STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145442	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Toulon	700 E Main St Toulon, IL 61483

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 - 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** 45395 Based on observation, interview, and record review, the facility failed to protect two cognitively impaired residents (R1, R8) who were at risk for abuse; and failed to prevent resident to resident physical abuse by two cognitively impaired residents (R2, R9). This failure affected 4 of 4 residents (R1, R2, R8 & R9) reviewed for abuse in a sample of 9. The failure resulted in R2 placing both of his hands around R1's neck and forcefully squeezing into R1's neck; and resulted in R8 being physically punched in the face with a closed fist by R9. Findings include: The final abuse investigation report provided by V1 (Administrator) documented an incident date of 04/27/2025 and indicated, resident was noted to have his peer put his hands around his neck. Report documented that R1 placed his hands around the neck of R2, however, during staff interviews, it was determined that R2 was the aggressor and R1 was the victim. 1. R1's electronic record documented last admitted [DATE] with a past medical history not limited to Alzheimer's disease, dementia, and major depressive disorder. Brief interview for Mental Status (BIMS) assessment dated [DATE] indicated severe cognitive impairment. R1's care plan report provided by facility on 05/14/2025 reads in part: impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, dementia, impaired decision making, psychotropic drug use and is at a medium risk for abuse/neglect as noted from abuse screening related to diagnosis of Alzheimer's, dementia, and major depressive disorder. Report also indicated that R1 has a terminal condition and is receiving hospice services that was initiated on 11/25/2024. R1's hospice note dated 04/27/2025 at 03:11 PM documented that resident is alert with usual confusion, and has been fine since incident this morning. R1's abuse/neglect screen dated 04/28/2025 indicated that R1 is at moderate risk for abuse and/or neglect. R1's psychosocial assessments dated 04/28, 04/29, and 04/30/2025 documented R1 was unable to recall any details related to a resident to resident physical altercation. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 05/13/2025 at 09:45 AM and 05/14/2025 at 08:44 AM, R1 was observed resting in a wheelchair on the memory care unit in front of the nurse's station. R1 was alert to self and was not interviewable. R2's electronic record documented admitted [DATE] with a past medical history not limited to vascular dementia, mood [affective] disorder, anxiety disorder and convulsions. Brief interview for Mental Status (BIMS) assessment dated [DATE] indicated severe cognitive impairment. Behavior note dated 03/26/2025 at 02:11 PM documented R2 was punching nurse during medication administration. Behavior note dated 03/27/2025 at 11:43 PM documented R2 would be aggressive to staff when trying to help resident sit down. Behavior note dated 04/06/2025 at 10:38 PM documented R2 can be resistive to care and can be combative at times. Behavior note dated 04/09/2025 at 02:43 PM documented R2 is aggressive with staff and was hitting, scratching, cussing. R1 was uncooperative and shoving with hospice staff at facility to shower resident. Behavior note dated 04/13/2025 at 06:02 PM documented R2 was pacing prior to supper then suddenly became agitated and refused nursing care. Behavior/Mood Charting dated 04/27/2025 at 12:03 PM documented R2 had agitation and was exit seeking. Physical aggression incident happened at 9:45 am with another male peer. no injuries noted. Intervention included as needed lorazepam administered at 11:30 AM. Hospice aware of both hospice residents involved and indicated could administer R2 a second lorazepam in 2hours if needed. Behavior note dated 04/28/2025 at 04:51 PM documented R2 struck nurse's hand when trying to administer medications to resident. R2's psychosocial assessments dated 04/28/2025 documented R2 was unable to recall any details related to a resident to resident physical altercation. R2's aggressive behavior assessment dated [DATE] documented resident does not have a history or recent episode of aggressive/agitated behavior and/or non-compliance with medications, treatments, regimen or resisting care with no known triggers. Behavior note dated 04/30/2025 at 12:46 AM documented R2 will usually follow directions but can become aggressive to staff and other residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's psychiatry note dated 04/30/2025 indicated resident was seen per staff request because R2 had an altercation with another resident. Appearance/Behaviors displayed were exit seeking and pleasantly confused. Plan of action indicated R2's diagnosis of dementia is worsening and unstable at visit with new orders to start haloperidol (antipsychotic) 5 milligrams (mg) intramuscularly every eight hours as needed for dementia and agitation, increase divalproex (mood stabilizer) 500mg to three times daily. R2's medication list includes sertraline 100mg daily for anxiety symptoms, trazadone 75mg nightly for sleep disturbance and lorazepam 0.5mg nightly for anxiety symptoms. Most recent gradual dose reduction on 04/30/2025 for sertraline, trazodone and lorazepam was contraindicated due to increased risk for worsening of anxiety and/or insomnia. (Review of active orders showed medication orders as indicated). Behavior note dated 05/07/2025 at 02:51 PM documented R2 was administered as needed lorazepam due to being restless, resistive with cares, punching staff, saying negative statements to staff, and wandering. Medication Administration Note dated 05/08/2025 at 04:29 PM documented R2 was administered haloperidol 5 mg due to agitation, cursing, walking fast up and down the hallway reaching out at staff. Behavior note dated 05/10/2025 at 02:06 PM documented that R2 was combative with staff while trying to record his vitals and was administered an as needed lorazepam for agitation. R2's care plan report reviewed at facility on 05/13/2025 documented that resident has impaired cognitive function, is/has the potential to be physically aggressive, the potential to be verbally aggressive at times, and is resistive to personal care at times related to dementia and is receiving anti-psychotic medications related to behavior management that was initiated on 05/13/2025 which is after the date of incident with R1. Care plan's focus for trauma informed care indicated that resident had a traumatic event, and circumstances occur and R2 is triggered by loud noises. On 05/13/2025 at 09:46 AM V4 (Licensed Practical Nurse) said R2 was anxious and resistive with cares this morning. At 09:59 AM, V4 indicated that R2 is aggressive at times with staff but not to his peers. On 05/13/2025 at 10:02 AM, V5 (Alzheimer Coordinator/Aide) said R2 was the aggressor in the incident between R1 and R2 on 04/27/2025. On 05/13/2025 at 10:06 AM, observed R2 was lying in bed and was not interviewable at this time. At 10:06 AM, V5 said R2 is very confused and can be combative at times. On 05/13/2025 at 12:00 PM, V1 (Administrator) said in the incident between R1 and R2, R2 was the aggressor and R1 was the victim. V1 then said both residents were sitting down at different tables on the memory unit not close to each other when something triggered R2 and he put his hands around R1's neck. V7 (Certified Nursing Assistant) ran over to the residents and had to wedge her hands under R2's hands and R1's neck to separate them. V1 added that R1 had no signs of injuries, R1 was monitored frequently, R2 was placed on 1:1 monitoring for the remainder of the shift (12 hours) and both residents were seen by a psych physician. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 05/13/2025 at 12:52 PM, V6 (Licensed Practical Nurse) said on 04/27/2025 at approximately 9:45 AM she was seated in the dining area on the memory (E) unit administering medications to another resident when V7 (Certified Nursing Assistant) rushed across the room. V6 couldn't see what was going on but V7 informed her that R2 had both his hands, one in front, and one to the back of R1's neck. V7 was trying to separate R2's hands from his neck. V6 said after R1 and R2 were separated, she assessed R1, but didn't see any markings on his neck. R1 complained that his neck hurt. V6 then said she administered an as needed lorazepam to R2 because he was pacing and wandering. R2 was placed on 1:1 monitoring, and staff performed frequent safety checks on R1. V6 said that R2 can be combative with staff, has behaviors, and is resistive with cares at times. She added a few days prior, R2 was hitting an aide that was trying to get his vital signs. On 05/13/2025 at 1:52 PM, V7 (Certified Nursing Assistant) said at 09:45 AM, she was clearing breakfast trays in the memory care unit. She added that R1 was seated at the table facing the nurse's station and R2 was wandering around the dining room then towards the nurse's station. V7 then said she heard R1 yell out, ouch stop it and when she looked over towards R1, V7 said she saw R2's right hand to the front of R1's throat and his left hand was to the back of R1's neck. V7 added that R2's fingers were digging into R1's neck and he looked mad. V7 then said she wedged her fingers in between R2's fingers which he was still squeezing around R1's neck and while also trying to push her away. V7 added that she yelled out for the other aide (V11) who was seated on other side of room feeding another resident to assist. V7 said she was able to pry R2's hands from R1's neck by the time V11 arrived and after they were separated, V7 and V11 both took R2 to his room and tried to calm him down. V7 said she made other reports on R2 to V1 (Administrator) about R2 grabbing her wrists and pulling her around the dining room who then followed her around after she got away from him. On 05/13/2025 at 2:05 PM, V7 said not too long after this incident, R1 was at the table with his walker next to him when R2 walked towards R1 and grabbed his walker then started walking away. V7 said when she attempted to get the walker from R2, he got agitated and shook the walker at her with a mean and irritated look to his face. V7 added that R2 tried to push her away with the walker but couldn't, so he let go of the walker then reached over and hit her in the stomach. V7 said the nurse gave him anxiety medication but he was still up walking around and was agitated so the nurse had to give him more medication. V7 also said that R2 has good days and bad days, and on his bad days, it is very bad. At times, R2 is resistive and combative and can't be redirected. On 05/14/2025 at 12:38 PM, V11 (Certified Nursing Assistant) said R2 is moody and will swing punches at staff for no reason, curse at us, etc. V11 then said on day of incident, she saw R2's hands around R1's neck and he was squeezing his hands. She added that V7 was trying to pry his fingers away from R1's neck and after they were separated, R1 had red marks to his neck that looked like finger marks. V7 added that the nurse (V6) said she didn't see any redness but she and V7 both saw them on R1's neck. She also said on the morning of this incident, R2 had grabbed her arm in which she had to pry his hands off and finally got away form R2, but he then started walking after V11. She added that R2 had punched V7 on the same day of incident. 2. Review of R8's abuse investigation report documented on 05/01/2025 (per V1 date is 5/11) at 05:40 PM, staff reported that a physical altercation occurred between R8 and a male resident. This report documented R8's diagnosis and mental status includes dementia, Brief Interview of Mental Status (BIMS) score of 01/15 which indicates severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R8's electronic record documented admitted [DATE] with a past medical history not limited to dementia, mood [affective] disorder, anxiety disorder and depression. Brief interview for Mental Status (BIMS) assessment dated [DATE] indicated severe cognitive impairment. R8's incident note dated 05/11/2025 at 07:24 PM documented another resident (R9) was walking very fast toward R8 and was witnessed by staff striking R8 on the right side of her face. R8 then complained of pain. R9 called R8 [NAME] and when he was informed by staff that R8 was not [NAME], R9 said he was sorry. R8's abuse/neglect screen dated 05/12/2025 indicated resident is at moderate risk. On 05/13/2025 at 10:00 AM, R8 was seated at a table in dining area on memory care unit. R8 was alert to self and was not interviewable. R8's care plan report reviewed at facility on 05/13/2025 documented that resident has impaired cognitive function/dementia or impaired thought processes related to dementia; is at a medium risk for abuse/neglect as noted from abuse screening related to dementia and mental health diagnosis. On 05/13/2025 at 11:52 AM, V1 (Administrator) said R8's incident occurred approximately at 5:40 PM, a male dementia resident (R9) hit R8 in the face. V1 added that R9 thought R8 was his daughter named [NAME] and after staff intervened and explained she was not, R9 apologized. V1 said that R8's face was red with no indication to send out emergently. R9 was added on the list to be seen by psych. On 05/13/2025 at 12:50 PM, V6 (Licensed Practical Nurse) said around 5:40 PM on 5/11/2025, she was finishing her med pass in the dining area on memory unit. She added that the aides were either still feeding residents or cleaning up from dinner; V10 (CNA) was in dining room and V9 (CNA) was down the hall. V6 then said R8 was sitting at the table being quiet when she noticed R9 get up fast and started walking fast to R8's table so she followed him. V6 said that R9 went right up to R8, called her [NAME], then hit her in the face with a closed fist. R8's right cheek looked red. On 05/13/2025 at 02:54 PM, V10 (Certified Nursing Assistant) said R9 had walked past him in the memory care dining room then he heard R8 scream out; prior to she was sitting quietly eating her dinner. V10 said when he turned, he heard R8 verbally reacting to what R9 did but V10 did not see any physical contact. He added that V6 (LPN) was by them and had it under control. V10 added that he did not see any injuries, but V6 said R8 had a mark on her face. R8's psychosocial assessments dated 05/14/2025 documented resident to resident physical altercation, resident hit R8 in the face. R8 is unable to recall incident. R9's electronic record documented admitted [DATE] with a past medical history not limited to dementia and history of falling. Brief interview for Mental Status (BIMS) assessment dated [DATE] indicated moderate cognitive impairment. R9's aggressive behavior assessment dated [DATE] documented resident has a history or recent episode of aggressive/agitated behavior and/or non-compliance with medications, treatments, regimen or resisting care including non-compliance with medications, resisting cares, and may be agitated at times. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Incident Note dated 05/11/2025 at 06:33 PM documented that R9 was walking very fast toward R8 and was witnessed by staff striking R8 on the right side of her face. R8 then complained of pain. R9 called R8 [NAME] and when he was informed by staff that R8 was not [NAME], R9 said he was sorry. Incident Follow Up note dated 05/12/2025 at 10:58 AM indicated R9 had a witnessed altercation with another resident, root cause determined to be dementia. New intervention is to have a medication review done by psych. R9's care plan report reviewed at facility on 05/13/2025 documented that resident has a behavior problem; is resistive to cares related to dementia; resident is/has potential to be physically aggressive related to dementia (05/12/2025); has impaired cognitive function. On 05/13/2025 at 10:15 AM, observed R9 seated at table in dining area on memory care unit. R9 was alert to self and not interviewable. On 05/14/2025 at 02:00 PM, V1 (Administrator) said the abuse incidents between R1, R2, R8, and R9 can be substantiated but could not be prevented due to the population and their unpredictable behaviors. Abuse policy effective 09/2024 reads in part: 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 and 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on interview and record review, the facility failed to follow physician's orders by not obtaining a urine sample as ordered in a timely manner for one of three residents (R3) reviewed for nursing services in a sample of 9. Findings include: R3's electronic record documented admitted [DATE] with a past medical history not limited to paraplegia, depression, extended spectrum beta lactamase (esbl) resistance, and urine retention. Brief interview for Mental Status (BIMS) assessment dated [DATE] indicated no cognitive impairment. R3's active orders as of 05/14/2025 showed resident is on enhanced barrier precautions for wounds, esbl in urine and straight catheterization (cath); esbl colonized (12/23/2024); infectious disease consult for diagnosis of esbl in urine; straight cath every four hours while awake due to urine retention; may straight cath during the night as needed for distention. R3's care plan report provided by facility on 05/14/2025 reads in part: resident is at risk/actual for urinary tract infection (UTI) due to diagnoses, straight cath every 4 hours, decrease intake of water, and preference to drink coffee all day long; has colonized multi-drug resistant organism noted to/in urine (esbl); enhanced barrier precautions related to chronic wounds, straight cathing; resident has a urinary tract infection related to ESBL with date initiated on 05/08/2025; requires contact isolation related to ESBL. Nursing Note dated 04/24/2025 at 10:40 AM submitted by V2 (Director of Nursing) indicated she spoke with R1's mother who was concerned with resident's behavior, being worn out more frequently and going to bed earlier. A request was sent to V12 (Medical Doctor) with orders received for bloodwork and urinalysis (UA). Nursing Note dated 05/02/2025 at 12:53 PM indicated R3's UA results were sent to V12 with no new orders received and were awaiting urine culture results. Review of laboratory requisition dated 05/03/2025 documented R3's urine specimen was collected on 04/29/2025 at 08:45 PM and showed abnormal results within multiple tests. On 05/14/2025 at 11:37 AM, V2 (Director of Nursing) said after she received the UA order for R3, she completed a laboratory (lab) requisite form and provided it to the floor nurse but did not create a laboratory order which would also alert staff to collect a specimen. V2 then said lab days are Monday, Wednesday and Friday so if R3's urine specimen was not collected with the last straight cath on Thursday night (04/24/2025), then it would need to be collected on the night before the next lab pick-up day on Monday the 28th. V2 added that staff failed to obtain R3's sample for several days. It should have been obtained on 04/24/2025 and collected on the following lab day on 04/25/2025. On 05/14/2025 at 01:51 PM, R3 reported no issues or concerns with nurses not performing his straight catheterization every four hours daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Entering and processing physician orders policy effective 04/25/2025 reads in part: when receiving physician's orders by telephone, enter the order into the resident's chart under order tab and according to the instructions for the type of order that is received. Be sure to indicate a diagnosis or indication for use.