STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145248	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Morton	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from physical and verbal abuse for three of four residents (R3, R4, and R6) reviewed for abuse in a sample of 12. Findings include:The facility's Abuse Prevention and Reporting-Illinois Policy, dated 3/2026, documents Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive in resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Definitions: Abuse: Abuse means any physical or mental injury; retaliation; or sexual assault inflicted upon a resident other than b y accidental means (210 ILCS (Illinois Compiled Statues) 44/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, .or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR (Code of Federal Regulations) 483.5). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish (42 CFR 483.12 Interpretive Guidelines). The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (42 CFR 483.5). Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means, and that requires medical attention (77 Illinois Administrative Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines.) Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines.) R3 and R4's Final Five-Day Reported Incident to Illinois Department of Public Health, dated 3/20/26, documents on 3/14/26 V3/Activity Aide heard yelling in the dining room. V3 entered the dining room to see R9 yelling at R4. R4 appeared upset with coffee on herself and the table. R4 reported to V3 that R3 had hit her. R8 and R9 both stated they had witnessed R4 throw coffee on R3, when R3 was trying to assist another resident in the dining room, which resulted in R3 slapping R4. Both R3 and R4 were immediately separated. R3's Abuse Allegation Interview, dated 3/14/26, documents I think I slapped a woman (identified as R4) open handed in the face. (R4) came and threw a drink on me. It got my orange shirt all wet and I had to change it. R4's Abuse Allegation Interview, dated 3/17/26, documents I was minding my own business in the dining room. This big man (R3) came up and slapped me several times for nothing. R3's MDS (Minimum Data Set) Assessment, (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 3/20/26, documents R3 is moderately cognitively impaired, requires supervision with most ADLs (Activities of Daily Living), had physical and verbal behaviors directed at others, and put others at significant risk for injury. R3's Care Plan documents R3 has potential to be verbally aggressive related to history of behaviors related to psychosis. This same Care Plan documents R3 has the potential to be physically aggressive related to history of related behaviors and psychosis such as spitting, throwing medications and water when agitated. R3's Progress Note, dated 3/20/26, documents IDT (Interdisciplinary Team) reviewed resident to resident altercation between (R3) and (R4) physical abuse. Root cause of allegation determined to be medication compliance along with increased stimuli. R4's MDS, dated [DATE], documents R4 is moderately cognitively impaired, requires partial/moderate assistance with most ADLs, and had no behaviors directed at others. R4's Care Plan documents R4 is/has potential to be verbally and physically aggressive related to anger, depression, poor impulse control related to metabolic encephalopathy, which includes throwing water on her peers. On 5/2/26 at 9:30 AM, R4 stated she remembers a big man (identified as R3) slapping her across the face in the dining room. [NAME] stated, I don't even know what I did to get slapped. On 5/2/26 AT 3:33 PM, V3/Activity Aide stated, A few months ago I was preparing to take my break when I heard loud yelling coming from the dining room. Upon entering the dining area, I observed two residents, (R3) and (R4), yelling at each other. I observed coffee had been spilled on (R4) and her table. (R4) immediately reported to me that (R3) had slapped her in the face twice. I observed visible finger marks on the left side of (R4's) face, consistent with her report. (R3) admitted to me that he had slapped (R4) because (R4) made him mad. On 5/3/26 at 8:55 AM, R9 reported witnessing a physical and verbal altercation that occurred in the dining room a few months prior involving R3 and R4. R9 reported that R4 was antagonizing R3 by intentionally blocking R3's path as R3 attempted to push another resident through the dining room. R9 stated, (R4) told (R3) to go on and that's when (R3) become upset. (R3) then slapped (R4) in the face with his hand and yelled shut up b***h. On 5/3/26 at 9:05 AM, R8 reported witnessing a physical altercation in the dining room occurring months prior. R8 reported, R4 threw a cup at R3, prompting R3 to slap R4 open handedly in the face. On 5/3/26 at 9:30 AM R3 states he slapped a female resident (identified as R4) in the face in the dining room a few months ago because R4 had threw a drink on R3. 2. R5 and R6's Final Five-Day Reported Incident to Illinois Department of Public Health, dated 2/27/16, documents On 2/23/26 (V6/LPN/Licensed Practical Nurse) heard yelling while walking down the hallway. (V6) entered (R5 and R6's) room and saw (R6) tussling with (R5) over items belonging to (R6). (R6) stated she was trying to find a clean pair of socks when (R5) went off on (R6) and started throwing things and hitting (R6) and (V6). V6/LPN's Witness Statement, dated 2/23/26, documents I was walking down the hall and heard yelling in (R5) and (R6's) room. Upon entering the room, I saw (R6) and (R5) tussling over items belonging to (R6). I pulled (R5) away while in her chair, whiling pulling (R5) back she started to physically hit (R5) in the arm approximately three times. R5's MDS dated , 3/27/26, documents R5 has short-term and long-term memory problems. On 5/2/26 at 12:13 PM V6/LPN stated, I recently witnessed a resident-to-resident altercation between (R5) and (R6). While passing (R5 and R6's) room, I saw (R5) attempting to take (R6's) belongings. When (R6) tried to reclaim (R6's) items, (R5) started hitting (R6) on the arm multiple times. When I was intervening to remove (R6) from the situation (R5) began hitting me. On 5/3/26 at 9:37 AM R6 reported that a few months ago, upon returning to her room from a hospital stay, R6 began looking for a pair of clean socks. R6 stated, My roommate, (R5), falsely accused me of stealing her socks. (R5) began hitting me in the face, arms, and upper body. A staff member (identified as V6/LPN) came into the room to help me and (R5) began hitting her as well.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that sufficient staff was available to meet the needs of residents. This failure has the potential to affect all 77 residents currently residing at the facility. Findings include:The facility's Census Report dated 5/1 /26 documents 77 residents reside within the facility.The Facility Assessment, dated 1/6/26, documents General Care: Activities of Daily Living- Bathing, Showers, Oral/Denture Care, Dressing, Eating, Support with Needs Related to Hearing/Vision/Sensory Impairments; supporting resident independence in doing as much of these activities by himself/herself. Bowel and Bladder- Bowel/Bladder Toileting Programs, Incontinence Prevention and Care, Intermittent or Indwelling or Other Urinary Catheter, Ostomy, Responding to Requests for Assistance to the bathroom/toilet promptly in order to maintain continence and promote dignity. Staffing Plan: Staff: Direct Care Staff- Refer to Facility Assessment Addendum and CMS (Centers for Medicaid and Medicare Services) Minimum Staffing Rule.The Illinois Long-Term Care Ombudsman Program Residents' Rights Booklet, dated 11/2018, documents Your rights to dignity and respect: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.The facility's Resident Council Minutes, dated 3/5/26, documents New Business: 2. Nursing: Residents say showers are improving. Customer service is still an issue. Call light response time is an issue at times. The facility's Resident Council Minutes, dated 4/2/26, documents New Business: 10. Nursing: Showers are becoming an issue, staffing concerns, cell phone usage, and customer service concerns were discussed.The facility's Water Pass-Hydration Policy, dated 12/2025, documents Purpose: To provide fresh drinking water to residents in a clean and sanitary manner to meet hydration needs. Guidelines: Fresh cold ice water will be provided to each resident a minimum of three times each day, unless contraindicated.The facility's Call Light Policy, dated 1/2026, documents Purpose: To respond to resident's requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a 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.Resident Council's Concern/Compliment Form, dated 2/5/26, documents Third shift only changed resident one time during the night.R8's Concern/Compliment Form, dated 2/17/26, documents Third shift on 2/17/26 did not change R8 all night. This same Concern Form documents an (unknown) CNA (Certified Nursing Assistant) came in the room and walked out, not returning to change R8. Resident Council's Concern/Complement Form, dated 3/5/26, documents Nurse staffing, nurse and CNAs are not stable, still using agency often. This same form documents Summary of Pertinent Findings: Continue to hire staff. Staff are being held accountable, so they are leaving.R9's Concern/Compliment Form, dated 3/2/26, documents This evening an (Unknown) third shift CNA took over an hour to answer call light and change me.R12's Concern/Complement Form, dated 3/4/26, documents (R12) voiced concerns during 3/4/26 on angel rounds regarding call light times from the previous weekend.R12's Concern/Compliment Form, dated 3/30/26, documents (R12) states that on 3/27/26 that she was not changed at all during night shift. This same Concern Form documents Summary of Pertinent Findings: Substantiated. Staffing concerns were reported and confirmed by V2/Director of Nursing. Corrective Action Taken: V1/Administrator and V2/Director of Nursing working on staffing together before new scheduler starts on 4/6/26.R11's Concern/Compliment Form, dated 4/24/25 documents (R11) states last night she was on her call light for more than thirty minutes before someone came and helped.The facility's Daily Assignment Sheet for Nursing and CNAs dated 3/27/26 one Agency CNA (V8), one Agency Nurse (V7), and one Facility LPN (Licensed Practical Nurse) (V9) worked 10 pm- 6am. The facility's Daily Staffing Calculator dated 3/27/26 documents Resident Census 72.On 5/2/26 at 9:51 AM, R7 stated he had staffing concerns involving a (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	specific night shift featuring only one CNA and two nurses (on 3/27/26). R10 stated no one was answering call lights and there was no CNA on his side of the building to help him or any resident. R7 stated, It seems as though second and third shifts are short a lot of time or they have agency CNA's who don't do their job. No one even came in and rounded the night of 3/27/26. On 5/2/26 at 10:00 AM, V4/RN (Registered Nurse) stated, I came into work the morning of 3/28/26 and V7/Agency LPN (Licensed Practical Nurse) reported that she was the only staff member on her side of the building during the entire night. V7 told me there was one Agency CNA (V8) and one nurse (V9/LPN). When I started my shift that morning, a lot of residents were upset because they had not been provided with incontinent care all night.On 5/2/26 at 12:13 PM V6/LPN stated, It can be challenging on third shift, especially with staffing inconsistencies and a lot of times ice water doesn't get passed. While we are typically scheduled for four CNAs and two nurses, we are often short-staffed. This shortage, combined with varying staff performance, leads to longer call light wait times and less frequent checks for incontinence and general care. On 5/3/26 at 9:05 AM R8 reported persistent delays in call light response times, particularly during the night shift, where she has waited over an hour for assistance recently. R8 stated that staff members have attributed these delays to being short-staffed. On 5/3/26 at 9:15 AM R12 stated my hygiene needs are not being met; specifically, on the third shift, I am often only changed once due to delayed response times. Staff state it is due to staffing shortages or agency staff just not doing their jobs. On 5/3/26 at 9:45 AM, R2 reported that her call light often goes unanswered for extended periods. As a result, [NAME] frequently performs self-transfers to use the bathroom independently. On 5/3/26 at 11:04 AM V11/LPN stated A lot of times ice water won't get passed on third shift because after the kitchen closes before 10:00 PM we can't get in the kitchen to get ice anymore, therefore third shift can't pass fresh ice water. We need more staffing because of agency. Agency staff often don't know what to do. It's just like a body filling the opening and not taking care of the residents timely. On 5/3/26 at 11:41 AM R11 stated the facility is always having staffing issues which causes her to have to wait longer on her call light and not get changed timely. R11 stated, I have recently had to wait over a 1/2 hour to an hour to get changed after being incontinent.On 5/3/26 at 12:27 PM, V8/Agency CNA stated, On 3/27/26 when I arrived at work all the CNAs were already gone. After around forty-five minutes, (V9/LPN) realized there was only one CNA for the entire building for third shift. (V9) called on-call to let them know of the shortage, but no one ever came in. I only stayed on one side of the building attempting to do incontinent rounds on the residents. That was on B side. If I had time I went to the other side and answered a few call lights but was unable to change anyone on A side. The Agency Nurse (V7) didn't want to do any incontinence cares because she was Agency as well and was having to complete her nursing duties. We should not have worked that short on night shift.On 5/8/26 at 11:56 AM, V1/Administrator verified that the night shift on 3/27/26, was understaffed with only two nurses and one CNA who worked. V1 stated, I was not notified by (V2/Director of Nursing) staff was working that short until two days later (3/30/26). I should have been notified immediately. V1 acknowledged the safety risks of the shortage, noting, That is not enough staff on third shift to take care of all the residents we have, ensuring rounds are being done and call lights are being answered timely. While V1 admitted that staffing has been an ongoing issue for the past three months despite using agency fill-ins, they noted that the facility is currently doing a lot of hiring in hopes of having full staff again.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview, and record review the facility failed to ensure fresh ice water is passed to residents three times per day per facility policy. This failure has the potential to affect all 77 residents residing within the facility. Findings include:The facility's Census Report dated 5/1/26 documents 77 residents reside within the facility.The facility's Water Pass-Hydration Policy, dated 12/2025, documents Purpose: To provide fresh drinking water to residents in a clean and sanitary manner to meet hydration needs. Guidelines: Fresh cold ice water will be provided to each resident a minimum of three times each day, unless contraindicated.R10's Concern/Compliment Form, dated 2/5/26, documents Nature of Concern/Compliment: (R10) told me sometime after 4:00 AM (R10) had asked for ice water. (R10) was told by two unknown CNA's (Certified Nursing Assistants) that between the hours of 4:00 AM - 6:00 AM they can't do that.On 5/2/26 at 9:45 AM, R2 had a cup of warm water sitting on R2's bedside table. R2 stated the staff occasionally pass fresh ice water on second shift and rarely on third shift. R2 stated she usually has to request fresh ice water which sometimes takes the staff a long time to bring when she does request it. R2 stated she would like fresh ice water passed to her every shift.On 5/3/26 at 9:15 AM, R12's water cup was sitting on R12's bedside table empty. R12 stated fresh ice water does not get passed three times a day. R12 stated, We are lucky if ice water gets passed one time a day. I would like it to be passed three times a day.On 5/3/26 at 11:25AM, R10 stated he prefers just ice in his cup, but the staff does not come around and offer it at least three times a day. R10 stated, Third shift will say they don't have access to the ice at times.On 5/2/26 at 12:13 PM, V6/LPN (Licensed Practical Nurse) stated she works third shift as a nurse and it can be challenging, especially with staffing inconsistencies and a lot of times ice water doesn't get passed.On 5/3/26 at 9:25 AM, V7/Agency LPN reported critical staffing shortages during her 6:00 PM to 6:00 AM shift on 3/27/26. According to V7, no CNAs were on her side for third shift. V7 stated that the lack of personnel made it impossible to complete essential tasks, including rounding on residents, changing them, and providing ice water.On 5/3/26 at 11:04 AM V11/LPN stated, A lot of times ice water won't get passed on third shift because after the kitchen closes before 10:00 PM we can't get in the kitchen to get ice anymore, therefore third shift can't pass fresh ice water.On 5/6/26 at 11:49 AM, V13/CNA stated that fresh ice water isn't getting passed a lot of times on second shift due to staffing and working with Agency CNA's most of the time.On 5/8/26 at 11:46 AM V2/Director of Nursing stated ice water should be passed every shift.