STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056747	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE BLOOMINGTON	**1509 NORTH CALHOUN STREET , BLOOMINGTON, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2569710/IL2636105 Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 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	S0000		11/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S0000	Continued from page 1 guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to implement appropriate accident and fall prevention interventions to prevent accidental removal of a feeding tube and falls for one of three residents (R1) reviewed for accidents on the sample list of six. These failures resulted in R1 pulling R1's feeding tube out requiring hospital reinsertion of the feeding tube and R1 falling and suffering a laceration above the left eyebrow requiring three sutures. Findings Include: The facility's Fall Prevention Program dated October 2024 documents the program's purpose is to assure the safety of all residents in the facility and is to include measures which determine the individual needs of each resident by assessing the risk of falls, implementing appropriate interventions to provide necessary supervision, and using assistive devices as necessary. A Fall Risk Assessment should be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions should be implemented for each resident identified at risk. R1's Care Plan dated July 2025 documents R1 admitted to the facility on 07/31/2025 and discharged on 8/3/25.	S0000		

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S0000	Continued from page 2 The same care plan documents admission diagnoses of Cerebral Infarction, Encephalopathy, Diabetes Mellitus, Chronic Embolism and Thrombosis, Seizures, Alcohol Abuse, and Stimulant Abuse. R1's Hospital Patient Discharge Plan Dated 7/31/2025 at 10:25am documents R1 was prescribed anti-coagulant and anti-platelet medications at discharge to continue at the facility. R1's Hospital Patient Discharge Plan Dated 7/31/2025 at 10:25am uploaded to the medical record documents in handwriting report that R1 is oriented to person only, does not follow directions, has a bed alarm and sitter and gets up alone. R1's Hospital Patient Discharge Plan Dated 7/31/2025 at 10:25am documents a Progress Note from V12 Hospital Physician dated 7/30/25 at 7:29pm stating R1 is encephalopathic and cannot follow commands. The same Progress Note documents R1 is status post gastrostomy tube (g-tube) insertion on 07/16/25. R1's Fall Care Plan initiated 7/31/25 documents R1 is at risk for falls and documents the following interventions dated 7/31/25: Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; Ensure the resident is wearing appropriate footwear; Physical Therapy evaluate and treat as ordered or as needed; and Review information on past falls and attempt to determine cause of falls. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team as to causes as needed. R1's Care Plan dated 8/1/25 documents a Focus Area that R1 exhibits impulsive behaviors with resultant medical concerns (falls, removing medical equipment). The same Care Plan documents the interventions as administer medications as ordered, date initiated 8/01/2025 and Room by Nurse's station, date initiated 8/01/2025 with no other interventions noted. V13, Social Service Director, Progress Note dated 7/31/2025 at 8:14am documents that R1's behaviors result in medical concerns such as falls and pulling out medical equipment. The same note does not contain any documented interventions. V6's Licensed Practical Nurse (LPN) Progress Note dated	S0000		

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S0000	Continued from page 3 7/31/2025 at 5:32pm documents R1 admitted to the facility with in the last three hours. R1 has been restless pulling on tube feeding and urinary catheter and climbing out of bed nonstop. Hard to redirect. Alert with confusion. Unable to verbally communicate needs. Family at bedside at this time. R1 continues to attempt to climb out of the bed. The Note documents a call was placed to psychiatric services with a condition report. V6's Licensed Practical Nurse (LPN) Progress Note dated 7/31/2025 at 7:25pm documents R1 sustained a fall on 07/31/2025 at 7:25 PM. The Note documents the incident occurred in the resident's room. Resident is alert and disoriented per usual baseline. No changes in range of motion from normal baseline. No new intervention is documented in the note to prevent falls. V6's Licensed Practical Nurse (LPN) Progress Note dated 7/31/2025 at 7:25pm documents V6 went to check on R1 when it was observed that the gastronomy tube (g-tube) was displaced and hanging on the floor. R1 stated R1 doesn't know what happened. The same note continues V6 called Director of Nursing (DON) for assistance, stated to send R1 to the emergency room (ER) to replace tube. 911 was called for transport. No new intervention is documented in the note after this accident. V2's Director of Nursing (DON) Progress Note dated 8/1/2025 at 10:30am documents the Interdisciplinary Team (IDT) met to discuss incident. R1 had an unwitnessed fall in his bedroom. R1 has been restless and attempting to get up out of bed. Resident was noted sitting on the floor and had removed his g-tube. Resident was assessed by unit nurse no injury noted. Sent to ER to have g-tube replaced. Returned to the facility the same evening. Root cause - self transferred. The new intervention documented was to keep R1's bed in lowest position. V3's Assistant Director of Nursing (ADON) Progress Note dated 8/1/2025 at 4:32pm documents Writer and DON entered R1's room. R1 was found standing up, pulling his gastrostomy tube. DON assisted resident on one side, writer assisted resident on other side. Chair was provided for resident to sit, once bandage was removed, resident's g-tube fell into resident's lap. 911 called, resident being sent to local emergency department, face sheet, bed hold and medication list provided to Emergency Medical Service (EMS). No new intervention is documented after R1's g-tube was pulled out for the second time The Activity Note dated 8/1/2025 at 6:44pm documents R1	S0000		

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S0000	Continued from page 4 returned from local hospital after placement of new g-tube. R1 immediately became anxious and voiced he wanted to leave facility. V6's Licensed Practical Nurse (LPN) Progress Note dated 8/3/2025 at 8:00pm documents R1 observed sitting on floor mat next to bed with blood on his face. When cleaned up, he was noted to have a laceration above the left eyebrow. He also had a wound on the left side top of scalp. DON was on site and stated to send to the hospital due to blood thinners. V2's Director of Nursing Progress Note dated 8/4/2025 at 3:13pm documents IDT met to discuss incident. R1 had an unwitnessed fall in his bedroom. He was noted sitting on the floor in his room on a floor mat that was next to his bed. Resident caused a laceration to the left brow and top of forehead. Moderate amount of bleeding noted from these areas. First aid applied and EMS called to transport resident to ER for evaluation. Root cause - self transfer. The Final Incident Report submitted to the State Agency on 08/11/2025 documents the Director of Nursing was notified at 9:00 AM on 8/4/25 that R1's laceration above the left brow was closed with three sutures. On 10/14/25 at 08:59am V6 stated R1 was impulsive and had poor safety awareness and R1 had multiple falls and pulled out the gastrostomy feeding tube multiple times needing to go to the local hospital for replacement. V6 stated that on 8/3/25 V6 arrived for work and was getting started on the shift and R1 fell hitting R1's head on the feeding tube pole and received a laceration above the left eyebrow. V6 stated R1 had a one-to-one sitter and a personal alarm when R1 was in the hospital and needed a one-to-one sitter while a resident at the facility. V6 stated R1 did not have an alarm in the facility. V6 stated R1 was confused and would not have known to push the call light for assistance. On 10/14/25 at 09:09am V3 stated that R1 was not able to use the call light due to decreased mental capacity. V3 stated R1 was impulsive with getting up and pulling out the feeding tube and needed a one-to-one caregiver. V3 stated no one was in the room with R1 when R1 fell on 8/3/25. V3 stated V3 was the off going nurse that day, and that a CNA (Certified Nursing Assistant) hollered down the hallway that R1 had fallen and was bleeding. On 10/14/25 at 1:17pm V2 confirmed the admission paperwork documented R1 is oriented to person only, does not follow directions, has a bed alarm and sitter	S0000		

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S0000	Continued from page 5 and gets up alone. V2 stated V2 was in the facility on 8/3/25 when R1 fell at the bedside and was injured needing to go to the emergency room. V2 stated R1 was severely cognitively impaired and would not have known to use his call light to call for help. V2 confirmed R1 did remove the feeding tube multiple times and was sent to the emergency room to have the feeding tube replaced. V2 confirmed R1 needed to have one to one care due to his impulsiveness and that R1 did not have one to one care at the facility. V2 confirmed R1 received three sutures to the laceration above the left eyebrow from the 8/3/25 fall. (B)	S0000		