator stated R289's careplan was entered on 3/24/24. V1 stated R289 did not have a behavioral careplan prior to 3/24/24. V1 Administrator stated R289 yells out in the dining room during mealtime "all the time". V1 Administrator stated "On 3/19/24 during supper time (R289) was yelling in the dining room. (R289) was yelling 'you f***** (expletive) b**** (expletive) ' and 'f***** (expletive) stupid b***** (expletive)' at the staff in front of a dining room full of people." V1 Administrator stated other residents are upset by (R289's) behaviors and outbursts. V1 stated "We (facility) are working on a behavioral plan for (R289) to make it a better environment for everyone."</p> <p>The facility policy titled 'Dignity' effective March 2024 documents the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER ARCADIA CARE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701
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(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 12 dignity and respect in full recognition of his or her individuality. The facility shall consider the resident's lifestyle and personal choices identified through the assessment processes to obtain a picture of his/her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. Maintaining a resident's dignity should include promoting resident independence and dignity while dining, protecting resident's private space, including residents in conversations during activities or when care is provided and refraining from practices demeaning to residents. (C)	S9999		