STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009427	A. BUILDING: _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE TOULON	HIGHWAY 17 EAST TOULON, IL 61483

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S 000	Initial Comments Complaint Investigation 2429287/IL180839	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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. 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	S9999		

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S9999	Continued From page 1	S9999		

care needs of the resident.

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 requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent staff physical abuse for one resident (R1) of three residents reviewed for abuse in the sample of four.

Findings include:

The facility's Abuse Prevention and Reporting policy and procedure, dated 9/2024, documents "This facility affirms the right of our residents to be from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment." "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident." "This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish." "Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment." This same policy documents Resident-to-Resident Abuse (of any type): "A resident-to-resident altercation should be reviewed as a potential situation of abuse."

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S9999	Continued From page 2	S9999		

"Resident-to-resident altercations that include any willful action that results in physical injury, mental anguish, or pain must be reported in accordance with regulations."

R1's medical record documents R1 with the following diagnoses: Dementia, Schizoaffective Disorder, Major Depressive Disorder, Anxiety disorder, and Generalized Idiopathic Epilepsy and Epileptic Syndromes. The Abuse/Neglect Screening for R1, dated 11/10/24, documents R1's "risk measure for likelihood for a history of previous/recent mistreatment and/or potential future problems/symptoms related to mistreatment" at a "6"; Indicating high risk due to score greater than five.

On 11/14/24 at 11:00 am, interview attempted with R1. R1 closed his eyes and when he opened his eyes, noted R1's eyes would roll up and only white sclera visible, then would lower eyes. R1 became tearful and began mumbling distorted words and not making sense.

The initial Abuse Investigation for R1, dated 11/10/24 documents an allegation of physical abuse to R1 by V8 Agency CNA/Certified Nursing Assistant was reported to V1 Administrator on 11/10/24 at approximately 4:18 am by V7 Agency LPN/Licensed Practical Nurse. V7 Agency LPN reported "that (V8 Agency CNA) was assisting (R1) when (R1) became combative during the transition, (V8 Agency CNA's) hand made contact with (R1's) head during assistance. (V8 Agency CNA) suspended immediately. Investigation initiated. Police notified and Responsible Parties notified. 5 day to follow."

The Progress Note for R1, dated 11/10/24 at 4:03 am, documented by V7 Agency LPN documents

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"(R1) found on floor by CNA, Nurse responded and attempted to perform assessment and vitals but unable to do so due to resident being combative. Nurse received help from CNA to get the resident off the floor, when attempting to do so (R1) became combative with a male CNA in return the CNA struck (R1) on the left side of face. CNA was instructed to leave the residents room and 911 was initiated. Sheriff department and EMS (emergency medical service) responded. Nurse gave sheriff department details of incident. (R1) sent out to (local hospital) via EMS for further evaluation. Administrator and POA (Power of Attorney) notified via telephone."

The Alleged Victim Interview form for R1, dated 11/11/24, documents "I was asleep, and they came into my room. they woke me up and tried to take my pants off. I wouldn't let them. They called the police. I was in a dead sleep. I thought I was having a dream." R1 stated the incident occurred about 3:30 at night in his room. R1 stated he can't remember the staff names that told him "Take all your clothes off - Take his socks." R1 reported he did not suffer injuries.

The Alleged Perpetrator Interview form for V8 Agency CNA, dated 11/11/24, documents "The nurse asked for help in (R1's) room. I went in (R1's) room with the nurse and two other staff members. (R1) was out of his bed and on the floor. (R1) was kicking and cursing and throwing his slippers at us. We placed the wheelchair close to him, we proceeded to lift him up off the floor and put him in his wheelchair. As soon as (R1) was placed in his wheelchair he punched me closed fisted on the right side of my face. I had a reflex and I hit (R1) open handed on the top of his head. After I hit him, I apologized. (R1) hit me closed fisted two more times on my shoulder

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S9999	Continued From page 4 area. (R1) went out to into the hallways cursing and yelling." On 11/15/24 V17 SSA/Social Service Assistant stated she did all the staff and resident interviews for R1's physical abuse allegation. V17 SSA stated she called all the staff who worked during the time of the allegation and wrote "word-for-word" everything they said. V17 SSA stated she did talk to V8 Agency CNA who "did say he hit R1 and that it was reflex only and hit him open handed on the head." On 11/15/24 at 10:45 am, V1 Administrator stated she was notified on 11/10/24 at approximately 4:15 am by V7 Agency LPN that there was an altercation between R1 and V8 Agency CNA. V7 Agency LPN sent V8 Agency CNA home, called the local police, and R1 was sent out to the local hospital for evaluation. V1 Administrator stated she called V8 Agency CNA and told him he was not allowed back into the facility pending investigation and notified the staffing agency of the allegation. V1 Administrator confirmed V8 Agency CNA admitted to hitting R1 and has been added to the facility's DNR (do not return) listing. (B)	S9999		