

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 12/11/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent a resident from physical abuse by another resident for one (R3) of 5 residents reviewed for physical abuse by another resident in the sample of 8 residents reviewed for abuse. This failure has the potential to affect all 18 residents currently living in the Memory Care Unit on E Hall. Findings include: On 11/4/25 the facility notified the state agency of a resident to resident physical altercation incident that had allegedly occurred between R2 and R3 on 11/4/25 at 11:30am in the Memory Care Unit. The facility's Abuse Prevention and Reporting - Illinois policy dated 12/2025 documents the following: this facility affirms the right of our residents to be free from abuse. 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. R2's medical record documents R2 is a [AGE] year-old resident of the facility's secure Memory Care Unit. R2's medical record includes the following diagnoses: Major depressive disorder, dementia and neurocognitive disorder. R3's medical record documents R3 is an [AGE] year-old resident on the facility's Memory Care Unit and includes the following diagnoses: Alzheimer's disease and dementia. R2's current Care Plan includes the following Focus dated 9/30/25: I have a behavior problem evidenced by verbal and physical aggression towards staff and peers, threatening staff, disruptive behavior, and rummaging for food r/t (related to) diagnosis of Dementia. Interventions for this focus include: (R2) to be monitored when assisting with clean up after meals, and Minimize potential for the resident's disruptive behaviors (verbal/physical aggression, disruptive behavior, rummaging for food) by offering tasks which divert attention such as 1:1 conversation, activity, looking out window, assess for pain and administer meds as needed. The facility's Preliminary 24-Hour Abuse Investigation Report submitted to the state agency dated 11/4/25 by V6 prior DON/Director of Nursing identifies the incident of 11/4/25 at 11:30am on E Hall as alleged physical abuse to a resident (R3) by another resident (R2). This report also documents: Residents assessed with no injuries noted, will continue to monitor for any injuries or psychosocial harm. E Hall is the designated secure Memory Care Unit within the facility. R2 is the aggressor named in the incident of 11/04/25. R3 is identified as the victim of physical abuse by R2. The facility's Incident Audit Report dated 11/04/25 and by V6/prior DON/Director of Nursing documents the following interview conducted with R2 by V6 on 11/4/25 at 12:58pm regarding the altercation as follows: He (R2) stated he did hit the other resident (R3) in the eye. States he (R2) was wiping the tables and peer (R3) swiped at him (R2), and he (R2) swiped back. The Incident Audit Report also documents the following interview/statement on 11/4/25 at 12:58pm by V4, LPN/Licensed Practical Nurse: I, the nurse behind the desk. I heard a loud noise from a peer. I saw this resident (R2) cleaning and moving the table a little bit by another peer (R3). (R2) was cleaning the table where Peer (R3) was sitting heard peer (R3) say Ouch, I got up from the desk and noted to see Peer (R3) covering both eyes and state, that hurt. The facility's Final Abuse Investigation Report dated 11/10/25 documents the following Summary and Analysis of the Evidence: Staff that were interviewed stated that (R2) was assisting with clearing food off of the tables after the meal. (R2) went to clear the dinnerware from in front of (R3). R3 attempted to make physical contact to (R2). R2 made physical contact to (R3's) right eye. On 11/4/25 at 9:45am and 11:40am neither R2 nor R3 responded to greetings or queries for an interview. On 12/1/25 at 10:45am V4 LPN verified she was on duty in the Memory Care Unit/E Hall on 11/4/25 at 11:30am V4 stated on 11/4/25 at 11:30am R2 was cleaning the tables in the dining room after the lunch meal. R2 attempted to remove R3's lunch tray, R3 reached out and R2 then hit R3 in the eye. V4 stated R3 did not make physical contact with R2 when he reached out to stop R2 from removing his tray. V4 stated both residents were assessed with no injuries noted, stating a skin assessment was conducted for R3 with no injury to his face or eyes noted. On 12/11/25 at 1:50 pm V1 (Administrator) and V2 DON verified there was a resident to resident physical abuse incident on 11/4/25, when R2 struck R3.</p>		