

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Arcadia Care Morton		STREET ADDRESS, CITY, STATE, ZIP CODE 190 East Queenwood Road Morton, IL 61550	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide enough food at meals for all residents to receive the meal listed on the menu, provide enough food to allow staff to cook residents the assigned menu, and answer call lights timely for eight of eight residents reviewed for dietary needs and call lights (R5, R6, R7, R8, R12, R13, R14, and R15) in a sample of 21. This failure has the potential to affect all 83 residents who reside at the facility. Findings Include: The facility's Midnight Census Report dated 12/29/2025 documents 83 residents reside at the facility. The Resident Rights policy revised 08/2017 documents Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's rights to: Exercise his or her rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facilities rules, as long as those rules do not violate a regulatory requirement. The Call Light policy revised 01/2022 documents Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. The [NAME] Job Description dated 05/2017 documents Summary: The [NAME] is responsible for food preparation in accordance with current applicable federal, state, and local standards, guidelines, and regulations, with our established policies and procedures, and as may be directed by the Dietitian and/or Director of Food Services, to assure that quality food service is provided at all times. Essential Duties and Responsibilities: Review menus prior to preparation of food. Ensure that all food service procedures are followed in accordance with established policies. The Dietary Aide Job Description revised 07/2023 documents Summary: The Dietary Aide is responsible for aiding all food functions as directed/instructed and in accordance with established food policies and procedures. Essential Duties and Responsibilities: Review, prepare & (and) serve meals in accordance with planned menus with standardized recipes & special diet orders. The Certified Nursing Assistant Job Description revised 07/2023 documents Job Summary: The primary purpose of a Certified Nursing Assistant is to provide residents of the facility in your nursing unit with nursing and care under the supervision of a Charge Nurse, and to safeguard the health, safety, and welfare of all residents of the facility, in accordance with the facility's established policies and procedures and applicable laws and regulations, and directions your supervisor, who includes the Administrator, Director of Nursing, Assistant Director of Nursing, House Supervisor, Charge Nurse, Rehabilitation Director or other members of the</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145248	Facility ID: 145248 If continuation sheet Page 1 of 18

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>facility's management to whom such persons report, in order to assure that the highest degree of quality care is maintained at all times. As a Certified Nursing Assistant, you are delegated the administrative authority, responsibility, accountability necessary for carrying out your assigned duties. Essential Duties and Responsibilities: Carry out assignments for resident care including (but not limited to): bathing, dressing, grooming, shaving, feeding, restorative nursing procedures and retraining. Answer call lights promptly. Wash, clean, and dry all incontinent residents. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. The Concern/Compliment Forms document the following concerns: On 10/2/25 Resident Council complained Call lights not being answered in a timely manner. On 10/23/25 R16 complained Long call light times. On 10/30/25 R16 complained Concerns about the dietary menu. On 11/6/25 Resident Council complained Call lights are not being answered in a timely manner. Resident Council Meeting Minutes for October, November, and December 2025 were reviewed with the following concerns. The 10/2/25 Minutes document Call lights not being answered in a timely manner. The 11/6/25 Minutes document that V31/Prior Director of Nursing was invited to the meeting to discuss nursing concerns that included call lights. The 12/4/25 Minutes document Grievances were written for call lights. Resident Council Meeting Minutes dated 1/1/26 documents Nursing: Call lights Not being answered in a timely manner, showers are still a concern. Dietary: All trays are getting late again, no milk on trays for cold cereal this morning. Residents feel that PB (Peanut Butter) & (and) J (Jelly) and grilled cheese are not good alternatives for meals. On 12/30/2025 at 12:00 PM, the Lunch Menu documented Beef and Bean Chili, Cornbread, and Snickerdoodle Blonde Bars. On the trays chocolate pudding was being served instead of the Snickerdoodle Blonde Bars. V7/Cook stated residents are having chocolate pudding because the facility is out of eggs needed to make the Snickerdoodle Blonde Bars. 1. R5's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R5's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 1/5/26 at 3:38 PM, R5 stated that earlier that day R5 went to the bathroom and removed her wet disposable brief and turned the bathroom call light on for someone to bring her another one. R5 sat on the toilet for 35 minutes, and no one came. R5 stated that her buttocks were hurting from sitting on the toilet. R5 finally put her wet disposable brief back on, shut off the bathroom call light and left the bathroom. When R5 got back to her call light in her room R5 turned it on. R5 was not sure how long it was before staff came in, but they (staff) shut the light off and said they were going to take R5 to the shower. R5 stated that she had the wet disposable brief on from about 8:45 AM until 10:30 AM when staff took her to the shower. R5 also stated that she is supposed to have help when going to the bathroom, but she does it by herself because there is not enough staff. R5 also stated that the kitchen runs out of food and R5 does not get served what the other residents are having. It does not matter what the menu says the kitchen serves what they have. 2. R6's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R6's BIMS (brief interview for mental status) score was 14 meaning cognition intact. On 12/31/25 at 9:48 AM, R6 stated that call lights can be answered in two minutes to two hours depending on the day. There is not enough staff especially on evening shift. 3. R7's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R7's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 12/29/2025 at 2:43 PM, R7 stated staff typically take a long time to answer her call light. R7 also stated that the meal portions get small when the kitchen starts running out of food and R7 does not always get what is on the menu. On 12/29/2025 at 2:46 PM, this surveyor was in R7's room talking to R7. R7 turned on her call light for assistance. No staff came to answer R7's call light until 3:10 PM. R7 stated this call light wait time is a normal occurrence. 4. R8's MDS/Minimum Data Set, dated [DATE]</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Section C (cognitive patterns) documents R8's BIMS (brief interview for mental status) score was 10 meaning mild cognitive impairment. On 12/29/2025 at 11:20 AM, R8 was in her room, lying on her right side underneath her covers, R8 was asleep and not interviewable. R5/R8's Roommate stated this morning (12/29/25) R8 had told R5 that she (R8) was wet. R5 put R5's call light on at 6:14 AM for R8 and it was not answered until 6:56 AM. During that time R8 was soiled in her own urine the entire time. 5. R12's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R12's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 12/30/2025 at 1:07 PM, R12 stated she never gets a menu, so she does not know what is being served at each meal. R12 stated it used to be on the facilities daily paper that is passed out to each resident but even when the menu was posted, the menu was never followed. R12 had a large plastic three shelf storage unit in her room that had various food items such as beef stew, tamales, soda, etc. (etcetera). R12 stated when she uses her call light that it will usually take a while and sometimes it can take a couple of hours. R12 stated her (family member) typically comes in daily and will help with R12's showers, or helps change R12's disposable brief, or R12's ostomy bag. R12 stated the staff depend on her (family member) to do these tasks for R12 due to the staff saying they are short staffed. 6. R13's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R13's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 12/30/2025 at 1:25 PM, R13 stated the facility does not serve enough food during meals. R13 stated she keeps snacks, so she does not go hungry. On R13's bedside table was a basket full of various food items. R13 stated she has long call light wait times when she needs staff assistance. 7. R14's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R14's BIMS (brief interview for mental status) score was 12 meaning mild cognitive impairment. On 12/30/2025 at 1:05 PM, R14 stated that the kitchen runs out of food all the time. R14 also stated he does not depend on staff to help him, he is independent, but that his roommate does depend on staff. R14 stated he has witnessed staff taking at least an hour to answer a call light for his roommate. 8. R15's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R15's BIMS (brief interview for mental status) score was 99 meaning severely cognitively impaired. On 12/30/2025 at 12:15 PM, V18/R15's Family Member stated R15 is not interviewable. V18 stated staff are short a lot. V18 stated he will put R15 on the toilet while he is at the facility visiting R15 because staff will not answer R15's call light fast enough. V18 stated staff will wait a long time to come in sometimes because staff know V18 helps R15. V18 said staff expect V18 to toilet R15. V18 stated it is frustrating that the facility is short on staffing. On 12/30/25 at 12:40 PM, V9/Certified Nursing Assistant/CNA stated that staffing is short and there is not enough staff to answer the call lights as soon as they should be answered. On 12/30/25 at 12:49 PM, V10/CNA stated, Being short on food has been a problem for a while. Especially for the residents that want to eat in their room. There is not enough of what is on the menu and these residents will get whatever can be found. Several of the residents have bought their own cereal to have available when the kitchen is out of food. Mornings there will not be any juice and when the kitchen runs out of eggs or sausage the resident will only get toast. Especially rooms 20 to 29 do not get what is on the menu because there is not enough food for all residents. R5, R12, R13, and R14 are some of the residents that buy food to have available when the facility runs out. On 12/30/25 at 12:57 PM, V11/CNA stated that running out of food for the residents is a huge issue. V11 also stated I have gone to get the resident a Peanut Butter and Jelly Sandwich because they did not get much food. On 12/31/2025 at 9:50 AM, V1/Administrator stated that residents should not have to wait more than ten to 15 minutes for the call light to be answered. V1 stated if staff are not busy and a call light is going off and they do not answer it,</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>that is not acceptable. V1 stated that the kitchen should have the ingredients needed to follow the menu and be able to provide the same meal to all residents for all meals. On 12/31/2025 at 10:00 AM during a joint interview with V22/CNA and V23/CNA while they were working on B Hall, they both stated that staffing is always short, staffing is never correct on the daily staffing sheets and that A Hall never has enough staff to help with how heavy the resident cares have become. Both also stated they never have time to get all the resident cares completed or are always behind due to them having to help dietary staff by delivering the hall trays and serving the meals and drinks in the dining room. On 1/2/25 at 9:36 AM, V20/Ombudsman stated that there are a lot of complaints about call lights from residents that say the call lights are not answered or staff will come in and turn the light off saying they will be back, and they do not return. On 1/3/25 at 2:47 PM, V30/Registered Nurse stated that there has been several days the facility ran out of the main menu items and deserts. A day or two before Christmas for breakfast the residents only got a small bowl of cereal and toast. V30 stated that she heard the reason they ran out of food was because the person ordering the food said there was a budget to follow. On 1/5/26 at 1:40 PM, V12/Previous Dietary Manager stated It is absolutely correct meals are not followed and they (the facility) do run out of food. I would send the order in for what I needed and then when it was reviewed by someone from corporate the order would be lowered. When enough food is not delivered you have to make substitutions, so residents get fed. V12 also stated I reported to the company compliance that we were running out of food, and I got written up. It was retaliation for making the call. I left the room got my things and said Merry F***** Christmas to you. You should be ashamed how you treat these residents, and I walked out. On 1/7/26 at 10:05 AM, V33/Registered Dietician stated that she was not told that the facility was not following the menu and not serving the same meals to all residents because the facility ran out of food. V33 stated that V12/Prior Dietary Manager was not good at keeping V33 informed of dietary issues. The menus are not set up in house and they should be followed. V33 also stated that substituting toast to replace sausage or eggs is not ok if that is what is occurring. V33 stated that she does not know why the facility would have run out of eggs so they could not make the Snickerdoodle Blonde Bar. On 1/7/26 at 2:07 PM, V34/Regional Dietary Manager stated that she has only been in her position for a month. V34 has heard complaints of the facility running out of food due to V12/Previous Dietary Manager was not ordering the correct amount of food.</p>		

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<p>F 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide showers at least weekly for residents and failed to provide incontinence cares forcing residents to sit in their own urine and feces for long periods of time for five out of six residents (R5, R7, R8, R12, and R13) reviewed for quality of care in the sample of 21. This failure resulted in R5, R7, and R13 experiencing pain/discomfort and developing psychosocial harm leaving them to feel degraded, angry, and helpless. Findings Include: The Resident Rights policy revised 08/2017 documents Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's rights to: Exercise his or her rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facilities rules, as long as those rules do not violate a regulatory requirement. The Certified Nursing Assistant Job Description revised 07/2023 documents Job Summary: The primary purpose of a Certified Nursing Assistant is to provide residents of the facility in your nursing unit with nursing and care under the supervision of a Charge Nurse, and to safeguard the health, safety, and welfare of all residents of the facility, in accordance with the facility's established policies and procedures and applicable laws and regulations, and directions your supervisor, who includes the Administrator, Director of Nursing, Assistant Director of Nursing, House Supervisor, Charge Nurse, Rehabilitation Director or other members of the facility's management to whom such persons report, in order to assure that the highest degree of quality care is maintained at all times. As a Certified Nursing Assistant, you are delegated the administrative authority, responsibility, accountability necessary for carrying out your assigned duties. Essential Duties and Responsibilities: Carry out assignments for resident care including (but not limited to): bathing, dressing, grooming, shaving, feeding, restorative nursing procedures and retraining. Keep resident's bed, dresser, bathroom, and general living area clean and tidy. Answer call lights promptly. Put resident's clothing away properly. Wash, clean, and dry all incontinent residents. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. The Incontinent Care policy revised 4/2021 documents Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. The Concern/Compliment Forms document the following concerns: On 10/2/25 Resident Council complained Showers are still a concern on all shifts. On 10/23/25 Resident Council complained Showers are still an issue on first and second shifts. On 12/2/25 R17 complained that she has only had one shower since she has been at the facility and would like another one. On 12/4/25 Resident Council complained Showers are improving but residents state they have to ask several times to get complete. On 12/2/25 R18 complained that she prefers a shower and is given a bed bath. R18 has to Nag staff to get a shower. Resident Council Meeting Minutes for October, November, and December 2025 were reviewed with the following concerns. The 10/2/25 Minutes document Showers are still a concern. The 11/6/25 Minutes document concerns with showers. The 12/4/25 Minutes document Grievances were written for showers. Resident Council Meeting Minutes dated 1/1/26 documents Nursing: Call lights not being answered in a timely manner, showers are still a concern. 1. R5's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R5's BIMS (brief</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>interview for mental status) score was 15 meaning cognition intact. Section GG (functional abilities) documents R5 requires partial/moderate assistance for toileting. On 1/5/26 at 3:38 PM, R5 stated that earlier that day R5 went to the bathroom and removed her wet disposable brief and turned the bathroom call light on for someone to bring her another one. R5 sat on the toilet for 35 minutes, and no one came. R5 stated that her buttocks were hurting from sitting on the toilet. R5 finally put her wet disposable brief back on, shut off the bathroom call light and left the bathroom. When R5 got back to her call light in her room R5 turned it on. R5 was not sure how long it was before staff came in, but they (staff) shut the light off and said they were going to take R5 to the shower. R5 stated that she had the wet disposable brief on from about 8:45 AM until 10:30 AM when staff took her to the shower. R5 also stated that she is supposed to have help when going to the bathroom, but she does it by herself because there is not enough staff. R5 stated it makes her feel helpless and angry that she does not get cared for properly. Sitting in a wet disposable brief is uncomfortable and causes burning. I deserve better. 2. R7's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R7's BIMS (brief interview for mental status) score was 15 meaning cognition intact. R7's MDS/Minimum Data Set Section GG (functional abilities) dated 12/22/2025 documents R7 is dependent with toileting cares, and dependent with rolling left to right. On 12/29/2025 at 2:43 PM, R7 stated that there are not enough staff to answer call lights or give showers. R7 stated that she had been administered MiraLAX (a liquid laxative). R7 was unable to recall the exact date the medication was given. R7 stated that she subsequently had a bowel movement and activated her call light to notify staff. According to R7, staff did not respond promptly, and R7 was required to remain soiled for more than 90 minutes. R7 further stated that after staff assisted with cleaning her, the bed linens were not changed. R7 expressed anger and distress regarding the incident, stating that the experience made her feel degraded and that her dignity was compromised. R7 reported that she filed a grievance regarding this incident but stated that no corrective action was taken. On 1/2/26 at 11:10 AM R7 stated that last week R7 asked for a shower and was given a quick bed bath because R7 is a mechanical lift, and it takes two staff to get R7 to the shower. R7 stated then on Tuesday 12/30/25 R7 had to wait two and a half hours to be changed. An agency CNA was working the night shift and said that she had a hernia so she could not lift to change R7 and R7 had to wait until the day shift came in to be changed. R7 stated It is degrading. I have no dignity whatsoever. I have been at the facility for two years and I deserve better treatment. 3. R8's MDS Section C (cognitive patterns) dated 11/19/2025 documents R8's BIMS (brief interview for mental status) score was 10 meaning moderately impaired. R8's MDS Section GG dated 11/19/2025 documents R8 is partial/moderate assistance with toileting cares, and partial/moderate assistance with rolling left to right, sit to lying, and toilet transferring. On 12/29/2025 at 11:20 AM, R8 was in her room, lying on her right side underneath her covers, R8 was asleep and not interviewable. R5/R8's Roommate stated this morning (12/29/25) R8 had told R5 that she (R8) was wet. R5 put the call light on at 6:14 AM for R8 and it was not answered until 6:56 AM. During that time R8 was soiled in her own urine the entire time. 4. R12's MDS Section C (cognitive patterns) dated 11/20/2025 documents R12's BIMS (brief interview for mental status) score was 15 meaning cognition intact. R12's MDS Section GG dated 11/20/2025 documents R12 is dependent for toileting and showers. R12 is always incontinent of urine and has an ostomy. On 12/30/2025 at 1:07 PM, R12 reported that her (family member) typically visits daily and assists R12 with showers, changing R12's disposable brief, and managing R12's ostomy bag. R12 stated that staff rely on her (family member) to perform these tasks, despite it not being his responsibility. R12 further stated that when her (family member) does not visit, staff attempt to provide R12 with a bed bath instead of a shower, and R12 must</p> <p>(continued on next page)</p>		

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F 0558 Level of Harm - Actual harm Residents Affected - Few	<p>repeatedly request staff to provide her scheduled shower.5. R13's MDS Section C (cognitive patterns) dated 12/15/2025 documents R13's BIMs (brief interview for mental status) score was 15, meaning cognitively intact. R13's MDS Section GG dated 12/15/2025 documents R13 is dependent on toileting cares, and substantial/maximal assistance for rolling left to right.On 12/30/2025 at 1:25 PM, R13 reported that on 12/29/2025 R13 waited all morning and afternoon for assistance with changing her soiled and wet (disposable brief). R13 stated that a staff member initially began to assist R13 but then left and did not return. R13 reported that both her (disposable brief) and bed linens were soiled. According to R13, the staff member stated there were no clean sheets available and left to locate some but did not return. R13 was visibly upset, tearful, and angry stating This made me feel terrible, I kept wondering am I going to live the rest of my life like this? Will I always be this mistreated?On 12/30/2025 at 2:20 PM, V16/Certified Nurse Assistant stated she worked on 12/29/2025 and it was after 3:00 PM when R13 voiced she had been asking for someone to change her all day. V16 stated R13 was covered in R13's urine all over R13's back up to R13's neck and down to R13's feet. V16 stated R13's disposable brief was saturated, and the smell of urine was very strong. V16 stated R13 was reddened everywhere the urine touched R13's skin and V16 Felt horrible for R13.On 12/30/2025 at 2:00 PM, V14/Certified Nurse Assistant V14 stated all staff are having to choose what resident cares to complete. V14 also stated when agency staff are called, they do not come into the shift until a few hours after the shift has started and that also slows down resident cares.On 12/31/2025 at 9:30 AM, V21/Certified Nurse Assistant stated staffing is becoming an issue, V21 stated the facility has not evaluated the resident load compared to the staff and that the last DON (Director of Nursing) was the only management staff who truly helped on the floor caring for residents and evaluated the true resident load or needs. V21 stated it is hard to care for residents when CNAs are required to do all the resident cares and dietary tasks during mealtimes. V21 also stated that CNAs are required to serve room trays, pick up room trays, serve in the dining room, and feed residents, all while trying to find time to chart and care for residents. V21 stated residents are suffering because CNA staff are not able to care for residents properly.On 12/31/2025 at 9:50 AM, V1/Administrator stated she was not aware that residents were sitting in their own urine and feces for long periods of time and that is not acceptable. V1 also confirmed CNAs are required to help with dietary tasks. V1 confirmed staff are over worked and V1 Does not know what to do about it.On 1/2/25 at 9:36 AM, V20/Ombudsman stated I got a call from (R7) recently and (R7) was very upset. (R7) was raising her voice saying her call light was on and staff were not coming. (R7) said that she had sat in feces for 90 minutes with her call light on and no one answered it. V20 also stated that there are a lot of complaints about call lights from residents that say the call lights are not answered or staff will come in and turn the light off saying they will be back, and they do not return.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Arcadia Care Morton		STREET ADDRESS, CITY, STATE, ZIP CODE 190 East Queenwood Road Morton, IL 61550	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all resident rooms were cleaned daily and trash was taken out daily for three of three residents (R2, R5, and R7) reviewed for housekeeping in the sample of 21. These failures have the potential to affect all 83 residents who reside in the facility. Findings Include: The facility's Midnight Census Report dated 12/29/2025 documents 83 residents reside at the facility. The Housekeeper Job Description revised 07/2023 documents Summary: The primary purpose of the Housekeeper is to perform the day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, and/or the Director of Environmental Services, to assure that our facility is maintained in a clean, safe, and comfortable manner. Essential Duties and Responsibilities: Ensure that work/cleaning schedules are followed as closely as practical. Clean, wash, sanitize, and/or polish fixtures, ledges, room heating/cooling units, bathroom fixtures etc.(etcetera). Clean floors including sweeping, dusting, damp/wet mopping, stripping, waxing, buffing, disinfecting etc. Discard waste/trash into proper containers and reline receptacle with plastic liner. Performs other duties as assigned. Resident Council Meeting Minutes dated 12/4/25, documents Grievances were written for soiled items in rooms. Resident Council Meeting Minutes dated 1/1/26 documents Laundry/Housekeeping: Resident's state when housekeepers are off work their rooms do not get cleaned. The Laundry and Housekeeping Schedule dated 12/15/25 to 1/6/25 documents there was one Housekeeping/Laundry Staff scheduled for days and none for 4:00 PM -12:00 AM on 12/20 and 12/21/25. There were two Housekeeping/Laundry Staff scheduled for days and none for 4:00 PM-12:00 AM on 12/17/25. There were two Housekeeping/Laundry Staff scheduled for days and one for 4:00 PM -12:00 AM on 12/16, 12/18, 12/27, and 12/28/25. 1. R2's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R2's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 12/31/25 at 9:34 AM R2 stated that his room did not get cleaned on 12/30/25 but he would have liked it to be cleaned. R2 also stated that when V3/Housekeeper is off his room does not get cleaned. V4/Housekeeper Manager is supposed to cover for V3 but does not clean the rooms. On 1/2/2025 at 1:35 PM, R2 stated My room was not cleaned again today. 2. R5's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R5's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 12/29/2025 at 11:15 AM, R5 stated her room does not get cleaned daily. R5 stated her trash is only taken out when she asks staff. On 1/5/26 at 3:38 PM, R5 stated that her room had not been cleaned since 12/30/25 and she was having to Mash the garbage down in her wastebasket. R5 also stated This morning there was water on the floor in the bathroom and I took my t-shirt to mop it up so I wouldn't fall. On 1/5/26 at 3:38 PM, R5's room had a strong odor of urine. R5's wastebasket sitting next to R5's wheelchair was full of trash. The bathroom wastebasket was full of soiled disposable briefs. On 1/6/26 at 11:05 AM, R5 was sitting in therapy and stated, My room still hasn't been cleaned. R5 stated that when she went to the bathroom this morning (1/6/26) there was something that looked like tea spilled on the floor next to R8's bed. R5 stated I decided I wasn't cleaning it up this time. On 1/6/26 at 11:15 AM, R8/R5's Roommate was lying in bed. There was a large brown dried sticky stain on R8's floor next to R8's bed. There was a soiled disposable brief in the bathroom wastebasket. The rest of the floor in the room and bathroom had not been swept or mopped. R8 stated that no one had cleaned the room. 3. R7's MDS/Minimum Data Set, dated [DATE] Section C (cognitive patterns) documents R7's BIMS (brief interview for mental status) score was 15 meaning cognition intact. On 12/29/2025 at 2:43 PM, R7</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arcadia Care Morton		STREET ADDRESS, CITY, STATE, ZIP CODE 190 East Queenwood Road Morton, IL 61550	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>stated she is lucky if housekeeping comes in to sweep and mop the floors. R7 stated her room is not cleaned daily, and her trash is not taken out daily. On 12/29/2025 at 11:25 AM, V3/Housekeeper stated if she is gone the daily cleaning does not get done in all the rooms. On 12/31/25 at 9:38 AM, V14/Certified Nursing Assistant stated that housekeeping did not clean the rooms on A Hall on 12/30/25. On 12/31/25 at 9:40 AM, V3/Housekeeper stated that she was off on 12/30/25 and no one cleaned the resident rooms on 12/30/25. On 12/31/25 at 11:58 AM V4/Housekeeping/Laundry Manager stated that when staff have a day off she fills in. V4 was asked who cleaned A Hall on 12/30/25. V4 stated that she did. When V4 was told that residents and staff had said the rooms on A Hall were not cleaned on 12/30/25 V4 said Hmm and then mumbled something about laundry. On 12/31/2025 at 1:00 PM, V1/Administrator confirmed resident rooms should be cleaned daily with the floors being swept/mopped and trash should be taken out daily or when the trash can is full. On 1/3/25 at 2:47 PM, V30/Registered Nurse stated that there was not a housekeeper for A side of the building and none of the residents' rooms were cleaned. On 1/5/26 at 12:40 PM, V1 stated the same staff are cross trained to do laundry and housekeeping. There should be at least three housekeeping/laundry staff on days with one doing laundry, the other two doing housekeeping, and one housekeeper/laundry staff that works 4:00 PM to 12:00 AM.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent falls, investigate one fall, notify the Physician and Residents Representative of two falls, and failed to put interventions in place for two falls for one resident (R19) of five residents reviewed for accidents in the sample of 21. Findings include: The Fall Prevention Program revised 05/2022 documents Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines: The Fall Prevention Program includes the following components: Use an implementation of professional standards of practice. Immediate change in interventions that were successful. Notification of physician, family/legal representative. Documentation requirements. Care plan incorporates: Identification of all risk/issues. Addresses each fall. Interventions are changed with each fall, as appropriate. Standards: Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determined possible safety interventions. Fall/safety interventions may be included but are not limited to: Call lights are answered promptly. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. In addition to the use of Standard Fall Precautions, the following interventions may be implemented for residents identified at risk: The resident will be checked approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the residents' risk factors and the plan of care. The Incident and Accident policy revised 5/2022 documents Policy: The incident/accident report is completed for all unexplained bruises or abrasions, all accidents, or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident to resident altercations. Procedure: An incident is defined as any happening, not consistent with the routine operation of the facility, that does not result in bodily or property damage. An accident is defined as any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident/accident report will be completed for: 6. All unexpected events occur that cause or pretend to a resident or employee. 1. An incident/accident report is to be completed by a RN/Registered Nurse or LPN/Licensed Practical Nurse and is to include: a. Date and time of an incident/accident. B. Full written statement and possible causes of incident physical assessment, injuries noted, vital signs, treatment, education of appropriate. R19's computerized Medical Record documents that R19 admitted to the facility on [DATE] with diagnoses which included Athetoid Cerebral Palsy, Anxiety, and Developmental Disorder of Speech and Language. R19's MDS (Minimum Data Set) assessment dated [DATE] documents Section C (Cognitive Patterns) a BIMS (Brief Interview for Mental Status) of 99, indicating (severely impaired cognition). Section GG (Functional Ability) documents R19 is dependent on staff for eating, all activities of daily living, transfers, and requires partial assist for bed mobility. R19's Care Plan documents R19 is at risk for falls r/t (related to) immobilization and decreased cognition. R19's Nursing Note dated 11/28/25 at 2:58 PM, documents Therapy was walking down the hall towards the nurses' station when she saw (R19) lean forward in the wheelchair and fall out of the chair and hit her head on the sharps container and the nurses cart. R19's Nursing Note dated 12/4/25 at 6:02 PM, documents (R19's) sustained a fall on 12/04/2025 5:05 PM. The incident occurred in the nurse station. Resident is alert</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and disoriented per usual baseline. An e(electronic)-mail written by V20/Ombudsman to V1/Administrator dated 12/11/25 at 10:19 AM, documents Good Morning (V1/Administrator). What was the outcome of (R7) stating that the residents were left in the ADR (Assisted Dining Room) alone and that (R19) fell while in the ADR alone . (R19) fell, hitting her head on (R7's) chair. R19's Witnessed Fall Report dated 12/13/25 at 6:15 PM, documents that R19 fell in the (Assisted) Dining Room. The CNA (Certified Nursing Assistant) called the nurse about the witnessed fall of (R19). The CNA said they witnessed (R19) slide out of the chair to the floor. There is no notification documented that the physician or resident's representative were notified of the fall. R19's Nursing Note dated 12/15/25 at 11:17 AM, documents: (R19) sustained a fall on 12/15/2025 8:50 AM. The incident occurred in the ADR (Assisted Dining Room). An e-mail written by V1/Administrator to V20/Ombudsman dated 12/19/25 at 2:00 PM, documents that V29/Prior Director of Nursing/DON was doing the investigation on R19's suspected fall on 12/3/25 in the ADR and V29's last day was unexpectedly yesterday. V1 will have to find the information and will get it to V20 shortly. The Incident/Accident Log printed 12/29/25 documents that R19 was admitted to the facility on [DATE]. R19 had a fall on 11/28 and 12/4/25 at the Nurses Station. R19 fell on 12/13 and 12/15/25 in the Assisted Dining Room/ADR. (There was a fall on 12/3/25 in the ADR for R19 that was not documented)V21's Witness Statement signed by V21/CNA dated 1/6/2026 documents I was working on 12/3/2025. At approximately 5-5:30 PM I heard a resident yell from the assisted dining room. When I entered the dining room (R19) was on the floor tipped back in her chair. I then yelled for a nurse and (V37/Licensed Practical Nurse/LPN) and (V38/LPN) entered. V37's Witness Statement signed by V37/LPN dated 1/6/2026 documents, I was assigned to B wing on 12/3/2025. At approximately 5-5:30 (PM) prior to dinner I heard (V21/CNA) yell for help from the assisted dining room. When I entered the dining room I observed (R19) lying on the floor on her back with her wheelchair under her. V38's Witness Statement signed by V38/LPN dated 1/6/2026 documents, On 12/3/2025 I was assigned to A wing. The Certified Nursing Assistant (V21) yelled for help. I entered the dining room and observed (R19) lying on the floor. We got (R19) back up into her chair. I assessed (R19's) head to ensure no injuries, no injuries were noted. On 1/2/25 at 9:36 AM, V20/Ombudsman stated that R7 told V20 on 12/4/25 that a resident (that was [AGE] years old that could not talk or do anything for herself, later identified as R19) fell in the assisted dining room and there was no staff in there to help. R7 kept yelling until staff finally came to help. V20 asked V1/Administrator about R19's 12/3/25 fall on 12/4/25 because V20 was worried if there were no staff in the ADR with the residents because that is not safe. V1 said she was not aware of the fall and would have V29/Prior DON look into it. V20 stated I still have not heard back about (R19's) fall. I sent an email to (V1) to follow up on the fall and I still have not got an answer about what happened. On 1/2/26 at 11:10 AM R7 stated that there was a resident (R7 did not know the residents name but described her as [AGE] years old that could not talk. The resident was later identified as R19) that fell backwards in her wheelchair while in the Assisted Dining Room hitting R7. R7 stated There is supposed to be staff in the dining room to help us. When (R19) fell I was yelling for help for (R19). (R20) was going to try to help but I was afraid that (R20) would fall and get hurt so I told (R20) not to try to lift (R19). Staff finally came to get (R19) off the floor. On 1/3/26 at 2:34 PM, V39/R19's Family Representative stated that R19 was admitted to the facility on [DATE] and was notified of R19 falling three times. V39 stated she would have liked to know if R19 had other falls. Staff told V39 that R19 fell because they (staff) could not use a seat belt to keep R19 in the wheelchair. V39 stated If they would put (R19) on the floor on a mat (R19) would be happy playing with her toys. On 1/3/25 at 2:47 PM, V30/Registered Nurse/RN stated There should be someone in the assisted dining room all the time with the residents. It is not</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe for them (residents) to be unattended. On 1/6/26 at 2:25 PM, V35/Regional Nurse Consultant stated that she had started the investigation today (1/6/26) to find out if R19 had a fall on 12/3/25. Staff confirmed that R19 did have an unwitnessed fall in the Assisted Dining Room on 12/3/25. The nurse (V38/LPN) did not do an Incident Report, make a Nursing Note, or do any notifications to the physician or R19's Representative, and no interventions were put in place for the fall on 12/3/25 in the ADR. V35 also stated that R19 also had a fall on 11/28, 12/4, 12/13, 12/15 and there was no intervention put in place for the fall on 12/15/25.		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions/EBP or perform hand hygiene during indwelling urinary catheter care for 1 resident (R9) of 3 residents reviewed for catheter care in the sample of 21. Finding include: The Urinary Catheter Care policy revised 09/2020 documents Purpose: To establish guidelines to reduce the risk of or prevent infections in resident with an indwelling catheter. Guidelines: 1. Disposable one-time use gloves shall be worn when emptying urinary drainage bags and when performing perineal care. 2. Hand hygiene shall be performed before and after touching any part of the urinary catheter drainage system. The Enhanced Barrier Precautions policy revised 12/2025 documents Statement of Purpose: Enhanced Barrier Precautions (EBP): recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Personnel: Personal providing direct care. Personal Protective Equipment: Gown and gloves. Policy: EBP may be considered and implemented for: Wounds and/or indwelling medical devices (central line, feeding tube, tracheostomy, drains, AV (arteriovenous) fistulas, etc. (etcetera). Personal Protective Equipment- Standard Precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: Dressing, Bathing/Showering, Providing Hygiene, Changing Linens, Incontinent Care, Medical Device Care, Wound Care. The Certified Nursing Assistant Job Description revised 07/2023 documents Job Summary: The primary purpose of a Certified Nursing Assistant is to provide residents of the facility in your nursing unit with nursing and care under the supervision of a Charge Nurse, and to safeguard the health, safety, and welfare of all residents of the facility, in accordance with the facility's established policies and procedures and applicable laws and regulations, and directions your supervisor, who includes the Administrator, Director of Nursing, Assistant Director of Nursing, House Supervisor, Charge Nurse, Rehabilitation Director or other members of the facility's management to whom such persons report, in order to assure that the highest degree of quality care is maintained at all times. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. Assure that established infection control and standard precaution practices are maintained when performing nursing procedures. R9's computerized Medical Record documents that R9 is an [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Dementia, Cognitive Communication Deficit, Retention of Urine, Obstructive and Reflux Uropathy, and Urinary Tract Infection. R9's Physician's orders, printed 12/31/25, document an order for Enhanced Barrier Precautions related to an indwelling urinary catheter and indwelling urinary catheter care every shift and as needed. Order date 8/30/24. R9's Care Plan documents Enhanced Barrier Precautions r/t (related to) indwelling catheter. Date Initiated 8/30/24. Intervention Educate staff/resident/family on enhanced precautions as needed. Gown and glove during high contact resident care activities (such as dressing, bathing, showering, changing briefs, assisting with toileting or wound care). The same Care Plan also documents Risk of infection and recurrent infections related to nutritional deficit and hydration deficit as evidenced by poor oral intake, dehydration, and weakened immune function. Date initiated 11/4/25. Interventions Ensure proper hygiene practices to prevent infection, such as hand washing, wound care, and maintaining a clean environment. Date initiated 11/4/25. On 12/31/25 at 10:03 AM, R9 was lying in bed watching television. V11/Certified Nursing Assistant/CNA entered R9's room to provide indwelling urinary catheter care. V11 applied gloves without washing his hands and did not put on a gown. V25/CNA came in the room to talk to R9's roommate. V11 asked V25 if V25</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>would help reposition R9 in bed so V11 could do catheter care. V25 assisted repositioning R9 and did not wear gloves or a gown. V11 then filled the washbasin with water and put several washcloths in the water. V11 used a washcloth to clean R9's penis. V11 then took another washcloth out of the washbasin and cleaned R9's scrotum. V11 then took another washcloth out of the washbasin and cleaned the catheter tubing and catheter bag. V11 then changed his gloves for the first time since starting care but did not wash his hands. V11 then pulled up and adjusted R9's pants. On 12/31/25 at 10:14 AM, V11/CNA was asked if a gown was required when doing catheter care. V11 stated that a gown was not required for catheter care. On 12/31/25 at 2:35 PM, V1/Administrator stated that when a resident is in Enhanced Barrier Precautions a gown and gloves should be worn for all high contact resident care, and this included indwelling urinary catheter care. V1 also stated that hands should be washed when entering a resident's room before putting on gloves and hands should be washed after each time gloves are removed. V1 also stated that gloves should be changed after touching anything dirty.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have enough staff to answer call lights, provide showers, provide incontinent care, clean residents' rooms daily, and prevent falls. The facility also failed to accurately report the number of staff that worked on the daily staffing report and failed to update the Facility Assessment Tool with the number of staff needed. This has the potential to affect all 83 residents residing in the facility. Findings include: The facility's Midnight Census Report dated 12/29/2025 documents 83 residents reside at the facility. The Facility Assessment Tool for 08/2025 through 08/2026 documents Requirement: Nursing facilities will conduct, document, and annually review a facility wide assessment, which includes both their resident population and the resources the facility needs to carry for their residents. Purpose: The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care needs, as well as your capabilities to provide services to the residents in your facility, at least annually, per the above requirement. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The intent of this facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. The Facility Assessment documents the facility should staff seven Certified Nursing Assistants/CNAs on days and evenings for 87-92 residents and three CNAs on Nights for a census under 86. (There is no guidance if the census is higher than 86 on nights.) It also documents Disclaimer: Use of this tool is an example and does not ensure regulatory compliance. Dated 7/1/24. The Staffing Calculator and Scheduling -User Guide (not dated) documents This guide provides clear instructions for administrators to use the Daily Staffing Calculator and Apploi Scheduler to ensure compliance with Illinois licensure minimum staffing requirements. Other Direct Care Staff - Therapists Direct resident care only; include resident-specific charting. Activity Staff Only direct resident engagement. (not planning/office time) Compliance Tips Count only direct resident care + (and) resident-specific charting. The Detailed Census Report for 12/1-12/31/25 documents a census of 86 residents daily on 12/26 and 12/27/25, 87-91 residents daily for the rest of the month. The Daily Staffing Calculator-Illinois Licensure Minimums (detailed) Report documents - Certified Nursing/CNA Hours as follows: 12/4/25-17 worked (18 needed), 12/5-16 worked (18 needed), 12/6-20 worked (22 needed), 12/7-20 worked (22 needed), 12/8-17 worked (18 needed), 12/13-21 worked (22 needed), 12/14-21 worked (22 needed), 12/22-17 worked (18 needed), 12/23-17 worked (18 needed), 12/26-16 worked (18 needed), 12/27-21 worked (22 needed), 12/28-21 worked (22 needed), and 12/31/25-17 worked (18 needed). The Daily Assignments Sheets dated 12/3 and 12/23/25 (picked at random) document that in addition to the nursing staff scheduled that on Wednesday 12/3/25 V1/Administrator/Registered Nurse/RN worked the floor 7:00 AM-9:00 AM, V41/MDS/Minimum Data Set Coordinator/RN worked the floor 8:00 AM-12:00 PM, and V29/Previous Director of Nursing worked the floor 12:00 PM-6:00 PM. On 12/23/25 V1 and V41 both worked the floor from 7:00 AM to 4:00 PM. The Daily Staffing Calculator-Illinois Licensure Minimums (Detailed) Reports dated 12/3 and 12/23/25 (picked at random) were reviewed for accuracy of the documented hours. On 12/3/25 there were 30 Therapists Hours documented (actual was 22.15 hours per V26/Therapy Director) and Activity Staff 22 hours were documented (actual was 16.5 hours per V40/Activity Director). On 12/23/25 there were 24 Therapists hours documented (actual was 20.03 hours per V26) and Activity Staff 24 hours were documented (actual was 15.45 hours</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arcadia Care Morton		STREET ADDRESS, CITY, STATE, ZIP CODE 190 East Queenwood Road Morton, IL 61550	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>per V40).The Labor Log by Therapist for 12/3/25 documents 28.27 hours. V26/Therapy Director hand wrote the treatment hours totaled 22.15 hours. The Labor Log by Therapist for 12/23/25 documents 25.13 hours. V26 hand wrote the treatment hours totaled 20.03 hours. The Laundry and Housekeeping Schedule dated 12/15/25 to 1/6/25 documents there was one Housekeeping/Laundry Staff scheduled for days and none for 4:00 PM -12:00 AM on 12/20 and 12/21/25. There were two Housekeeping/Laundry Staff scheduled for days and none for 4:00 PM-12:00 AM on 12/17/25. There were two Housekeeping/Laundry Staff scheduled for days and one for 4:00 PM -12:00 AM on 12/16, 12/18, 12/27, and 12/28/25.The Incident/Accident Log printed 12/29/25 documents that R19 was admitted to the facility on [DATE]. R19 had a fall on 11/28 and 12/4/25 at the Nurses Station. R19 fell on 12/13 and 12/15/25 in the Assisted Dining Room/ADR. (There was a fall on 12/3/25 in the ADR for R19 that was not documented)The Concern/Compliment Forms document the following concerns: On 10/2/25 Resident Council complained Call lights not being answered in a timely manner. Resident Council also complained Showers are still a concern on all shifts. On 10/23/25 R16 complained Long call light times. On 10/30/25 R16 complained Concerns about the dietary menu. On 11/6/25 Resident Council complained Call lights are not being answered in a timely manner. Resident Council also complained Showers are still an issue on first and second shifts. On 12/2/25 R17 complained that she has only had one shower since she has been at the facility and would like another one. On 12/4/25 Resident Council complained Showers are improving but residents state they have to ask several times to get complete. On 12/2/25 R18 complained that she prefers a shower and is given a bed bath. R18 has to Nag staff to get a shower.Resident Council Meeting Minutes for October, November, and December 2025 were reviewed with the following concerns: 10/2/25 Call lights not being answered in a timely manner. Showers are still a concern. 11/6/25 concerns with call lights and showers. 12/4/25 Grievances were written for cell phones, showers, soiled items in rooms, and call lights. Resident Council Meeting Minutes dated 1/1/26 documents that Nursing: Call lights are not being answered in a timely manner, showers are still a concern and when housekeepers are off work their rooms do not get cleaned.On 12/29/2025 at 2:43 PM, R7 stated that there are not enough staff to answer call lights or give showers. R7 stated that she had been administered MiraLAX (a liquid laxative). R7 was unable to recall the exact date the medication was given. R7 stated that she subsequently had a bowel movement and activated her call light to notify staff. According to R7, staff did not respond promptly, and R7 was required to remain soiled for more than 90 minutes. R7 further stated that after staff assisted with cleaning her, the bed linens were not changed. R7 expressed anger and distress regarding the incident, stating that the experience made her feel degraded and that her dignity was compromised. R7 reported that she filed a grievance regarding this incident but stated that no corrective action was taken.On 12/30/2025 at 12:15 PM, V18 (R15's Family Member) stated that when he visits R15's he has to put R15 on the toilet due to the call light not being answered timely and a lack of staff. On 12/30/25 at 12:49 PM, V10/CNA stated that staffing is often short. Especially on the night shifts. They do not have enough staff to get the residents up and dressed in the mornings. V10 stated that on 12/23/25 they had V10 on the daily but not on the main schedule so V10 did not show up for work. V10 got a call V10 needed to come to work. V10 called V11/CNA to see how short the facility was and V11 said that he was the only one on his unit and he needed help. V10 stated that she went in and worked about four hours to help. V10 stated It is a daily occurrence that we get here and there is not enough staff. There is no one here at 6:00 AM to address that. It has happened two to three times in one week that it is just me and one other CNA in the building. We get here at 6:00 AM and go from one end of the hall to the other and do the best we can. Along with doing the resident care we have to stop care to feed in the assisted dining room. V10 also stated It</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>is not ok to leave residents in the ADR unattended. We have been told not to do it, but we have to because there is not enough staff. On 12/30/2025 at 1:07 PM, R12 stated when she uses her call light that it will usually take a while and sometimes it can take a couple of hours. R12 stated her family member typically comes in daily and will help with R12's showers, or helps to change R12's disposable brief, or her ostomy bag. R12 stated the staff here depend on her family member to do these tasks for R12 due to the staff saying they are short staffed. On 12/30/2025 at 1:05 PM, R14 was in his room, in his wheelchair, dressed. R14 voiced he does not depend on staff to help him, he is independent, but that his roommate does depend on staff. R14 stated he has witness staff taking at least an hour to answer a call light for his roommate. On 12/30/2025 at 1:25 PM, R13 stated she has long call light wait times when she needs staff assistance. On 12/31/25 at 9:48 AM, R6 stated that call lights can be answered in two minutes to two hours depending on the day. There is not enough staff especially on evening shift. On 12/31/2025 at 10:00 AM in a joint interview, V22/Certified Nurse Assistants/CNA and V23/CNA were working on B Hall and stated staffing is always short, staffing is never correct on the daily staffing sheets and that A Hall never has enough staff to help with how heavy the resident cares have become. V22 and V23 both stated they never have time to get all the resident cares completed or are always behind due to the demand to help dietary staff and resident cares. On 1/2/25 at 9:36 AM, V20/Ombudsman stated that there is a bad issue with the facility being short of CNAs. There are a lot of agency staff working so the facility may have the number of staff that they say are needed so it looks good on paper, but it is not. I got a call from (R7) recently and (R7) was very upset. (R7) was raising her voice saying her call light was on and staff were not coming. (R7) said that she had sat in feces for 90 minutes with her call light on and no one answered it. V20 also stated that there are a lot of complaints about call lights from residents that say the call lights are not answered or staff will come in and turn the light off saying they will be back, and they do not return. On 1/2/26 at 11:10 AM R7 stated that last week R7 asked for a shower and was given a quick bed bath because R7 is a mechanical lift, and it takes two staff to get R7 to the shower. R7 stated then on Tuesday 12/30/25 R7 had to wait two and a half hours to be changed. An agency CNA was working the night shift and said that she had a hernia so she could not lift to change R7 and R7 had to wait until the day shift came in to be changed. R7 stated It is degrading. I have no dignity whatsoever. I have been at the facility for two years and I deserve better treatment. On 1/2/26 at 11:55 AM, V1 Administrator stated that staffing is a struggle. Several days a week V1 will work the floor from 7 AM to 11 AM then have the Director of Nursing or V41/MDS/Minimum Data Set Coordinator work the floor the rest of the day. There have been times V1 has had to work the floor all day. V1 stated that the facility needs to hire three nurses for 12-hour shifts, one full time day nurse, one part time day nurse, and one part time night nurse. The Certified Nursing Assistants/CNAs work 8(eight)-hour shifts and there needs to be seven CNAs hired, one full time for days, three full time for evenings, two part time evenings, and one part time nights. Until they get the positions filled the facility has had to use a lot of agency staff. There have been problems with the agency staff not taking care of the residents like facility staff do. V1 has had complaints about agency staff being on their phone, not answering call lights, and not providing the care the residents should get. V1 stated I have to do finagling to get the staffing numbers I need. On 1/3/25 at 2:47 PM, V30/RN stated that there are times the staffing is very poor. Evening shift needs more CNAs because there are not many regular staff and agency is used to fill in. The agency staff are not familiar with the residents and are not as efficient as staff that know the residents. There was a day that at 6:00 AM there were only two CNAs in the building and there should have been 8. On 1/3/26 at 3:04 PM, V31/CNA stated that she</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>usually works the night shift and when she comes in there are not enough staff working evenings. Most of the staff on evenings are agency staff and they do not get everything done that needs to get done. The facility needs more reliable CNAs. V31 also stated that she thinks residents are having falls because there is not enough staff. On 1/5/25 at 11:00 AM, V11/CNA stated that lack of staff is an issue and that is one of the reasons V11 recently resigned. On 12/23/25 at 6:00 AM there were only two CNAs to start the shift and there should have been seven. V11 stated It's not just one day this happened it happens often. When we ask for help it may be hours before we get it. There are cares that can't be done. I am one person and can only do so much. V11 also stated There is supposed to be staff in the Assisted Dining Room at all times but that's not possible. On 1/6/26 at 10:55 AM, R12 was sitting in therapy in her wheelchair. R12 stated that there is not enough staff. I can't get them to get me up. They won't get me up twice a day like they are supposed to because they say they are too busy. If they do get me up, I'm left sitting in my wheelchair all day. I want to go home and I'm not gonna get there if they don't get me up. On 1/6/26 at 2:25 PM, V35/Regional Nurse Consultant stated that R19 had an unwitnessed fall in the ADR on 12/3/25. V35 also stated that R19 also had falls on 11/28, 12/4, 12/13, and 12/15/25. On 1/6/26 at 2:47 PM, V1/Administrator stated that the CNAs work 7.5 (seven and a half) hours, and the nurses work 12 hours. Since IDPH (Illinois Department of Public Health) last cited the facility for staffing the facility determined their needs to be a minimum of 18 CNAs Monday to Friday and 22 CNAs for Saturday and Sunday. V1 also stated that the Facility Assessment was not updated and does not show the accurate number of CNAs needed daily to provide the care the residents need. When V1 was shown that two of the random sampled reported daily staffing numbers (12/3 and 12/23/25) were not accurate for the Therapy Hours and Activity Hours V1 stated that she gets the numbers daily from V26/Therapy Director and V40/Activity Director and was not aware they were not accurate. V1 also stated that she will need to start getting the accurate numbers from V26 and V40.</p>		