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	06/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to answer and follow up with call lights in a timely manner for three of three residents (R3, R4, and R5) in a sample of six. Findings include: The facility's Call Light policy, effective 01/2026, documents to respond to residents' requests and needs in a timely and courteous manner. This form documents to listen to residents' requests. Do not make him or her feel that you are too busy to help. Respond to request. If item is not available, or request is questionable, get assistance from charge nurse. Return to the resident with a prompt reply. On 6/22/26 at 12:45pm, R4's call light was activated. At 1:00pm R4's call light was answered, and R4 was told that she would be right back to help her with her toileting needs. At 1:10pm, R4 stated that she needed to be changed because she was incontinent of stool. R4 stated that she was told they would be right back to assist her, but they still have not come back. At 1:20pm, R4 reactivated her call light because she was not assisted with her toileting needs. R4's call light was answered at 1:25pm and assistance was provided. On 6/22/26 R3 activated her call light at 12:50pm. At 1:10pm R3's call light remained on. R3 stated that she had her call light on about a half hour ago, which was answered, and she was told by the staff that she did not have time to put R3 on the bedpan and left the room. R3 stated that she needed to have a bowel movement. R3 was becoming more anxious and agitated the longer she waited. At 1:25pm V5, Licensed Practical Nurse, was summoned to R3's room. V5 stated that call lights are to be answered as soon as possible, and 40 minutes is too long for the call light to be on. R5's Concern/Compliment form, dated 4/16/26, documents that there is a lack of follow-through time after answering call lights. R5 documented that it was over a half an hour after her call light was answered. R5's Concern/Compliment from, dated 5/20/26, documents that her call light was activated for a pillow, and she had to sleep without a pillow. The facility's Resident Council Minutes, dated 6/4/26, documents that call light response is an issue on third shift. On 6/23/26 at 10:00m R6, Resident Council President, stated that there have been complaints concerning call lights not being answered in a timely manner, the last couple of months in Council meetings. R6 stated that there were also complaints about follow-up after call lights were answered. R6 stated that staff will say they will be right back, but never come back. On 6/23/26 at 2:00pm, V1, Administrator, stated that call lights are to be answered as soon as possible. V1 also stated that follow-up is to be as soon as possible, too.

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

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	06/23/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to maintain a full-time qualified Director of Nursing. This failure has the potential to affect all 79 residents residing in the facility. Findings include: The Facility Assessment, dated 1/6/26, documents that one Director of Nursing will be staffed. This form documents the final rule regarding Nursing Services, see Code of Federal Regulations section 483.35 for details. Centers for Medicare and Medicaid Services Code of Federal Regulations Section 483.35 documents that facilities must designate a full-time RN as the Director of Nursing and utilize RN services for at least 8 consecutive hours a day, 7 days a week (with specific waivers/exemptions allowable in certain rural areas). On 6/22/26 at 10:30am, V1, Administrator, stated that there is no Director of Nursing at this time. On 6/23/26 at 10:00am, R6, Resident Council President, stated that it seems like care has gone downhill since there has not been a Director of Nursing. The facility's Census Report, dated 6/22/26, documents that 79 residents reside in the facility.

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	06/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement isolation precautions for one of three residents (R1) reviewed for infection control in a sample of six. Findings include: The facility's Infection Precaution Guidelines, effective 01/2026, documents that it is the policy of this facility to, when necessary, prevent the transmission of infections within the facility through the use of Isolation Precautions. This form also documents Contact Precautions: in addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident care items. This form documents that the above epidemiologically important organisms include (multidrug-resistant organisms) such as methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococcus (VRE), other highly transmissible infections such as Clostridium difficile and herpes, etc. R1's current Physician Order Sheet documents for R1 to take Sulfamethoxazole-Trimethoprim 800-160mg (milligrams) tablet by mouth twice daily MRSA of the throat. On 6/22/26 at 11:30am, R1 did not have an isolation sign posted on her door, nor was there Personal Protective Equipment (PPE) available. R1 stated that staff wear gloves during care, but no other PPE. On 6/23/26 at 11:45am R1 did not have an isolation sign or PPE available. On 6/23/26 at 11:45am, V9, Registered Nurse, stated that she was unsure as to what isolation R1 should be on, but verified that R1 did have MRSA of the mouth and was positive for C-diff (Clostridioides Difficile). V9 stated that it is the Director of Nursing or Infection Preventionist's responsibility to post the signs for isolation. V9 stated that there is neither a DON nor an Infection Preventionist employed at this facility. V9 verified that R1 did not have an isolation sign posted, nor had PPE readily available for use. On 6/24/26 at 2:00pm, V1, Administrator, verified that R1 should have had a sign placed on her door indicating that she was in contact isolation. V1 stated that V3, Corporate Infection Preventionist, is covering infection control, but is only at the facility three days a week.