

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Toulon		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review the facility failed to thoroughly assess and document an accurate assessment for one resident (R1) transferred to the emergency room of three residents reviewed for hospitalizations in a total sample of thirteen.</p> <p>Findings Include:</p> <p>The Facility's Assessment of Resident policy dated 10/2024 documents the purpose of the policy is to gather comprehensive information as a basis for identifying resident problems/needs and developing or revising an individual plan of care. The policy also documents begin assessment based on resident position. Conduct head to toe examination on admission incidents, and significant status changes and periodically as necessary. Conduct specific system assessment, as required by the diagnosis, history or physical complaint. If reassessing resident, review previous nursing progress notes, physician's orders and progress notes, weights, intake/output records laboratory test results, resident's response to current treatments. Document resident comments, complaints as appropriate and assessment findings in the nursing progress notes.</p> <p>R1's Nurse's Notes dated 5/19/25 document that R1 was sent to the emergency room due to a rash on his leg. R1's discharge instructions from the hospital emergency room document that he had cellulitis and was to start on oral antibiotic.</p> <p>R1's Nurse's Notes dated 5/20/25 at 5:35 PM documents Family took resident to (local emergency room).</p> <p>R1's Change in Condition Evaluation form dated 5/20/25 and filled out by V10 (Licensed Practical Nurse) documents Review Findings and Provider Notifications: This condition symptom or sign has occurred before 3. Unknown.</p> <p>On 6/23/25 at 9:00 AM V2 (Assistant Director of Nursing) confirmed that R1 was sent in on 5/20/25 (to Emergency Room) for the same thing he was sent to the emergency room for on 5/19/25, therefore, the question of this condition symptom or sign has occurred before 3 should have been marked yes instead of Unknown.</p> <p>R1's Change in Condition Evaluation form dated 5/20/25 and filled out by V10 (Licensed Practical Nurse) did not have any information under 3. Other relevant information: and summarize your observations, evaluations and recommendations.</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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's most recent blood pressure, pulse, respiration, oxygen saturation, and temperature documented on the 5/20/25 Change in Condition Evaluation were noted to be the information that was documented on the 5/19/2025 Change in Condition Evaluation form.</p> <p>R1's Most Recent Blood Glucose documented on the 5/20/25 Change in Condition Evaluation was dated 12/10/2023.</p> <p>R1's Change in Condition Evaluation form dated 5/20/25 documents were the change in condition and notifications reported to primary care clinician? Yes. Date and Time of clinician notification 5/19/2025.</p> <p>R1's Change in Condition Evaluation form dated 5/20/25 documents Name of family/resident representative notified: listed V8 (R1's Healthcare Power of Attorney) Date and time of family/resident representative notification 5/19/25.</p> <p>On 6/23/25 at 10:15 AM V2 (Assistant Director of Nursing) confirmed that the Change in Condition Evaluation form dated 5/20/25 did not contain any information in 'other relevant information' and 'summarize your observations, evaluations and recommendations.' V2 confirmed that the vital signs were from 5/19/25, confirmed that the notification of family and doctor were from 5/19/2025 and that the facility did not have any further documentation of accurate assessment sent to the emergency room and that no further documentation of doctor and family being notified of R1's transfer to the emergency room on 5/20/25.</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>Based on observation, interview and record review the facility failed to have fall interventions in place for one resident (R3) of three residents reviewed for falls in a total sample of thirteen.</p> <p>Findings Include:</p> <p>The Facility's Fall Prevention Program dated 5/2022 documents the purpose as to assure the safety of all residents in 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. Safety interventions will be implemented for each resident identified at risk.</p> <p>R3's Nurse's Notes dated 5/8/25 at 10:30 AM documents The CNA (Certified Nurse Aide) observed (R3) sitting half upright onto the buttock, near the bed.</p> <p>R3's current care plan had an entry dated 5/10/25 Add non-slip material to wheelchair.</p> <p>On 6/20/25 at 1:30 PM R3 was propelling herself in the main dining room area of the facility. R3 did not have any non-slip material to the seat of her wheelchair. V7 (Licensed Practical Nurse) was present and confirmed there was no non-slip material in R3's chair.</p>		