

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 09/17/2025
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)
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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure a resident was free from abuse when R2 was deprived of utilizing a jacket for one of three residents (R2), reviewed for abuse in a sample of 5.FINDINGS INCLUDE:The facility's Abuse Prevention and Reporting- Illinois policy, dated 11/2016, documents, 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. The policy also documents, Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. 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.A facility's Concern/Compliment Form, dated 7/18/2025, documents, Nature of concern, on 6/15/2025, V19/R2's family and V7/R2's Power of Attorney were visiting (R2) and noticed (R2) didn't have his jacket on. (R2) was asking where his jacket was because (R2) was cold. V6/Certified Nursing Assistant/CNA informed V19 and V7 that she took (R2's) jacket from him because (R2) wanted to leave the facility and was having exit seeking behaviors. V6 informed V19 and V7 that she hung (R2's) jacket in the shower room and wasn't going to give it back.On 9/16/25 at 11:05 A.M., R2 was sitting in a common area, where the room temperature was at an ambient comfortable level. R2 was wearing a medium thickness jacket with his arms curled around himself. R2 stated I am cold all the time and I like to wear my jacket most of the time. Sometimes they won't let me have my jacket. Other unidentified residents were sitting in the common areas, not wearing jackets, and they did not appear uncomfortable.On 9/16/2025 at 12:15 P.M., V7 stated on 6/15/2025 sometime after 6 p.m., me and V19 were visiting (R2) at the facility. (R2's) jacket was missing and (R2) was complaining of being cold. V7 also stated (R2) is always cold and is always wearing a jacket. I asked V6 if she knew where (R2's) jacket was and V6 told me Yes it's in the shower room, I took it because (R2) thinks he is leaving and has been trying to exit the doors. V7 stated that V6 refused to give the jacket back. (R2) was wearing a blanket wrapped around himself to try and keep warm. V7 stated (R2) lived with her for 8 years prior to nursing home placement and has always wore a jacket around the house. V7 stated she called the facility the next day and spoke to the nurse on duty and reported the incident with the jacket. V7 was unable to recall the nurses name she spoke to. V7 was told by the facility that they were unsure of where the jacket was. The jacket was never found after it was taken from (R2). (R2) was wrapping a blanket around himself to try and keep warm. V7 also stated on July 17, 2025, V19 spoke to (R2) on the phone and (R2) expressed that he was walking his laps in the hallway, and he was cold and didn't want to walk anymore since he was cold.On 9/16/2025 at 12:30 P.M., V2/Director of Nursing, confirmed on 7/18/25 she received an email concern from V19 that (R2's) jacket was taken from him by V6 because (R2) was attempting to exit the facility. V2 stated she called V6 to get her side of the story, but didn't investigate the matter any further. V2 confirmed V6 took the jacket and staff shouldn't take personal items from residents to address behaviors.On 9/16/2025 at 3:00 P.M., V15/CNA stated sometime in the middle of June, during shift change, V6 reported to me she took (R2's) jacket and hung it in the shower room. When (R2) wears his jacket (R2) exit seeks more. I did see (R2's) jacket hanging in the shower room at that time. (R2) always complains of being cold, and (R2) always wants to wear a jacket. For several weeks, back in June and July, (R2) didn't have a jacket, and we were having (R2) use a blanket to keep warm.On 9/16/2025 at 4:00 P.M., V6/Certified Nursing Assistant stated, I did take (R2's) jacket from him because of wandering behaviors. When (R2) has his jacket on (R2) exit seeks more and makes attempts to leave the unit through the inner doors and doors to the outside. V6 also stated she doesn't think (R2) should have his jacket, since it causes (R2) to have behaviors.On 9/17/2025 at 10:00 A.M., V1/Administrator confirmed V6 did take (R2's) jacket because of wandering behaviors.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was immediately reported to the Administrator and the State Agency for one of three residents (R2) reviewed for abuse in the sample of 5. FINDINGS INCLUDE: The facility's Abuse Prevention and Reporting- Illinois policy, dated 11/2016, documents Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must immediately report it to the administrator. The policy also documents, Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but no more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. A facility Concern/Compliment Form, dated 7/18/2025, documents, Nature of concern, on 6/15/2025, V19/R2's family and V7/R2's Power of Attorney were visiting (R2) and noticed (R2) didn't have his jacket on. (R2) was asking where his jacket was because (R2) was cold. V6/Certified Nursing Assistant informed V19 and V7 that she took (R2's) jacket from him because (R2) wanted to leave the facility. V6 informed V19 and V7 that she hung (R2's) jacket in the shower room and wasn't going to give it back. As of 9/17/2025, the facility has no documentation of R2's allegation of potential abuse being reported to the state agency. On 9/16/2025 at 12:30 P.M., V2/Director of Nursing stated she received the complaint form on 7/17/2025 from V19. However, she didn't notify V1/Administrator until the next day.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to investigate an allegation of potential abuse for one of three residents (R2) reviewed for abuse, in the sample of 5.FINDINGS INCLUDE:The facility's Abuse Prevention and Reporting- Illinois policy, dated 11/2016, documents, Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.A facility Concern/Compliment Form, dated 7/18/2025, documents, Nature of concern, on 6/15/2025, V19/R2's family and V7/R2's Power of Attorney were visiting (R2) and noticed (R2) didn't have his jacket on. (R2) was asking where his jacket was because (R2) was cold. V7 says (R2) lived with her for 8 years prior to nursing home placement, and (R2) always wore a jacket around the house. V6/Certified Nursing Assistant informed V19 and V7 that she took (R2's) jacket from him because (R2) wanted to leave the facility and was having exit seeking behaviors. V6 informed V19 and V7 that she hung (R2's) jacket in the shower room and wasn't going to give it back.As of 9/17/2025, the facility has no documentation of an investigation regarding R2's allegation of potential abuse.On 9/17/2025 at 10:00 A.M., V1/Administrator confirmed she did not investigate R2's allegation of potential abuse.</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>(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to use a full mechanical lift for 3 (R1, R4, R5) residents who require a full mechanical lift for transfers in a sample of 22. Findings include: The facility's policy titled Incident and Accidents-Illinois, effective 10/2024, documents not in its entirety, 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. Physical or mental mistreatment (abuse-actual or suspected) of a resident is considered an 'incident' whether or not actual injury has occurred. An 'accident' is defined as any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. The facility's policy titled Transfers-Manual Gait Belt and Mechanical Lifts, effective 4/2025, documents not in its entirety, In order to protect the safety of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents. 1. Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted. 5. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following categories: 0=Independent; 1=1 person transfer (25%/percent or less assistance from the caregiver) with gait belt; 2=2 person transfer with gait belt (ONLY when use of mechanical lift is not possible); ss=Sit to Stand Lift with 1 caregiver; H=Mechanical Lift (Hoyer) with 2 caregivers. 6. Residents transferring and lifting needs shall be documented in care plans and reviewed via care plan time frame and as needed. 7. Assessment of the resident's transferring needs shall include: a. Mobility status; b. Weight bearing ability; c. Cognitive status. 8. Failure to comply with lifting guidelines may result in disciplinary action as deemed appropriate. The Care Plan Item/Task Listing Report documents that R1, R4, and R5 all require (full body mechanical lift) for transfers. The facility Concern/Complaint Form, dated 6/11/25, documents, Resident (R1) is a (full body mechanical lift) and for 2 (two) nights in a row, she (R1) has not had a sling under her. Corrective Actions Taken- Including measures to protect resident and prevent reoccurrence: Cheat sheets for staff updated with transfer, status in-service on using (full body mechanical lift) slings on appropriate residents. The facility A and B Hall CNA (Certified Nursing Assistant) Kardex report sheets (cheat sheets) document that R1, R4, and R5 all require (full body mechanical lift) for transfers. R1's admission Record documents that R1's date of admission to the facility was 5/9/23 and her diagnoses on admission include but not limited to Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance, Schizoaffective Disorder Bipolar Type and Other Specified Disorders of Bone Density and Structure Other site. R1's Minimum Data Set assessment (MDS), dated [DATE], documents R1 is rarely/never understood, uses a wheelchair for mobility, and is Dependent for bed mobility and transfers. R1's current care plan documents, The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Dementia, Fatigue. R1's current care plan also documents, Transfer: The resident is dependent upon staff for transfers between surfaces. (Full Body Mechanical Lift) between surfaces until PT (Physical Therapy) evaluation. R1's facility investigation report documents, On 8/16/25, it was reported to the Administrator by staff that (R1), an [AGE] year-old resident with unspecified dementia with behavioral disturbances, had discoloration on her upper, right thigh and shin area. R1's facility investigation report also documents, Immediate Cause- Staff manually transferred the resident using a 2-person assist instead of using the (full body mechanical lift) as required. Contributing Factors- Lack of proper equipment setup: The resident did not have a (full body mechanical lift) sling in place under her (R1), making the lift unusable at the time of transfer. On 9/16/25 at 10:30 AM, R1 is sitting up in her high back wheelchair in dining room, dressed in clean clothes, well kempt and appears comfortable. No lift sling noted under R1 at this time. On 9/16/25 at 1:13 PM, V2 (DON) stated, Transfer status for residents will come up on POC (Point of Care) charting under Kardex. So that would show the staff how someone transfers. On 9/16/25 at 1:20 PM, V13 (Certified Nursing Assistant/CNA) stated, (R1) is usually a (full mechanical lift) but we had no clean slings to transfer her this morning so (V5/CNA) and I stood her up and transferred her to her chair. She (R1) will stand. We usually put a sling in her chair before getting her (R1) up if we don't use the (full body mechanical lift) just so she has one in there later in the day for someone else to use for transferring her (R1). But like I said previously there were no clean slings so that is why she does not have one under her today. It would be nice if everyone had their own slings, but they don't. She (R1) is a (full mechanical lift) PRN (as needed) but for anyone else that</p>		